

**CMS-1533-P-151 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter : Mr. JAMES MARX**

**Date & Time: 06/06/2007**

**Organization : BROAD STREET SOLUTIONS**

**Category : Nurse**

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

**SEE ATTACHMENT**

**CMS-1533-P-151-Attach-1.DOC**

Thank you for the opportunity to comment on *CMS-1533-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates*. The topic of providing quality medical care and preventing healthcare associated infections have been my profession for the past 28 years. I am a registered nurse and certified infection control professional (CIC) with *Broad Street Solutions*, a healthcare consulting company for acute care hospitals and long term care facilities.

The proposed payment adjustment for adverse events to one step to providing the motivation for some healthcare providers. This must be done based on science and practical application. I have reviewed the proposed topics related to health associated infections and offer the following comments:

Catheter Related Urinary Tract Infection- This was offered as event that was best example for ease in capturing the infection in a unbiased manner. One important aspect of this is the relation of time and the two conditions required. Coding is not time dependent. If the event occurs during the stay, the coder would list the event. The relationship between when a urinary catheter is inserted or removed, will effect whether the subsequent urinary tract infection was related to the presence of a urinary catheter. Infection Control Professionals (ICP) use the scientifically based Definitions of Infection, published by the Centers for Disease Control and Prevention (CDC)<sup>1</sup>. The definition for a catheter related urinary tract infection are as follows:

- Patient has at least *one* of the following signs or symptoms with no other recognized cause: fever (>38 C), urgency, frequency, dysuria, or suprapubic tenderness  
*and*  
patient has a positive urine culture, that is, 10<sup>5</sup> microorganisms per cm<sup>3</sup> of urine with no more than two species of microorganisms.
- Patient has at least *two* of the following signs or symptoms with no other recognized cause: fever (>38 C), urgency, frequency, dysuria, or suprapubic tenderness  
*And* at least *one* of the following:
  - a. Positive dipstick for leukocyte esterase and/or nitrate
  - b. Pyuria (urine specimen with 10 WBC/mm<sup>3</sup> or 3 WBC/high power field of unspun urine)
  - c. Organisms seen on Gram stain of unspun urine
  - d. At least *two* urine cultures with repeated isolation of the same uropathogen (gram-negative bacteria or *S. saprophyticus*) with 10<sup>5</sup> colonies/ mL in nonvoided specimens
  - e. 10<sup>5</sup> colonies/mL of a single uropathogen (gram-negative bacteria or *S. saprophyticus*) in a patient being treated with an effective antimicrobial agent for a urinary tract infection
  - f. Physician diagnosis of a urinary tract infection
  - g. Physician institutes appropriate therapy for a urinary tract infection
- Patient has had an indwelling urinary catheter within 7 days before the culture  
*and*  
patient has a positive urine culture, that is, 10<sup>5</sup> microorganisms per cm<sup>3</sup> of urine with no more than two species of microorganisms  
*and*

<sup>1</sup> Horan TC, Gaynes RP. Surveillance of nosocomial infections. In: Hospital Epidemiology and Infection Control, 3rd ed., Mayhall CG, editor. Philadelphia: Lippincott Williams & Wilkins, 2004: 1659-1702.

patient has *no* fever ( 38 C), urgency, frequency, dysuria, or suprapubic tenderness.

Based on these definitions, I offer the following scenarios that would both be Coded but that would not meet the CDC definitions:

- Day 1 patient has urinary catheter placed. It is removed on Day 3. The patient meets the definition of infection for a urinary tract infection on Day 12. (Only infections that occur within 7 days of removal are consider catheter related)
- Day 5 patient has a urinary catheter placed and is diagnosed by a physician with urinary tract infection. The urine culture is negative and the patient does not meet the definition of infection
- Day 4 the patient has a urinary catheter placed and on Day 5 meets the definition of infection. This infection was not present on admission and was not caused by the insertion of the catheter. (Infections that occur within 48 hours of the device being placed are not consider to be related to the device)

Urinary catheters can be placed using several different methods. Each carries a different risk of infection. The most commonly use urinary catheter is through the urethra. An urinary catheter can be placed and left in the bladder (indwelling catheter), or placed and removed after the bladder is drained (intermittent catheter). In addition, the urinary catheter can be placed through an incision made through the lower abdomen into the bladder(suprapubic catheter). These difference are clearly outlined in the CDC definitions of infection, but not in the proposed CMS Catheter Related Urinary Tract Infection.

In a 300 bed acute care hospital in Cedar Rapids, IA, we requested coding data for all patients that meet the proposed CMS Catheter Related Urinary Tract Infection. From January 2006- April 2007, there were 13 patients that met this definition. We then reviewed each patient Medical Record to see if these same people met the most recently published CDC definition of a catheter related urinary tract infection. Eleven had an infection that was present on admission and one did not meet the CDC definitions of infection. Only one patient met the CDC definition of a urine catheter related infection. As part of the routine infection surveillance program from January 2006-October 2006, the facility ICP identified 42 urine catheter related infections that were not coded using the proposed CMS methodology.

I urge CMS not to use the proposed Catheter Related Urinary Tract Infection indicator as it is currently proposed.

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619-656-7887

**CMS-1533-P-152 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mr. Bruce Blount

**Date & Time:** 06/06/2007

**Organization :** T.H.E. Brain Trust

**Category :** Individual

**Issue Areas/Comments**

**DRG Reform and Proposed MS- DRGs**

DRG Reform and Proposed MS-DRGs

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Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

Bruce Blount  
(609)758-0806

**CMS-1533-P-153 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mrs. Mary Lou Forshee

**Date & Time:** 06/06/2007

**Organization :** Mrs. Mary Lou Forshee

**Category :** Individual

**Issue Areas/Comments**

**GENERAL**

GENERAL

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a family member of a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

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When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

**CMS-1533-P-154 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mrs. Sarah Moe

**Date & Time:** 06/06/2007

**Organization :** Mrs. Sarah Moe

**Category :** Individual

**Issue Areas/Comments**

**DRG Reform and Proposed MS- DRGs**

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a {brain tumor patient or family of, caregiver of, doctor of, nurse of, a brain tumor patient, etc} and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

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When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

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**CMS-1533-P-155 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Ms. Trueda Gooding

**Date & Time:** 06/07/2007

**Organization :** Ms. Trueda Gooding

**Category :** Individual

**Issue Areas/Comments**

**DRG Reform and Proposed MS- DRGs**

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am the mother of a son fighting a glial brain tumor and know how important Gliadel wafers are in the fight against these tumors. I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

**Rationale:** The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

Trueda Gooding

**CMS-1533-P-156 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mrs. Barbara Wright

**Date & Time:** 06/07/2007

**Organization :** Mrs. Barbara Wright

**Category :** Individual

**Issue Areas/Comments**

**DRG Reform and Proposed**

**MS- DRGs**

DRG Reform and Proposed MS-DRGs

My husband has Stage 4 GBM; it is critical that patients like him should be covered to have the glio wafers to help to control the growing tumors; this is a very worthwhile procedure and way too costly for the individual patient. Please continue to cover paying for this treatment.

**CMS-1533-P-157 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mr. Thomas Harlow

**Date & Time:** 06/07/2007

**Organization :** Shamokin Area Community Hospital

**Category :** Hospital

**Issue Areas/Comments**

**Update Factors**

Update Factors

As a rural, Medicare Dependent Hospital in Pennsylvania, the impact of a number of the changes in the proposed rule will be significant. One of the most troubling changes is the 2.4% 'behavioral offset', which assumes the 'worst case scenario' without appropriate supporting data. We concur with the comments outlined in the letter from the Hospital and Healthsystem Association of Pennsylvania to Acting Administrator Norwalk.

In addition, we also support a transition period for implementation of the MS-DRG system over a four (4) year period. Such a transition will allow hospitals, such as ourselves, the opportunity to educate our employees and physicians to assure proper, accurate coding, along with allocation of required resources through our budgetary process.

Again, we concur with the comments provided by the Hospital and Healthsystem Association of Pennsylvania, and urge your serious consideration of these comments. A copy of the HAP comments will be attached for your review.

CMS-1533-P-157-Attach-1.DOC



## THE HOSPITAL &amp; HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

June 12, 2007

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

***RE: CMS-1533-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Proposed Rule***

Dear Ms. Norwalk:

On behalf of Pennsylvania's nearly 250 member hospitals and health systems, The Hospital & Healthsystem Association of Pennsylvania (HAP), welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the fiscal year (FY) 2008 hospital inpatient prospective payment system (PPS), as published in the May 3, 2007, *Federal Register*. The proposed rule builds on efforts to implement the most significant revisions of Medicare's inpatient hospital rates since 1983.

As proposed, this rule includes changes to the reimbursement system that will have a considerable impact on Pennsylvania hospitals. The proposed operating payment and capital payment reductions, as well as the additional wage index decreases, and the adjustments to DRGs are disproportionately harmful to Pennsylvania hospitals. **The total estimated reduction in payment for Pennsylvania hospitals as a result of this proposed rule is \$67.5 million in federal fiscal year 2008, and an estimated \$1.6 billion over the next five years.** Such reductions and attempts at backdoor budget cuts will only further erode our scarce resources, and challenge our hospitals that much more with respect to caring for our patients.

#### **Medicare-Severity Diagnosis-Related Groups**

One of the most prevalent changes in the proposed 2008 rule is the implementation of MS DRGs for FFY 2008. As indicated in comments submitted last year, Pennsylvania hospitals support meaningful improvements to Medicare's inpatient PPS. While it is believed that the proposed MS-DRGs provide a reasonable framework for patient classification, **as proposed there would be a redistribution of approximately \$31 million in FY 2008 for Pennsylvania hospitals.**

HAP believes a transition period is necessary to afford hospitals the opportunity to incorporate the extensive classification system, address budgetary implications, etc. To that end, **HAP urges CMS to phase-in the MS-DRGs over a four-year period.**

In addition, HAP opposes the proposed "behavioral offset" cuts related to the move to severity-adjusted diagnosis-related groups (DRGs) as well as the proposed cuts to capital payments. The proposed rule **includes a 2.4 percent reduction to both operating and capital payments in both FYs 2008 and 2009—\$1 billion over five years—to eliminate prospectively what is presumed by CMS to be classification changes that do not reflect real changes in case-mix.**

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Leslie Norwalk, Esquire  
June 12, 2007  
Page 2

**HAP contends that such a prospective reduction in payment is not justified and is a backdoor attempt at budget cuts.**

### **Capital Payment Update**

The proposed rule would eliminate the capital payment update for all urban hospitals (a 0.8 percent cut) and the large urban hospital capital payment add-on (an additional 3 percent cut). **These changes would result in a payment cut of \$27.5 million over five years to urban hospitals.**

We are opposed to these unnecessary cuts, which fail to recognize how vital these capital payments are to the ongoing maintenance and improvement of hospitals' facilities and technology. We also oppose your consideration of possible future cuts to the indirect medical education and disproportionate share hospital adjustments under the capital system. CMS should not make any cuts or other adjustments to the capital PPS.

### **Wage Index**

As proposed, most wage indices in Pennsylvania are projected to decrease. The only two regions in Pennsylvania experiencing an increase from the wage index are a result of falling below the rural floor and then being adjusted to that level. In addition, the expiration of the Section 508 provision, which had helped hospitals in Pennsylvania with significant wage index issues, causes further losses. **The combined impact on Pennsylvania hospitals of the changes to the wage index and the expiration of the 508 provisions is estimated to be a \$75 million loss.**

HAP has enclosed more detailed comments on the proposed rule, which further delineate our concerns and recommendations.

HAP appreciates the opportunity to submit these comments and recommendations. If you have any questions regarding our comments, please feel free to contact me or Melissa Speck, director for policy development, at (717) 561-5356 or [mspeck@haponline.org](mailto:mspeck@haponline.org).

Sincerely,

CAROLYN F. SCANLAN  
President and Chief Executive Officer

Attachment

**The Hospital & Healthsystem Association of Pennsylvania  
Detailed Comments on the Proposed Rule  
FY 2008 Inpatient Prospective Payment System**

**DRG REFORM AND PROPOSED MS-DRGS**

In response to payment recommendations from the Medicare Payment Advisory Commission (MedPAC) to address the proliferation of physician-owned, limited-service hospitals, the Centers for Medicare & Medicaid Services (CMS) in fiscal year (FY) 2006 began significant efforts to reform the diagnosis-related groups (DRGs) and the calculation of the corresponding relative weights. While CMS adopted cost-based weights in FY 2007, it chose not to implement proposed adjustments to the DRG classification system to further recognize severity of illness. In FY 2008, CMS proposes continuing the transition to cost-based weights and offers a refinement to the current DRG system to better account for patient severity.

The hospital field supports meaningful improvements to Medicare's inpatient prospective payment system (PPS). We believe that HAP and CMS share the common goal of refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. We also believe that the system should be simple, predictable, and stable over time. One of the fundamental values of a *prospective* payment system is the ability of providers to reasonably estimate payments in advance to inform their budgeting, marketing, staffing and other key management decisions.

Another core feature of the PPS is clinically cohesive and meaningful DRGs that are intuitive for providers and coders to follow, and that reflect similar resource use within DRGs. Ultimately, the inpatient PPS should foster innovation and best practice in care delivery. We believe that these are essential characteristics of a well-functioning PPS, and it is within these policy goals that we evaluate CMS' proposal.

However, payment changes alone will not remove the inappropriate incentives created by physician self-referral to limited-service hospitals. Even with the DRG changes proposed by CMS, physicians will still have the ability and incentive to steer financially attractive patients to facilities they own, avoid serving uninsured, Medicaid and other low-income patients, practice similar forms of selection for outpatient services, and drive up utilization. We urge CMS to address the real issue of self-referral: to rigorously examine the investment structures of physician-owned, limited-service hospitals.

**Severity of Illness**

For FY 2008, CMS proposes to refine the current DRG system by implementing Medicare-Severity DRGs (MS-DRGs), increasing the number of DRGs from 538 to 745. In addition, CMS has undertaken an overhaul of today's complication and comorbidity (CC) list and created up to three tiers of payment for each DRG based on the presence of: a *major* complication or comorbidity (MCC), a *minor* complication or comorbidity, or *no* complication or comorbidity.

Hospitals support meaningful improvements to Medicare's inpatient PPS. HAP believes that MS-DRGs represent a reasonable approach to DRG refinement. However, it is important for the field to be assured that CMS is committed to this system for the near future, and that because of the extensive changes to the system, that CMS be willing to build in the time needed to ensure

that both the agency and hospitals are adequately prepared for this significant change.

**HAP urges CMS to adopt the MS-DRGs over a four-year transition period**, as the implementation of the more extensive classification system, though budget neutral, would redistribute nationally, somewhere between \$800 million and \$900 million among hospitals. In Pennsylvania, this would equate to \$31 million among hospitals.

**HAP recommends the following four-year transition (for FY 2008—2011):**

**FY 2008**—The emphasis should be on preparation for and testing of the new classification system. This provides CMS with adequate time to finalize data and a CC list, introduce and test software for case classification and payment, including the definitions and instructions for case classification and payment, and train its fiscal agents. It also gives hospitals adequate time to implement and test the new system and adjust operations and staffing for predicted revenues. This also will allow vendors and state agencies time to incorporate such changes into their respective software and information systems.

**FY 2009**—DRG weights should be computed as a blend derived one-third from the MS-DRGs and two-thirds from traditional DRGs.

**FY 2010** —DRG weights should be computed as a blend derived two-thirds from MS-DRGs and one-third from traditional DRGs.

**FY 2011**—DRG weights should be derived using only the MS-DRGs.

The weights would be established by CMS running the “old GROUPER” from 2008 without any changes to the CC list to establish where cases originated, and running the “new GROUPER” from 2009 with the new CC list, then blending the two weights based on the schedule above. Since there is not a perfect crosswalk from the old DRGs to the new ones, the weight used for payment in a given year would be established by blending the MS-DRG weight with a volume-weighted average of the CMS-DRG weights that feed into that particular MS-DRG. Thus, only one weight would be published in advance.

While there are many other ways to transition the system, we believe that this is easiest for CMS to implement, maintains the prospective nature of the system, is equitable across hospitals, does not require any sort of subsequent reconciliation, and does not require CMS or hospitals to run more than one GROUPER the entire year. We also believe that the length of the transition is appropriate given the large amount of money shifted within the system.

#### **Behavioral Offset**

**Until MS-DRGs are fully implemented, and CMS can document and demonstrate that any increase in case-mix results from changes in coding practices rather than real changes in patient severity, there should be no “behavioral offset.”**

The proposed rule includes a 2.4 percent cut in both FYs 2008 and 2009 to eliminate what CMS claims will be the effect of coding or classification changes that do not reflect real changes in case-mix. The 2.4 percent “behavioral offset” cut is based on assumptions made with little to no data or experience, and cannot be justified in advance of making the DRG changes. **HAP**

**opposes the “behavioral offset,” which will cut payments to hospitals in Pennsylvania by \$1 billion over the next five years. We do not believe that this cut is warranted—it is a backdoor attempt at budget cuts.**

Inpatient hospitals have operated under the current DRG system for 23 years. The proposed MS-DRGs would be a *refinement* of the existing system; the underlying classification of patients and “rules of thumb” for coding would be the same. There is no evidence that an adjustment of 4.8 percent over two years is warranted when studies by RAND, cited in the preamble, looking at claims between 1986 and 1987, at the beginning of the inpatient PPS, showed only a 0.8 percent growth in case mix due to coding. Even moving from the original cost-based system to a new patient classification-based PPS did not generate the type of coding changes CMS contends will occur under the MS-DRGs.

The detailed comments below illustrate why the examples CMS uses to justify the coding adjustment are flawed. In addition, we also provide many reasons why we do not expect a significant increase in payment due to coding.

Maryland experience. In the rule, CMS uses the experience of Maryland hospitals moving to 3M’s All-Patient Refined DRGs (APR-DRGs) as a basis for the behavioral offset. However, MS-DRGs and APR-DRGs are two completely different ways to classify patients, and generalizing from one system to the other cannot be done. The existing classification rules will change only marginally with the introduction of MS-DRGs, whereas they are very different under the APR-DRG system. Differences include:

APR-DRGs consider multiple CCs in determining the placement of the patient and, ultimately, the payment. In fact, to be placed in the highest severity level, more than one high-severity secondary diagnosis is required. APR-DRGs consider interactions among primary and secondary diagnoses. Something that bumps one case type to a higher severity level might not affect another. This is not true for MS-DRGs. APR-DRGs consider interactions among *procedures* and diagnoses as well. MS-DRGs do not.

APR-DRGs have four severity subclasses for *each* base DRG, while MS-DRGs have three tiers, and this is only for 152 base DRGs—106 base DRGs only have two tiers, and 77 base DRGs are not split at all. Less than half the number of patient classifications in the MS-DRG system are dependent on the presence or absence of a CC—410 for MS-DRGs versus 863 for APR-DRGs.

All of these differences greatly reduce the possibility for changes in coding to affect payment and make the Maryland experience an invalid comparison.

IRF PPS experience. CMS also draws on the example of the inpatient rehabilitation facility (IRF) PPS to justify the coding adjustment. This is an appropriate comparison. The coding changes seen under the IRF PPS were the result of moving from a cost-based system to a PPS, not the marginal difference of moving from the existing CMS-DRGs to the refined MS-DRGs.

In addition, coding under the IRF PPS is driven by the Inpatient Rehabilitation Patient Assessment Instrument (IRF-PAI). This provides an incentive for IRFs to code in a way that differs from the inpatient PPS, which does not utilize a patient assessment instrument. Coding for the IRF-PAI differs significantly from the long-standing coding rules that inpatient PPS hospitals have followed for the following reasons:

The IRF-PAI introduced a new data item into coding—namely “etiological diagnosis.” The definition of this new diagnosis and the applicable coding rules are significantly different than the “principal diagnosis” used to determine the DRG. More importantly, the Official Coding Guidelines that apply to all other diagnostic coding do not apply to the selection of the ICD-9-CM etiologic diagnoses codes.

The Official Coding Guidelines do not consistently apply to the coding of secondary diagnoses on the IRF-PAI. Several different exceptions to the guidelines have been developed by CMS for the completion of the IRF-PAI.

The definition of what secondary diagnoses may be appropriately reported differs under the IRF-PAI from the definition used by other inpatient coders.

Greater use of codes. Most hospitals are already coding as carefully and accurately as possible because of other incentives in the system to do so, such as risk adjustment in various quality reporting systems. Analysis of Medicare claims from 2001 to 2005 suggests that hospitals have been coding CCs at high rates for many years. More than 70 percent of claims already include CCs, and more than 50 percent of claims have at least eight secondary diagnoses (the maximum number accepted in Medicare’s DRG GROUPEX). Hospitals’ assumed ability to use even more CCs under MS-DRGs is very low.

According to an article in the magazine *Healthcare Financial Management*, the level of coding on claims suggests that the presence of a CC on a bill is not strongly influenced by financial gain. The proportion of surgical cases with a CC code is higher for cases where there is no CC split and, thus, no financial benefit, than on those cases where there is a CC split and a corresponding higher payment. Thus, coding is driven primarily by coding guidelines and what is in the medical record rather than by financial incentives.

In addition, it must be recognized that many cases simply do not have additional CCs to be coded. For many claims, additional codes are simply not warranted and not supported by the medical record. Therefore, there is no opportunity for a coding change to increase payment.

**CMS should not implement a “behavioral offset” at this time.** Once the MS-DRGs are fully implemented, CMS can investigate whether payments have increased due to coding rather than the severity of patients and determine if an adjustment is necessary. CMS is not required to make an adjustment at this time, and should not do so without an understanding of whether there will even be coding changes in the first few years of the refined system. CMS can always correct for additional payments made as a result of coding changes in a later year when there is sufficient evidence and an understanding of the magnitude.

#### **Inpatient Psychiatric PPS**

We urge CMS to carefully consider the implications of its proposed MS-DRG changes on the inpatient psychiatric facility PPS; specifically, the DRGs for alcohol/drug use and the changes to the CC list.

## CAPITAL IPPS

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

For FY 2008, CMS proposes eliminating the capital update for all urban hospitals (a 0.8 percent cut) and the large urban hospital add-on (an additional 3 percent cut). However, CMS proposes to update capital payments for rural hospitals by 0.8 percent (the capital input price index). In addition, CMS is considering discontinuing the IME and DSH adjustments to capital payments.

These cuts, based solely on the discretion of the administration with no congressional direction, are unprecedented. According to MedPAC, overall Medicare margins will reach a ten-year low in 2007 at *negative* 5.4 percent. These cuts would amount to a decrease in capital payments of \$880 million nationally, and \$27.5 million for Pennsylvania hospitals, over the next five years. Hospitals cannot sustain in an already under-funded system, when faced with such reductions in payment.

Capital cuts of this magnitude will disrupt 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.

**HAP is opposed to these unnecessary cuts, which ignore how vital these capital payments are to the ongoing maintenance and improvement of hospitals' facilities and technology.**

CMS justifies the cuts based on an analysis that purports to show that hospitals are experiencing substantial positive margins under the capital payment framework. The analysis, which averages hospital inpatient Medicare capital margins for the period from 1996 to 2004, is deficient in several respects. What hospitals experienced in 1996 is irrelevant to the operating environment today, 11 years later. Looking at a snapshot rather than a full capital cycle of 15 to 20 years is misleading. The averaging system is meant to balance the high spending cycles of some hospitals with the low spending cycles of others over time, but isolating any given portion of the cycle may not achieve this. In addition, the regression establishing the capital PPS was based on total costs, not just capital costs, so CMS should be looking at total margins. As noted earlier, MedPAC estimates an overall hospital Medicare margin in 2007 of negative 5.4 percent. Whether or not hospitals experience a narrow positive margin for their capital payments is of small consequence to the hospital losing money, on average, every time it treats a Medicare beneficiary. Moreover, this should not be discussed in isolation from the overall payment effect in an effort to mask the fact that these are significant capital cuts.

CMS' analysis concludes in 2004, the year when the margin dropped to its lowest point, 5.1 percent, in the time period CMS selected—34 percent below the 2003 capital margin and 41 percent below the 2002 capital margin. Extending that trend line projects that capital margins today are negative, which should not be a surprise because it is the very same overall Medicare

margin trajectory that MedPAC has documented—a sharp and steady decline since 2002—from positive 2.4 percent to an estimated negative 5.4 percent in 2007.

Hospitals must make a healthy positive margin in low spending years in order to access loans and take on large, long-term financial obligations. Yet, CMS is suggesting that a modest capital margin (5.1 percent in 2004, and likely lower today) is excessive. In 1991, CMS even stated that hospitals must accrue profits to supplement payments in high spending years.

In addition, CMS has not fully considered the ramifications of dramatic capital cuts on the use of technology and the quality of hospital infrastructure. Reduced capital payments would make buying the advanced technology and equipment that patients expect much more difficult for the nation's hospitals, and could have the effect of slowing clinical innovation. These changes disadvantage large urban and teaching hospitals, where much of the innovation and cutting-edge research is generated. These hospitals will be even more challenged to keep up with leading technology, facilities, and patient care. Moreover, for many hospitals, investing in information technology would become even more challenging. Without these facility and technological improvements, *all* patients will be deprived of these advances. At a time when the administration and Congress are pushing for such investments, this proposal may have the opposite effect of slowing needed adoption of health information technology.

**HAP also opposes possible future cuts to the IME and DSH adjustments under the capital system.** CMS has no analysis of the impact of these proposed changes on the high-caliber medical education of our future physicians and the community-wide services on which hospitals often lose money providing, such as burn and neonatal units. It is irresponsible of CMS to make such changes without a clear understanding of the broader ramifications.

#### **DRGS: HOSPITAL-ACQUIRED CONDITIONS**

The DRA of 2005 requires CMS to identify by October 1, 2007, at least two preventable complications of care that could cause patients to be assigned to a CC DRG. The conditions must be either high cost or high volume or both, result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and be reasonably preventable through the application of evidence-based guidelines. The DRA mandates that for discharges occurring on or after October 1, 2008, the presence of one or more of these preventable conditions would not lead to the patient being assigned to a higher-paying DRG. That is, the case would be paid as though the secondary diagnosis were not present. Finally, the DRA requires hospitals to submit the secondary diagnoses that are present on admission when reporting payment information for discharges on or after October 1, 2007. CMS recently announced that the start date for coding what is present on admission would be delayed until January 1, 2008, due to technical difficulties in software programming to accept the new information.

In the proposed rule, CMS seeks comments on how many and which conditions should be selected for implementation in FY 2009, along with justifications for these selections. CMS puts forward 13 conditions it is considering, but it recommends only six conditions for implementation at this time. The six conditions are:

- Catheter-associated urinary tract infections
- Pressure ulcers
- Object left in during surgery

- Air embolism
- Blood incompatibility
- Staphylococcus aureus septicemia

HAP urges CMS to implement this policy gradually starting with a small number of conditions because there are significant challenges to correctly identifying cases that meet the criteria laid out by Congress. In addition, there are difficulties ensuring appropriate accuracy in the billing data that will enable the correct identification of the relevant cases. CMS should consider not only the criteria for selection set forth in the DRA, but also the ability of hospitals to accurately identify and code for these conditions. Some of the proposed conditions may not be feasible at this time.

Conditions to include for FY 2009. HAP believes that three of the six conditions representing the serious preventable events identified by CMS—object left in during surgery, air embolism and blood incompatibility—are appropriate conditions to include for FY 2009. Because these conditions are identified by discrete ICD-9 codes, they can be coded by hospitals. More importantly, these are events that can cause great harm to patients and for which there are known methods of prevention.

Conditions not ready for inclusion for FY 2009. The other three conditions—catheter-associated urinary tract infections, pressure ulcers, and staphylococcus aureus septicemia—present serious concerns for FY 2009. The correct identification of all three of these conditions will rely on the correct identification and coding of conditions that are present on admission. CMS proposes to rely on the present-on-admission coding that it had originally planned to implement starting October 1, 2007, but which has now been pushed back to January 1, 2008, due to technical difficulties. Implementing a present-on-admission coding indicator will be a major challenge for hospitals and will require extensive education to the hospital field including physicians.

Coding accuracy can only be achieved when physicians have been educated about the need to carefully identify and record, in an easily interpretable manner, whether pressure ulcers, urinary tract infections, or staphylococcus aureus are present on admission. To date, we are unaware of any efforts by CMS to initiate such an education process. Only after reasonable reliability in physician identification and recording of the complications that are present on admission are achieved can claims be coded in such a way that CMS could accurately identify those cases that should not be classified into the higher-paying DRGs. The two states that have undertaken the use of present-on-admission coding have reported that such educational efforts have taken 24 months or more, making it highly unlikely that CMS' plan to use present-on-admission coding for payment purposes less than a year after initiating the coding, and without any education of clinicians, would lead to the correct identification of the cases envisioned in the DRA. **We urge CMS to delay implementation of the payment classification changes for cases involving pressure ulcers, catheter-associated urinary tract infections, and staphylococcus aureus until after it has taken the necessary steps to permit accurate identification of the relevant cases.**

In addition, these conditions are high cost or high volume, but they may not always be reasonably preventable. There is good evidence to suggest that, even when reliable science and appropriate care processes are applied in the treatment of patients, not all infections can be prevented. There is concern among infection control experts that the definitions of some of these conditions need to be reviewed and updated before they can be implemented successfully in a hospital reporting

program. Additionally, we believe that hospitals face significant challenges in diagnosing these conditions accurately on admission and coding for them at that time. Specific concerns with each of the three conditions follow.

**Catheter-associated urinary tract infections**—Many clinicians believe that urinary tract infections may not be preventable after several days of catheter placement, and prevention guidelines are still debated by clinicians.

**Pressure ulcers**—It is difficult to detect stage I pressure ulcers on admission, as the skin is not yet broken, even though the tissue is damaged. The National Pressure Ulcer Advisory Panel recently released revised guidelines for staging pressure ulcers and included a new definition for a suspected deep tissue injury. Although difficult to detect initially, this condition may rapidly evolve into an advanced pressure ulcer, and it is especially difficult to detect in individuals with darker skin tones. We also are concerned that the present-on-admission coding of pressure ulcers will rely solely on physicians' notes and diagnoses, per Medicare coding rules, and cannot make use of additional notes from nurses and other practitioners. Certain patients, including those at the end of life, may be exceptionally prone to developing pressure ulcers, despite receiving appropriate care. There also is evidence of an increased risk of pressure ulcer recurrence after a patient has had at least one stage IV ulcer. If CMS decides to include pressure ulcers under the hospital-acquired conditions policy, the agency should exclude patients enrolled in the Medicare hospice benefit and patients with certain diagnoses that make them more highly prone to pressure ulcers because, in these cases, the condition may not be reasonably prevented.

**Staphylococcus aureus septicemia**—Accurately diagnosing staphylococcus aureus septicemia on admission will be a challenge. Patients may be admitted to the hospital with a staphylococcus aureus infection of a limited location, such as pneumonia or a urinary tract infection. Subsequent development of staphylococcus aureus septicemia may be the result of the localized infection and not a hospital-acquired condition. Additionally, the proliferation of changes in coding guidelines for sepsis in recent years presents further challenges to hospital coding personnel to accurately capture present-on-admission status. Finally, there is still some debate among clinicians regarding the prevention guidelines for staphylococcus aureus septicemia.

In addition, after talking with infectious disease experts, we believe the category of staphylococcus aureus septicemia is simply too large and varied to be able to say with confidence that the infections were reasonably preventable. **We urge CMS to narrow this category to include only patients for whom it is reasonably clear that the hospital was the source of the infection and that it could have been reasonably prevented.**

With regard to the seven conditions that CMS mentions in the proposed rule but does not recommend for implementation, we agree that these conditions cannot be implemented at this time because of difficulties with coding or a lack of consensus on prevention guidelines.

Further, HAP feels that implementation of three of the six conditions representing the serious preventable events identified by CMS—object left in during surgery, air embolism, and blood incompatibility would align with our Pennsylvania Department of Public Welfare initiative for reduction in payment of preventable conditions.

Unintended consequences. HAP encourages CMS to consider the unintended consequences that might arise from implementing the hospital-acquired conditions policy. Trying to accurately

code for urinary tract infections that are present on admission may lead to excessive urinalysis testing for patients entering the hospital. The necessity to complete diagnostic tests before a patient is admitted to confirm present-on-admission status could lead to delayed admissions for some patients and disrupt efficient patient flow. In addition, HAP contends that there would likely be an increase in use of antibiotics for treatment, leading to antibiotic-resistant organisms.

Other technical clarifications. HAP would like clarification from CMS on how hospitals may appeal a CMS decision that a particular patient falls under the hospital-acquired conditions policy and is not eligible for a higher complication or comorbidity DRG payment.

## HOSPITAL QUALITY DATA

The DRA expanded quality reporting requirements for hospitals to be eligible to receive a full market basket update. The DRA provided the Secretary with the discretion to add quality measures that reflect consensus among affected parties and replace existing quality measures on the basis that they are no longer appropriate. In the proposed rule, CMS puts forward five new measures—four process measures and one outcome measure—to be included for the FY 2009 annual payment determination. To receive a full market basket update, hospitals would have to pledge to submit data on these and all measures currently included in the Hospital Quality Alliance's (HQA) public reporting initiative for patients discharged on or after January 1, 2008.

New quality measures. HAP is in agreement with CMS proposing to add only measures that have been adopted by the HQA for public reporting in FY 2009. The HQA's rigorous, consensus-based adoption process is an important step towards ensuring that all stakeholders involved in hospital quality—hospitals, purchasers, consumers, quality organizations, CMS and others—are engaged in and agree with the adoption of a new measure, and CMS should continue to choose from among the measures adopted by the HQA in linking measures to payment. The measures proposed for FY 2009 are well-designed, represent aspects of care that are important to patients, and provide insights into the safety, efficiency, effectiveness, and patient-centeredness of care.

Adoption by the HQA is only one of three criteria that we believe all new measures included in the pay-for-reporting program should fulfill. In addition to HQA adoption, all measures should be endorsed by the National Quality Forum (NQF) through its consensus review process. We appreciate CMS' statement that, should any of the measures proposed for FY 2009 not receive NQF endorsement by the time of publication of the final rule, they will not be adopted for FY 2009. Finally, prior to inclusion in the pay-for-reporting program, all measures should undergo a field test to identify any operational issues and assess the degree to which the measures can be implemented successfully by hospitals and data vendors.

Because we believe that all measures for public reporting should be adopted by the HQA, endorsed by the NQF, and tested in the field before implementation, we have concerns with some measures listed by CMS for possible implementation for FY 2009 or subsequent years because they do not fulfill these criteria. We urge CMS to carefully evaluate the value of the measures considered for reporting. Measures should be evidence-based, contribute to the comprehensiveness of performance measurement, be under a hospital's control, and account for potential unintended consequences. We recommend that CMS only propose and select measures that meet all of these conditions. **If the measures are NQF-endorsed and HQA-adopted, CMS can be assured that they meet these conditions. Therefore, CMS should only choose measures that have been selected by these two groups.**

The NQF currently is developing national quality goals. **We believe that CMS should look to the NQF goals as a framework for the types of measures that should be included in the pay-for-reporting program.** The HQA has agreed that the NQF's national goals should provide a foundation for its future work. CMS should indicate its intent to follow the national goals as well.

We commend CMS for including in the proposed rule the measures that hospitals will be required to report to receive their full FY 2009 inpatient payments, as this early notice allows hospitals sufficient time to establish the proper data collection processes. **We urge CMS to continue with this timely rulemaking to notify hospitals of the reporting requirements for the next fiscal year.**

Measure maintenance. HAP believes it is critical that the measures included in the pay-for-reporting program represent best clinical practice. Therefore, we are pleased that CMS recognizes that there may be a need to retire, replace, or revamp reporting measures. Currently, CMS and the Joint Commission have a process for reviewing measures and identifying modifications that should be made as a result of changes in scientific evidence. **As a process is developed to retire or replace measures for the pay-for-reporting program, we urge them to include hospitals, data vendors, and other stakeholders.** When amending measures, CMS and the Joint Commission should take into account the ability of hospitals, the data warehouse, and data vendors to successfully and quickly implement changes in reporting measures. In particular, to understand the effects that reporting changes have on hospitals, CMS should seek input from hospital data collection personnel as a part of the measure review process.

In addition to establishing a process for retiring or replacing measures, **CMS should develop a policy for suspending measures when there is a change in science or an implementation issue** arises during a reporting period and needs to be addressed immediately. For example, in past years, influenza vaccine shortages have precluded hospitals' ability to perform well on a measure. More recently, the NQF endorsed as a measure the percentage of pneumonia patients receiving initial antibiotics within six hours of arrival at the hospital. This measure replaced a similar one regarding the receipt of antibiotics within four hours of arrival. The four-hour measure is no longer endorsed by the NQF due to clinical concerns that, within this shorter time frame, some patients whose pneumonia diagnoses were not yet confirmed were receiving antibiotics unnecessarily. Despite the fact that the four-hour measure is no longer endorsed by the NQF, it continues to be included as a measure for Medicare's pay-for-reporting program. We urge CMS to prioritize the development of a policy to address these situations.

## **OCCUPATIONAL MIX ADJUSTMENT**

By law, CMS must collect data every three years on the occupational mix of employees from hospitals subject to the inpatient PPS in order to construct an occupational mix adjustment to the wage index to control for the effect of hospitals' employment choices—such as greater use of registered nurses (RNs) versus licensed practical nurses or certified nurse aides—rather than geographic differences in the costs of labor.

Hospitals collected the hours and wages of employees from January 1 through June 30, 2006. CMS proposes to use these data in adjusting the FY 2008 area wage index. CMS also requested

comments on what occupational mix adjustments to use for hospitals that did not turn in the data and whether to penalize such hospitals in the future.

For FY 2008, we believe that CMS' proposal to use the area's average adjustment for non-responsive hospitals and the national average adjustment for non-responsive counties is reasonable. For FY 2009 and beyond, because data from all hospitals is needed to construct an accurate national average hourly wage, full participation is critical. **We urge CMS to construct an application of the occupational mix adjustment that encourages hospitals to report but does not unfairly penalize neighboring hospitals. We also encourage CMS to establish some sort of appeal process for hospitals with extenuating circumstances.**

## **WAGE DATA**

CMS expanded its collection of contract labor with cost reporting periods beginning on or after October 1, 2003, to include administrative and general (A&G), housekeeping, dietary, and management and administrative services. The FY 2008 wage index, based on FY 2004 cost report data, marks the first year CMS can determine what the impact would be if it included such costs in the wage index. CMS contends that the data are reasonable and accurate, and that the vast majority of hospitals would not be affected by the change. Thus, CMS proposes to include such contract labor costs in the wage index for FY 2008.

However, we believe that the impact is greater than suggested by CMS due to an error in the calculation. We agree that lines 22.01 (Contract A&G Services), 26.01 (Contract Housekeeping Services), and 27.01 (Contract Dietary Services) are and should be included in Step 4. The purpose of Step 4 is to allocate a portion of overhead wages and wage-related costs to the excluded areas, and then to subtract a commensurate amount from wages and wage-related costs included in the wage index. However, while line 9.03 (Contract Management and Administrative) was included in the total wages in Step 2, lines 22.01, 26.01, and 27.01 were not. This results in a double negative effect. First, the contract labor for those three lines was never included. And second, a portion of those same costs are being subtracted from the wages and wage-related costs included in the wage index.

**CMS should fix the calculation and then reassess the impact on hospitals. In addition, a transition should be considered if the impact on any individual hospital is great.**

## **WAGE INDEX**

In FY 2009, CMS is required by law to consider changes to the area wage index. HAP agrees that the wage index is not functioning, and alternatives should be considered. There are some fundamental concerns with the wage index, as well as with MedPAC's recommendation which CMS should take into account as deliberation begins over the next year. AHA convened a workgroup, which was comprised of many state, regional, and metropolitan hospital association executives as well as other national hospital associations to rank concerns related to wage index. HAP concurs with the concerns listed below, in particular the apparent self-perpetuation in which hospitals with low wage indices are unable to increase wages to become competitive in the labor market.

- ✓ Volatility of wage index year to year.
- ✓ Self-perpetuating—hospitals with low wage indices are unable to increase wages to become competitive in the labor market.
- ✓ Unrealistic geographic boundaries.
- ✓ Geographic boundaries create “cliffs” where adjacent areas have very different indices.
- ✓ Inaccurate measure of actual labor costs.
- ✓ Fiscal intermediaries are inconsistent in their interpretations.
- ✓ Hospitals can be penalized for erroneous data submitted by other hospitals in the same geographic area.
- ✓ Exclusion of some personnel from the wage index calculation—outsourcing of low-wage workers raises an area’s wage index.
- ✓ Regarding MedPAC’s recommendation, which will be released in its June report, the AHA workgroup had the following concerns.

Data source. MedPAC considered the use of Bureau of Labor Statistics (BLS) data rather than the hospital-reported data collected on CMS’ Medicare cost reports. While this approach may be significantly less burdensome for hospitals, there are critical differences between the two data sets that must be carefully evaluated. The new data source is the cornerstone of the MedPAC approach and represents a fundamental change. Many of the other aspects of the draft proposal possibly could be applied using hospital wage data as it is currently collected. Key differences between the CMS and BLS methodologies include:

**Inclusion of non-hospital employers**—The BLS wage data for a particular occupation are collected from *all employers*, not just short-term, acute-care hospitals participating in Medicare. Wage rates, however, vary depending on the type of employer (hospital, nursing home, physician office, insurance company, university, etc.), and the mix of employers varies by market. Thus, wage rates will be influenced by the specific mix of hospital vs. non-hospital employers of the same occupations. For example, the mean hourly wage of an RN working in a general medical and surgical hospital in 2005 was \$27.80 compared to \$24.76 for an RN working in a nursing care facility, according to BLS. Consequently, the BLS data may not be an accurate reflection of labor costs experienced by hospitals in communities with a higher proportion of other types of health care organizations.

In addition, section 1886(d)(3)(E) of the *Social Security Act* specifies that the wage index must be based on data from “subsection (d) hospitals.” The BLS data set would need to be altered to remove the wages and hours for non-inpatient PPS providers to satisfy this requirement, or the law would have to be changed to accommodate the use of BLS data.

**Different treatment of certain types of personnel in wage data collection**—Wages paid by companies that offer temporary employees to health care providers are included in the BLS sample. Thus, contract workers are included. However, their wages reflect the lower rate that the

employees are paid *by* the agency as opposed to what the hospitals pay *to* the agency for the contract workers. This may understate labor costs in shortage areas with high use of registry nurses.

In addition, there are employee wages included in the current CMS data that are not included in the BLS data, such as Part A physicians' time unrelated to medical education. This may materially affect wage estimates in areas with a high penetration of teaching hospitals, particularly those that have provider-based clinics where employed physicians provide care not associated with teaching residents.

**Process to review/verify data**—Unlike CMS' public process for review and correction of wage data at the hospital level, BLS has a strict confidentiality policy that ensures that the sample composition, lists of reporting establishments, and names of respondents are kept confidential. Hospitals would be unable to verify the accuracy of the data.

**Not designed to capture differences in wage growth between geographic areas**—Every six months, BLS surveys 200,000 establishments ("a panel"), building the full sample of 1.2 million unique establishments over a three-year period. The data collected at each of these different points in time is combined on a rolling basis to create the annual estimate. For example, the May 2005 release of wage data is built from data collected in November 2002, May, and November 2003, May and November 2004, and May 2005.

Before estimates can be released, the five previous panels must be adjusted to the current reference period. Using the example above, the data collected in November 2002 and for each subsequent panel would need to be inflated to May 2005. This is done using a "single national estimate" of wage growth for broad occupational divisions, called the *Employment Cost Index*. This approach fails to account for any differences in wage growth between markets over the three-year period. As BLS notes, "*This procedure assumes that there are no major differences [in wage growth] by geography, industry, or detailed occupation.*"

**Pay-period rather than full-year data**—While CMS collects wage data for a 12-month period, the BLS survey captures only two payroll periods per year—one in May and the other in November—each capturing data from one-sixth of the total number of sampled establishments. (As noted above, data from six panels—with one survey every six months—are combined on a rolling basis over a three-year period to create the annual estimate.)

**BLS excludes the cost of benefits** – According to the HAP Annual Survey, benefits represent over 25 percent of hospitals' labor costs nationally. Looking across states, this percentage varies from a low of 18 percent to a high of 31 percent. Therefore, any adjustments made to include benefit costs would have to be market-specific. If benefits information is to be added, it would have to be collected on CMS' Medicare cost report in order to adjust the BLS data. This would negate the potential benefit of eliminating the collection of hospital-specific wage data.

**BLS excludes pay counted by CMS**—The BLS data excludes shift differentials, overtime pay and jury duty—all of which CMS includes. Overtime pay can be a cost associated with local labor shortages, and shift differentials can vary as well, depending on local labor market conditions.

**Full-time and part-time employees are equally weighted**—While CMS collects both wages and hours, BLS collects a count of workers within a series of wage ranges. The survey makes no distinction between full-time and part-time workers in estimating wage rates from the data collected. To the extent that the use of part-time versus full-time workers varies by market or type of employer, this could distort the wage calculation if part-time hourly wages are lower than full-time wages.

**Data subject to sampling error**—Estimates using a sampling methodology like the BLS approach are going to be less reliable than using the entire universe of PPS hospitals, as is done by CMS. Both surveys would be subject to a non-sampling error (e.g., errors from respondents providing incorrect data). However, the CMS process allows for extensive public scrutiny of the data while the BLS approach does not.

#### Geographic boundaries.

**Current geographic boundaries**—The current wage index methodology, with the exception of some commuting pattern adjustments, assumes that there is no interrelationship between areas. By simply being on opposite sides of a geographic boundary, two hospitals can have very different reimbursement, even though they are competing for the same workforce. More refined areas—as in MedPAC’s proposal to vary wage indices by county—may be more realistic and less arbitrary. On the other hand, the “smoothing” approach, whereby wage index values or wages of neighboring areas are artificially constrained to allow only a 10 percent difference in wage indices, may mask actual variation in wages between areas. For example, there may be real, greater differences between outlying counties and an urban core.

In addition, MedPAC plans to use the decennial census to determine variation between the counties. So, for 2008, MedPAC would use the 2000 census data to establish the relationship between counties within a metropolitan statistical area until the 2010 census is available. Using data this old may create differences in wage indices that are inconsistent with the actual difference experienced in wages.

**Single rural area wage index**—While a single wage index for all rural areas of a state may be reasonable for small states, it may not adequately reflect wage variation in large states. While varying the wage indices within rural areas may make sense, we recommend further examination of MedPAC’s approach as to whether the decennial census data—now seven years old—produces accurate estimates of current area wage differences.

**Year-to-year volatility**—Volatility in wage indices from one year to the next makes it difficult for hospitals to estimate Medicare payments for budgeting purposes. While the three-year rolling average employed by BLS may reduce volatility, alternative approaches should be examined, including those that do not rely on BLS data.

#### **RURAL FLOOR**

CMS proposes applying the budget-neutrality adjustment associated with the rural floor to the wage index rather than the standardized amount in FY 2008. While it considered both an iterative process and a uniform reduction, the agency said the uniform reduction is operationally easier and results in the same wage indices.

HAP supports this move assuming that it removes the compounding effect of applying the budget-neutrality adjustment for the rural floor to the standardized amount annually since 1998. We believe that it was an unintended error to repeatedly apply the rural floor budget-neutrality adjustment without first reversing the prior year's adjustment as is done with the outlier calculation each year. We also suggest that CMS remove the effects of the adjustments made from 1999 through 2006 by increasing the positive budget-neutrality adjustment proposed to the standardized amount intended to just reverse the 2007 adjustment.

## **PHYSICIAN OWNERSHIP IN HOSPITALS**

The proposed rule would require that all physician-owned hospitals at the beginning of an admission or outpatient visit disclose to patients that physicians have an ownership interest or investment in the hospital and offer to make a list of physician investors available on request. The beginning of an admission or outpatient visit is defined to include pre-admission testing or to require registration. Such hospitals also would have to require, as a condition for medical staff privileges, that physician investors disclose to their patients that they have an ownership interest when they refer patients to the hospital for services. **HAP supports implementation of a physician-ownership disclosure requirement.**

There are several specific aspects of the proposal that deserve comment:

**Locus of requirement**—CMS asked whether the requirement should be located in the provider agreement or conditions of participation. **We recommend that the ownership disclosure requirement be incorporated into provider agreements** because the conditions of participation should be focused on care delivery standards.

**Scope of requirement**—CMS asked whether the definition of a “physician-owned hospital” should exclude physician ownership or investment interests based on the nature of the interest, the relative size of the investment, or the type of investment (e.g., publicly-traded securities and mutual funds). **We recommend that the only exception to the definition of a “physician-owned hospital” be when physician ownership is limited to holding publicly-traded securities or mutual funds that satisfy the requirements for the exception under §411.356(a),(b). We oppose any exception based on the size of investment.** It is important for patients to know whenever there is a duality of interest on the part of their physician that could cause a conflict of interest in making decisions about their care. The size of that interest is immaterial to the fact that the conflict may exist.

**Definition of the beginning of an admission or outpatient visit**—The “beginning of an inpatient admission or outpatient visit” specifically includes pre-admission testing and registration. **We recommend that the definition be clarified to include scheduling as well as pre-admission testing and registration.** Patients should receive these disclosures at the earliest opportunity so that they have an ability to act on the information if they choose.

**Provision of list of physician investors**—The proposal would require that physician-owned hospitals offer to provide patients with a list of the physician investors on request, but does not establish any time frame for doing so. **We recommend that the list be provided to patients at the time the request is made.** We believe providers should be able to provide the list immediately upon inquiry, so that patients would get the information in time to consider it.

## PATIENT SAFETY MEASURES

As part of the DRA-required report to Congress, CMS also raised the issue of the safety of patients in physician-owned specialty hospitals. Recent events and media coverage of safety concerns also have highlighted problems. The proposed rule would address these issues in several ways:

Require a written disclosure to patients of how emergencies are handled when the hospital does not have a physician available on the premises 24 hours a day, 7 days a week; and seek comment on whether current requirements for emergency service capabilities in hospitals both with and without emergency departments (EDs) should be strengthened in certain areas, including required staffing competencies, certain equipment availability, and required 24-hours-a-day, 7-days-a-week ED availability.

While these requirements may sound reasonable, we believe they miss the mark on the real issue to be addressed: safety concerns in physician-owned specialty hospitals.

It makes sense to apply special requirements like these to physician-owned specialty hospitals, but not to all hospitals. The reason: The safety concerns that have been raised with physician-owned specialty hospitals occur because these facilities operate outside the traditional network of care delivery in this country. They are free-standing facilities, are generally not part of a larger system of care, most often have no transfer agreements with other hospitals or providers of care in a community, and tend to specialize in one type of care delivery, challenging their ability to treat the unexpected event or emergency.

This is not the case with full-service community hospitals. Full-service community hospitals are part of a network of care in their community, involving referrals from local physician practices, reliance on local trauma support networks, participation in local emergency medical transport systems, and transfer agreements among facilities. Even small and rural hospitals located in more remote areas are part of a planned network of care and patient triage. Small and rural hospitals often stabilize and transport patients to other facilities, but that transport is communicated, the receiving hospital is alerted, and the patient's clinical information collected at one hospital goes with the patient to the next hospital. Small and rural hospitals also are often connected to a system of care through telemedicine, which allows for access in more remote areas to specialists and other clinical expertise available at larger, more urban hospitals. **Applying additional requirements for this group of hospitals is unnecessary and costly.**

The broader network of care delivery, of which full-service community hospitals are a part, is the best way to ensure that care is provided to patients at the right time and in the right setting.

The kinds of requirements discussed in the proposed rule can be used to assure that physician-owned facilities, in the absence of being a part of the broader care network, meet minimum standards for patient safety.

## IME ADJUSTMENT

In the FY 2007 final rule, CMS finalized a policy to exclude residents' time spent in non-patient care activities from the resident count for purposes of IME (in all settings) and direct graduate medical education (in non-hospital settings) payments. Since that time, the agency has received

questions about the treatment of vacation or sick leave and orientations. While recognizing that this time is neither devoted to patient care nor non-patient care, but rather a third category, the proposed rule would treat vacation and sick time differently than it would treat orientation time. Orientation time would continue to be included as part of the full-time equivalent (FTE) count, as it always has.

Under the proposed rule, vacation and sick time would be removed from the total time considered to constitute an FTE resident. Thus, it would be removed from both the numerator and denominator of the FTE calculation. CMS acknowledges that this would result in lower FTE counts for some hospitals and higher counts for other hospitals, solely because of this regulatory change.

HAP appreciates CMS' efforts to clarify its policies, and its attempt to not penalize hospitals for offering sick and vacation leave for its residents. However, CMS' proposal is operationally impractical. Hospitals would not only have to keep track of the leave for each resident, but then somehow apportion the leave to each of the hospitals the residents rotate through. **We recommend that CMS instead treat sick and vacation leave similarly to how it proposes to treat orientation time as part of the FTE count.** We do not believe that it is necessary for CMS to parse each hour of residents' time; otherwise lunch hours and other exceptions would have to be considered. The vast majority of time counted in the FTEs is related to patient care, and any further changes would have minor effects, nationally speaking, while having major implications at the individual hospital level.

#### **REPLACED DEVICES**

In the calendar year 2007 outpatient PPS final rule, CMS adopted a policy that requires a reduced payment to a hospital or ambulatory surgical center when a device is provided to them at no cost. Similarly, CMS believes that payment of the full inpatient PPS DRG in cases in which the device was replaced for free or at a reduced cost-effectively results in Medicare payment for a non-covered item.

Unlike the current outpatient PPS policy (which applies only when a device is provided at no cost), CMS proposes to reduce the amount of the Medicare inpatient PPS payment when a full or partial credit towards a replacement device is made or the device is replaced without cost to the hospital or with full credit for the removed device. However, CMS proposes to apply the policy only to those DRGs under the inpatient PPS where the implantation of the device determines the base DRG assignment (22 DRGs), and situations where the hospital receives a credit equal to 20 percent or more of the cost of the device.

CMS also proposes to use new condition codes to report the use of such devices to trigger manual processing by the FIs. The hospital would be required to provide paper invoices or other information to the FI (or Medicare Administrative Contractor) indicating the hospital's normal cost of the device and the amount of the credit received. In cases where the device is provided without cost, CMS proposes that the normal cost of the device will be subtracted from the DRG payment. In cases where the hospital receives a full or partial credit, the amount credited will be subtracted from the DRG payment.

CMS justifies this change by noting that "in recent years, there have been several field actions and recalls with regard to failure of implantable cardiac defibrillators and pacemakers." Although

HAP does not dispute this fact, we believe it ignores the underlying concept of the DRG payment system.

DRG payments are fundamentally based on averages of historical costs and charges. To reduce the payment for cases involving replacement of a medical device assumes that either these types of cases have not occurred in the past or are occurring at such a dramatic increase as to materially skew the averages used to develop the DRG weights. In fact, CMS notes that "we believe that incidental device failures that are covered by manufacturers' warranties occur routinely." This statement acknowledges that incidental device failure has occurred in the past and was likely covered by the manufacturer warranty. If so, this practice is part of the historical cost and charge data used to develop the current DRG weights for cases involving implantation. Reducing payment for certain cases involving a re-implantation would ignore the average DRG weight for those cases that already implicitly include this reduction. **Therefore, we ask CMS to reconsider implementing this proposal.**

**However, if CMS implements this policy, we agree that it should limit the number of DRGs to which the policy applies. In addition, we agree that insignificant credits or refunds should not trigger this policy. However, CMS should consider raising the proposed threshold from 20 percent to greater than 50 percent or the majority of the cost of the device.** Given the administrative burden of manually processing these claims, it is not worth the burden on the hospitals' or FIs' part if only a nominal portion of the cost of the device is at issue. In addition, inpatient PPS payments are often less than costs. If CMS implements this policy, **estimated costs should be calculated from the charges on the claims and only reduce the DRG payment by the device cost if the payment is greater than the cost of the case less the cost of the device.**

## **NEW TECHNOLOGY**

Section 503 of the *Medicare Modernization Act* (MMA) provided new funding for add-on payments for new medical services and technologies and relaxed the approval criteria under the inpatient PPS to ensure that the inpatient PPS would better account for expensive new drugs, devices, and services. However, CMS continues to resist approval of new technologies and considers only a few technologies a year for add-on payments. **HAP also is disappointed that CMS has not increased the marginal payment rate to 80 percent rather than 50 percent, consistent with the outlier payment methodology.**

HAP is also concerned about CMS' ability to implement add-on payments for new services and technologies in the near future. Recognizing new technology in a payment system requires that a unique procedure code be created and assigned to recognize this technology. The ICD-9-CM classification system is close to exhausting codes to identify new health technology and is in critical need of upgrading.

Since the early 1990s, there have been many discussions regarding the inadequacy of ICD-9-CM diagnoses and inpatient procedure classification systems. ICD-10-CM and ICD-10-PCS (collectively referred to as ICD-10) were developed as replacement classification systems.

The National Committee on Vital and Health Statistics (NCVHS) and Congress, in committee language for the MMA, recommended that the Secretary undertake the regulatory process to upgrade ICD-9-CM to ICD-10-CM and ICD-10-PCS. Congress' call for action recognized that

procedure classification codes serve to identify and support research and potential reimbursement policies for inpatient services, including new health technology, as required under the *Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000*.

To date, despite these recommendations, as well as the recommendations of several federal health care agencies and offices and health care trade and professional associations, the Department of Health and Human Services (HHS) has not yet moved forward to adopt the ICD-10 classification upgrades. Absent a switch to ICD-10 soon, hospitals will experience significant coding problems that will affect the efficiency of the current coding process, adding significant operational costs. In addition, failure to recognize this looming problem will only impede efforts to speed the adoption of electronic health records.

At the April 2005 ICD-9-CM Coordination and Maintenance (C&M) committee meeting, many expressed the need to start limiting the creation of new procedure codes in order to allow the classification system to last at least two more years. ICD-9-CM procedure code categories 00 and 17 were created to capture a diverse group of procedures and interventions affecting all body systems. The establishment of these code categories represented a deviation from the normal structure of ICD-9-CM and a stopgap measure to accommodate new technology when no other slots in the corresponding body system chapters (e.g., musculoskeletal system, circulatory system, etc.) were available. The plan was to use codes in chapter 00 first and then begin populating chapter 17.

Category 00 is now full, and the C&M committee is entertaining proposals for codes in category 17. At the April 2005 C&M meeting, a proposal was presented that would, in effect, leave only 80 codes available in this category. In order to conserve codes, this proposal was rejected and replaced instead with three codes that did not provide information as to what part of the body the surgery was performed on. Many of the specific body system chapters are already filled (e.g., cardiac and orthopedic procedures). In recent years, as many as 50 new procedure codes have been created in a single year. This means that it is possible for ICD-9-CM to completely run out of space in less than a year. We concur with the NCVHS recommendation to issue a proposed rule for adoption of ICD-10. We also would support an implementation period of at least two years.

**We strongly recommend that the Secretary expeditiously undertake the regulatory process to replace ICD-9-CM with ICD-10-CM and ICD-10-PCS.** HHS should take the necessary steps to avoid being unable to create new diagnosis or procedure codes to reflect evolving medical practice and new technology. It is easier to plan for this migration than to respond to the significant problems that will likely result in unreasonable implementation time frames. It is imperative that the rulemaking process start immediately.

Thank you for your consideration of this important matter!

**CMS-1533-P-159 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mr. James T. Kirkpatrick

**Date & Time:** 06/07/2007

**Organization :** Massachusetts Hospital Association

**Category :** Hospital

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-1533-P-159-Attach-2.PDF

CMS-1533-P-159-Attach-1.DOC

CMS-1533-P-159-Attach-3.PDF



#159

Massachusetts Hospital  
Association

June 5, 2007

Leslie Norwalk  
Acting Administrator  
Centers for Medicare and Medicaid Services (CMS)  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

**RE: CMS-1533-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Proposed Rule.**

Dear Ms. Norwalk:

The Massachusetts Hospital Association (MHA), on behalf of our member hospitals and health systems, appreciates this opportunity to comment on the proposed rule for the FY 2008 Inpatient Prospective Payment System (IPPS). *We will be submitting comments on other aspects of the proposed rule- this letter contains our comments on the proposal for allocating the wage data of multicampus hospitals. In this letter, we comment on the multicampus hospital wage data issue and provide specific suggestions for achieving the appropriate wage data allocation.*

Wage Index for Multi-Campus Hospitals:

Congress' intent in establishing the area wage adjustment under PPS was to pay hospitals at rates that reflect the relative wage levels of the labor markets in which the hospitals are located. To fulfill this intent, it is necessary that the wage adjustment applied to payments for hospitals in a given area reflect the wages of all the hospitals and hospital campuses located in that area. Conversely, the wage adjustment for hospitals in a given area should not include data from hospitals, or hospital campuses, which are not located in that area. CMS does have the responsibility to use the authority granted to it to ensure that Congress' intent in establishing payment policy is met.

Yet in the case of the Boston-Quincy wage area, the wage index is calculated using data including the two Bristol County campuses of Southcoast Hospitals Group, despite the fact that the Bristol County campuses are located in another wage area. We further note that Medicare services provided by these campuses are not paid by Medicare at the Boston-Quincy wage index. Another definitive indication of the current policy contradiction with regard to treatment of this multicampus hospital is that its Bristol County campuses have been reclassified by the Medicare Geographic Classification Review Board to the Boston-Quincy CBSA. *We strongly appreciate and support CMS' recognition that this policy contradiction must be corrected by reallocating the multicampus hospital's wage data among the two affected wage areas for purposes of accurately calculating Medicare wage indexes.* Specifically, this reallocation will allow the wage data for the two Southcoast hospital campuses located in Bristol County to be removed from the calculation of the Boston-Quincy Wage Area Index.

We are hopeful that CMS will continue to be flexible regarding the methodology that will be used to implement this important proposal, particularly for this "transition" year when the time to respond is limited to the 60 day comment period.. The solution proposed by CMS would carve out the wage data for those campuses that are not located in the Boston-Quincy CBSA (in the case of Massachusetts) by using FTE data. However, it may be more difficult to collect this data in the short

timeframe allowed for purposes of FFY 2008 than anticipated by CMS, especially in the case of hospitals that have fully integrated operations. For instance, a large number of hospital employees in multi-hospital campuses do not work at a single location but provide services to all locations and such hospitals have difficulty deciding how to count the employees that are serving more than one campus. Given that hospitals are encountering difficulty in compiling and submitting the requested FTE data by the comment period deadline we request flexibility from CMS in allocating wage data for this "transition" year, after which the necessary reporting changes can be made to accurately allocate wage data. *In the event that the hospital is unable to comply with the FTE data request in time, we urge CMS to use an alternative allocation methodology.*

We believe that there are at least three much less administratively burdensome methods, using readily accessible official data (i.e., submitted to government agencies or contractors), which can be used to apportion such a hospital's wages to each of its campuses:

The first two options use data from the Provider Statistical and Reimbursement System (PSR). This report provides the strongest documentation possible since it comes directly from the hospital's Fiscal Intermediary and has information specific to each provider number: therefore it would separately identify Medicare discharges and associated reimbursement from Southcoast's Plymouth County campus and discharges and reimbursement from its Bristol County campuses. The relevant information is contained in **Report # OD44203, Report Type 110 and Report Title: "Provider Summary Report, Inpatient - Part A, Prospective Payment Provider"** and **"Summary Report #OD44203, Report Type 998"** for outpatient reimbursement. These reports are available for each year that the campuses were split by provider numbers, starting in 2006. A sample copy of each report is attached. We believe the PSR data provide two options to allocate Southcoast's wage data between the Boston-Quincy campus (one provider number) and the two (combined) Bristol County campuses (another provider number):

Option 1: Count of Medicare Discharges from each campus

- Report # OD44203, Report Type 110 and Report Title: "Provider Summary Report, Inpatient - Part A, Prospective Payment Provider"
- Data element to be used: Raw count of Medicare discharges at each campus
- Divide Bristol County campus discharge count by total Medicare discharges for all Southcoast campuses to derive percentage of Southcoast wages and hours to be removed from the Boston-Quincy wage area.

Option 2: Medicare Inpatient and Outpatient Reimbursement Total inpatient and outpatient reimbursement may be a better allocation basis since it reflects relative intensity of service. For this, two PSR data reports would be needed:

- Report # OD44203, Report Type 110 and Report Title: "Provider Summary Report, Inpatient - Part A, Prospective Payment Provider" for inpatient reimbursement; Data Elements to be used: Inpatient Gross Reimbursement
- PLUS from "Summary Report #OD44203, Report Type 998" for outpatient reimbursement; data element to be used: Outpatient Gross Reimbursement: the "Total" row should be used.
- Sum Inpatient and Outpatient reimbursement to Bristol County campuses.
- Divide total Bristol County reimbursement by Total Southcoast Reimbursement (i.e., all campuses) to derive percentage of Southcoast wages and hours to be removed from the Boston-Quincy wage area.

**CMS-1533-P-158 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mrs. JoAnn Sei

**Date & Time:** 06/07/2007

**Organization :** Mrs. JoAnn Sei

**Category :** Individual

**Issue Areas/Comments**

**DRG Reform and Proposed MS- DRGs**

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a daughter a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

**Rationale:** The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

The Southcoast Hospital License, issued by the Massachusetts Department of Public Health, provides a third option for apportioning Southcoast's wage data to the Boston campus and the Bristol County campuses.

- Summary of bed data provided in table below:

Campus	County	CBSA	Beds	% of Total Beds
Tobey, Wareham, MA	Plymouth	Boston-Quincy	64	9.36%
Charlton Memorial, Fall River, MA	Bristol	Providence-Fall River- New Bedford	296	43.27%
St. Luke's, New Bedford, MA	Bristol	Providence-Fall River- New Bedford	324	47.37%
		Subtotal Bristol County Beds	620	90.64%
<b>Total Acute Care Beds</b>			684	
Beds exclude Psychiatric and Rehabilitation so reconciling to DPH license:	Psychiatric		32	
	Rehabilitation		32	
	Total for Reconciliation to DPH License		748	

- From this, it is clear that only 9.36% of the acute care beds of Southcoast Hospital are located in the Boston-Quincy CBSA.

***We urge CMS to request two reports for Southcoast Hospital Group, Inc. (Provider Number 220074) from National Government Services as quickly as possible to ensure that the deadline is met: Report # OD44203, Report Type 110 and Report Type 998. We have been informed by National Government Services that they have the required data readily available for the full FY2006. To expedite matters, we suggest contacting Mr. Gene Nickerson, Director, Medicare Audit Reimbursement Department at (207) 253-3325 or via regular mail at 110 Free Street, South Portland, Maine 04101-3908.***

We commend CMS' recognition of the fact it is unacceptable to continue to include the data for the Bristol county campuses of the Southcoast hospital group in the Boston-Quincy wage index. This recognition calls for flexibility in the actual methodology used to apportion the wage data and we urge CMS to consider the alternatives outlined above. ***The fact remains that it is far less important what administrative methodology is used for this purpose than it is to correctly calculate the Boston-Quincy wage index for FY2008 and to end this gross payment policy distortion.***

We hope you will give serious consideration to our comments. If I can provide you with any additional information regarding our comments, please do not hesitate to contact me at (781) 272-8000, ext. 173. Thank you for your attention to this important issue.

Sincerely,



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



# The Commonwealth of Massachusetts

DEPARTMENT OF PUBLIC HEALTH

## HOSPITAL LICENSE

In accordance with the provisions of the General Laws, Chapter III, Sections 51-56 inclusive, and the regulations promulgated, thereunder, a license is hereby granted to:

**Southcoast Hospitals Group, Inc.**

Name of Applicant

for the maintenance of **Southcoast Hospitals Group, Inc.** at **363 Highland Avenue, Fall River, MA 02720**

and satellites as listed below. The license is valid until **November 23, 2006** subject to revocation or suspension, either wholly or with respect to a specific service or specific services, or a part or parts thereof.

### CAMPUSES

Southcoast Hospitals Group, Inc. Charlton Memorial Hospital Campus 363 Highland Avenue Fall River, MA 02720	Southcoast Hospitals Group, Inc. St. Lukes Hospital Campus 101 Page Street New Bedford, MA 02740	Southcoast Hospitals Group, Inc. Tobey Hospital Campus 43 High Street Wareham, MA 02571
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#### HOSPITAL SERVICES

	BEDS	BEDS	BEDS	TOTAL BEDS
Medical/Surgical	246	256	42	544
Intensive Care Unit	16	16	10	42
Coronary Care Unit	8	8		16
Pediatric Service		25	6	31
Obstetrics Services	26	19	6	51
Psychiatric Service		32		32
Rehabilitation Service	32			32

#### TOTAL NUMBER OF BEDS

	328	356	64	748
Well Infant Nursery Bassinets	29	20	9	58
Special Care Nursery Bassinets	8	8		16
Ambulatory Care Services	X	X		
Emergency Service	X	X	X	
Cardiac Catheterization Services	X	X		
Primary Stroke Service	X	X	X	
Hospice Services		X		

Commissioner of Public Health

November 24, 2004  
Date Issued

LICENSE No **V113**



#159

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

PROGRAM ID: MD430502 - V36.C  
PAID DATES: 10/01/96 THRU 01/31/07  
RUN DATE: 02/20/07  
PROVIDER FYE: 09/30  
PROVIDER NUMBER:

PROVIDER SUMMARY REPORT  
INPATIENT - PART A  
PROSPECTIVE PAYMENT PROVIDER

PAGE: 3534  
REPORT #: OD44203  
REPORT TYPE: 110

REVENUE

CODE DESCRIPTION

\*\*\*\*\*  
\*\*\* ACCOMMODATION CENSUS \*  
0110 RM & BD PRIVATE  
0111 RM & BD MED/SURG/GY  
0112 RM & BD OB  
0120 RM & BD SEMIPVT 2 B  
0121 RM & BD SEMIPVT MED 1  
0122 RM & BD SEMIPVT OB  
0160 RM & BD OTHER  
0180 LEAVE OF ABSENCE  
0201 ICU / SURGICAL  
0202 ICU / MEDICAL  
0206 ICU / BURN CARE  
0207 ICE / TRAMA  
0209 ICU / OTHER  
0210 CORONARY CARE

TOTAL ACCOMODATIONS 2  
DISCHARGES  
MEDICARE DAYS 2  
CLAIMS

\*\*\* ANCILLARY CHARGES \*\*\*  
0250 PHARMACY 29  
0253 PHARMACY TAKE HOME  
0254 PHARMACY LESS THAN  
0255 PHARMACY RADIOLOGY  
0258 PHARMACY I.V. SOLUT  
0259 PHARMACY OTHER  
0260 I.V. THERAPY  
0270 MEDICAL & SURGICAL  
0271 NON-STERILE SUPPLIE  
0272 MED & SURG STERILE  
0274 MED & SURG PROSTHET  
0275 MED & SURG PACEMAKE

# 159

P R O V I D E R   S T A T I S T I C A L   A N D   R E I M B U R S E M E N T   S Y S T E M

PROGRAM ID: MD430502 - V36.C

PAID DATES: 10/01/96 THRU 01/31/07

RUN DATE: 02/20/07

PROVIDER FYE: 09/30

PROVIDER NUMBER:

PROVIDER SUMMARY REPORT

INPATIENT - PART A

PROSPECTIVE PAYMENT PROVIDER

PAGE: 3538

REPORT #: OD44203

REPORT TYPE: 110

REVENUE CODE	DESCRIPTION	SERVICES FOR PERIOD 10/01/00 - 09/30/04	CHARGES	UNITS	SERVICES FOR PERIOD 10/01/04 - 09/30/05	CHARGES	UNITS	SERVICES FOR PERIOD 10/01/05 - 09/30/06	CHARGES	UNITS	SERVICES FOR PERIOD 10/01/06 - 09/30/07	CHARGES
*****												
TOTAL CHARGES												

\*\*\*\*\*  
 FEDERAL SPECIFIC  
 DAYS OUTLIER  
 COST OUTLIER  
 NEW TECHNOLOGY

FEDERAL PAYMENTS  
 DSH PAYMENTS  
 HOSPITAL SPECIFIC  
 INDIRECT MED ED PMT  
 -DISCHARGES AFTER 9/88  
 TOTAL PPS CAPITAL

GROSS REIMBURSEMENT  
 LESS:  
 CASH DEDUCTIBLE  
 BLOOD DEDUCTIBLE  
 COINSURANCE  
 NET PRIMARY PAYOR  
 PAYMENTS MADE UNDER MSP  
 OTHER

NET REIMBURSEMENT

INFORMATIONAL ONLY:  
 \*\*\*\*\*  
 INTEREST PAYMENTS  
 TRANSFER PAYMENTS  
 (INCLUDED IN NET REIMB)  
 INDIRECT MED ED PMT  
 -DISCHARGES BEFORE 10/88  
 TOTAL ADJUSTMENTS

**CMS-1533-P-160 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :**

**Date & Time:** 06/07/2007

**Organization :**

**Category :** Health Plan or Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

The "Crosswalk from CMS DRGs to MS-DRGs" is somewhat misleading and some entities are interpreting it as a one-to-one mapping. It should be clarified that the groups of CMS v24 DRGs between a set of red lines map to the corresponding group of MS-DRGs between the same red lines, but that an individual DRG code cannot be mapped directly to an MS-DRG. Due to the inability to crosswalk from v24 to MS-DRGs (v25), CMS should release the MS-DRG grouper and allow additional time for hospitals and payers to conduct impact analyses prior to implementation.

**CMS-1533-P-161 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :**

**Date & Time:** 06/07/2007

**Organization :**

**Category :** Health Plan or Association

**Issue Areas/Comments**

**DRG Reform and Proposed**

**MS- DRGs**

DRG Reform and Proposed MS-DRGs

The "Crosswalk from CMS DRGs to MS-DRGs" is somewhat misleading and some entities are interpreting it as a one-to-one mapping. It should be clarified that the groups of CMS v24 DRGs between a set of red lines map to the corresponding group of MS-DRGs between the same red lines, but that an individual DRG code cannot be mapped directly to an MS-DRG. Due to the inability to crosswalk from v24 to MS-DRGs (v25), CMS should release the MS-DRG grouper and allow additional time for hospitals and payers to conduct impact analyses prior to implementation.

**CMS-1533-P-162 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Dr. Gaston Hernandez

**Date & Time:** 06/07/2007

**Organization :** University of Connecticut

**Category :** Individual

**Issue Areas/Comments**

**DRG Reform and Proposed MS- DRGs**

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

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I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

**Rationale:** The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

**CMS-1533-P-163 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mr. Bernard Becker

**Date & Time:** 06/07/2007

**Organization :** Stormont-Vail

**Category :** Hospital

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-1533-P-163-Attach-1.DOC

# Stormont-Vail HealthCare

June 5, 2007

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

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

Dear Ms. Norwalk:

I appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' proposed rule for the fiscal year 2008 hospital inpatient prospective payment system (PPS).

While my colleagues and I support many of the proposed rule's provisions, we oppose the proposed "behavioral offset" cuts related to the move to severity-adjusted diagnosis-related groups (DRGs) and the cuts to capital payments.

We also believe that the 2.4 percent cut to both operating and capital payments in both FYs 2008 and 2009 (\$24 billion over five years) will not remove the inappropriate incentives created by physician self-referral to limited-service hospitals. Physicians will still have the ability and incentive to steer financially attractive patients to facilities they own, avoiding uninsured Medicaid and other low-income patients.

We also oppose the elimination of the capital payment updates for all urban hospitals and the large urban hospital capital payment add-on (which contains an additional 3 percent cut). These changes would result in a payment cut of \$880 million over five years to urban hospitals. These unnecessary cuts ignore how vital capital payments are to the ongoing maintenance and improvement of hospitals' facilities and technology.

We also oppose your consideration of possible future cuts to the indirect medical education and disproportionate share hospital adjustments under the capital system. CMS should not make any further cuts or adjustments to the capital PPS.

These cuts will further deplete scarce resources, ultimately making the mission of hospitals to care for patients even more challenging.

We support the position taken by the American Hospital Association and urge your consideration of this position to help ensure the viability of the community hospital.

Sincerely,



Bernard H. Becker, MA, SPHR  
Vice President & CHRO

**CMS-1533-P-164 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mrs. Carol Wheeler

**Date & Time:** 06/07/2007

**Organization :** Stormont-Vail HealthCare

**Category :** Hospital

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-1533-P-164-Attach-1.DOC



**CMS-1533-P-165 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mr. Richard Murray

**Date & Time:** 06/07/2007

**Organization :** Kennedy Health System

**Category :** Hospital

**Issue Areas/Comments**

**Imputed Floor**

Imputed Floor

See Attached

CMS-1533-P-165-Attach-1.DOC



June 1, 2007

Ms. Leslie V. Norwalk, Esq.  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
**Attention: CMS-1533-P**

**Re: File Code CMS-1533-P**

Dear Ms. Norwalk:

Please note that the following comments correspond to the "Imputed Floor" section contained in the FFY 2008 proposed IPPS rule published in the May 3, 2007 Federal Register.

Kennedy Memorial Hospitals-University Medical Center continues to support the Centers for Medicare and Medicaid Services (CMS) proposal related to "Special Circumstances of Hospitals in All-Urban States" set forth in the FFY 2005 proposed Inpatient Prospective Payment System (IPPS) rule published in the May 18, 2004 Federal Register. Conversely, Kennedy Memorial Hospitals-University Medical Center objects to the proposed expiration of the imputed floor for the following reasons:

- CMS does not give any substantive rationale as to the reason the imputed floor should expire. For comparative purposes, please note the following quote from CMS in the FFY 2005 final rule:

We think it is also an anomaly that hospitals in all-urban States with predominant labor market areas do not have any type of protection, or "floor", from declines in their wage index. Therefore, we are adopting the logic similar to that articulated by Congress in the BBA and are adopting an imputed rural policy for a 3-year period.

- CMS does not provide in the FFY 2008 proposed rule any change in either the existence or effect of the aforementioned "anomaly"; therefore, CMS does not provide any substantive support for the elimination of the imputed floor.

- We believe that it would be improper for CMS to include in the final rule any empirical analysis regarding the imputed floor, as that would constitute avoidance of public commentary.
- CMS has contradicted itself by stating in the FFY 2008 proposed rule that “we believe the policy should apply only when required by statute.” However, in the FFY 2005 final rule, CMS responded to commenters’ contention at that time that “any special provision for urban-only States should be subject to legislative action.” Citing Social Security Act (SSA) section 1886(d)(3)(E) as the authoritative basis for establishing the imputed floor, CMS correctly noted that the agency “does have the discretion to adopt a policy that would adjust wage areas” in the manner established by CMS at that time; that is, the policy reflected in the imputed floor regulation.
- In addition, in the past CMS has repeatedly utilized SSA section 1886 (d)(5)(I)(i) to implement wage index adjustments absent specific statutory authority. Furthermore, CMS is currently relying on this section of the SSA for another proposed wage index matter in these proposed regulations.
- CMS notes in the proposed rule that “Urban providers in ... the Mid-Atlantic Region (NJ) will experience a decrease ... by 0.2 percent ... from the imputed rural floor no longer being applied” in New Jersey. We respectfully request that CMS provide the public, during the public comment period, with the rationale that supports the agency’s conclusion in this regard. We request that the agency furnish this information during the public comment period so that interested parties will have due opportunity to review the rationale and comment, as they deem appropriate.
- On an individual hospital level, the reduction in funds under the expiration of the imputed floor will present a severe financial hardship on our hospital. Kennedy Memorial Hospitals-University Medical Center, located in Camden and Gloucester counties, has benefited over the past three years from the imputed rural floor legislation. Hospitals in New Jersey, including Kennedy, are faced with increasing numbers of patients who are uninsured or underinsured. At the same time, hospital based physicians in New Jersey have repeatedly turned to hospitals for additional payments as they are faced with rapidly rising malpractice costs, inadequate reimbursement rates, and uncompensated care. Kennedy’s hospital facilities are older, as are most New Jersey hospitals, and require significant maintenance and renovation costs each year. Reductions in Medicare and Medicaid payments continue to widen the revenue shortfalls facing hospitals in New Jersey. It has been well documented that the State of New Jersey is currently in financial crisis and will be unable to assist hospitals meet revenue shortfalls, particularly uncompensated care shortfalls, to the extent required.

*Ms. Norwalk*

*6/8/2007*

*Page 3 of 3*

Additional payments from the imputed rural floor legislation, which unless extended will expire on September 30, 2007, are very important to Kennedy in meeting the financial challenges we face.

As noted above, the expiration of the imputed floor would have a detrimental impact on Kennedy Memorial Hospitals-University Medical Center. As such, Kennedy Memorial Hospitals-University Medical Center does not support the expiration of the imputed floor due (among other things) to the fact that the rationale for implementing the imputed floor three years ago has not changed since the inception of the imputed floor regulation. Therefore, we urge CMS to extend the imputed floor regulation.

Thank you for considering these important comments and we look forward to your response.

Respectfully submitted,

*Richard E. Murray*

Richard E. Murray  
President/CEO

**CMS-1533-P-166 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Julie Bower

**Date & Time:** 06/07/2007

**Organization :** Julie Bower

**Category :** Academic

**Issue Areas/Comments**

**DRG Reform and Proposed MS- DRGs**

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a daughter of a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

**Rationale:** The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter! For patients like my mom who are on Medicare and depend on these type of procedures, I feel that it is in the best interest of the Medicare program to allow these patients access to the current standard of care.

Sincerely,  
Julie Bower, MPH

**CMS-1533-P-167 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Ms. Christy Brewsaugh

**Date & Time:** 06/07/2007

**Organization :** Ms. Christy Brewsaugh

**Category :** Individual

**Issue Areas/Comments**

**DRG Reform and Proposed  
MS- DRGs**

**DRG Reform and Proposed MS-DRGs**

I am a family member of a brain tumor patient. My 39-year-old niece is a 13-year brain cancer survivor. She has undergone three craniotomies so far. I urge you to change the proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23. /// You propose the following titles for these MS-DRGs: /// -- MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC /// -- MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC /// I would like to suggest that the DRGs be restructured so that their titles are the following: /// -- MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant /// -- MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC /// Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors. /// When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!) /// The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without an MCC. /// My niece has not so far been treated with Gliadel, or any other implanted devices. However, she has had two recurrences of her brain cancer, at six-year intervals, and she may well need such a treatment in the future. I have hundreds of friends in similar situations. /// I have written before seeking approval for the Gliadel Wafer. I attach a copy of my June 2004 letter to the Center for Medicare and Medicaid Services concerning the proposed rule on the Gliadel Wafer. /// I urge you to consider the requested change. It is critical for the future of brain tumor treatment outcomes. I also urge you to make the change permanent so that brain tumor patients, families, and advocates need not come begging repeatedly every few years. /// Thank you for your consideration. /// Sincerely, Christy Brewsaugh, 28525 SE Broadleaf Road, Eagle Creek, Oregon 97022, 503-630-5806 home, 503-593-4256 cell (Cingular), 503-224-6602 work

**CMS-1533-P-168 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mr. David Knocke

**Date & Time:** 06/07/2007

**Organization :** Stormont-Vail HealthCare

**Category :** Hospital

**Issue Areas/Comments**

GENERAL

GENERAL

See attachment

#168

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.

**CMS-1533-P-169 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mrs. Carol Perry

**Date & Time:** 06/07/2007

**Organization :** Stormont-Vail HealthCare

**Category :** Hospital

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-1533-P-169-Attach-1.DOC

# Stormont-Vail HealthCare

June 5, 2007

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

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

Dear Ms. Norwalk:

I appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' proposed rule for the fiscal year 2008 hospital inpatient prospective payment system (PPS).

While my colleagues and I support many of the proposed rule's provisions, we oppose the proposed "behavioral offset" cuts related to the move to severity-adjusted diagnosis-related groups (DRGs) and the cuts to capital payments.

We also believe that the 2.4 percent cut to both operating and capital payments in both FYs 2008 and 2009 (\$24 billion over five years) will not remove the inappropriate incentives created by physician self-referral to limited-service hospitals. Physicians will still have the ability and incentive to steer financially attractive patients to facilities they own, avoiding uninsured Medicaid and other low income patients.

We also oppose the elimination of the capital payment updates for all urban hospitals and the large urban hospital capital payment add-on which contains an additional 3 percent cut). These changes would result in a payment cut of \$880 million over five years to urban hospitals. These unnecessary cuts ignore how vital capital payments are to the ongoing maintenance and improvement of hospitals' facilities and technology.

We also oppose your consideration of possible future cuts to the indirect medical education and disproportionate share hospital adjustments under the capital system. CMS should not make any further cuts or adjustments to the capital PPS.

These cuts will further deplete scarce resources, ultimately making the mission of hospitals to care for patients even more challenging.

We support the position taken by the American Hospital Association and urge your consideration of this position to help ensure the viability of the community hospital.

Sincerely,

*Carole Perry RN, MBA, PhD*  
Operating Committee Member

**CMS-1533-P-170 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Ms. Debra Yocum

**Date & Time:** 06/07/2007

**Organization :** Stormont-Vail HealthCare

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-1533-P-170-Attach-1.DOC

#170

# Stormont-Vail HealthCare

June 5, 2007

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

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

Dear Ms. Norwalk:

I appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' proposed rule for the fiscal year 2008 hospital inpatient prospective payment system (PPS).

While my colleagues and I support many of the proposed rule's provisions, we oppose the proposed "behavioral offset" cuts related to the move to severity-adjusted diagnosis-related groups (DRGs) and the cuts to capital payments.

We also believe that the 2.4 percent cut to both operating and capital payments in both FYs 2008 and 2009 (\$24 billion over five years) will not remove the inappropriate incentives created by physician self-referral to limited-service hospitals. Physicians will still have the ability and incentive to steer financially attractive patients to facilities they own, avoiding uninsured Medicaid and other low income patients.

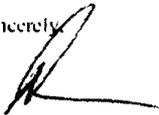
We also oppose the elimination of the capital payment updates for all urban hospitals and the large urban hospital capital payment add-on which contains an additional 3 percent cut). These changes would result in a payment cut of \$880 million over five years to urban hospitals. These unnecessary cuts ignore how vital capital payments are to the ongoing maintenance and improvement of hospitals' facilities and technology.

We also oppose your consideration of possible future cuts to the indirect medical education and disproportionate share hospital adjustments under the capital system. CMS should not make any further cuts or adjustments to the capital PPS.

These cuts will further deplete scarce resources, ultimately making the mission of hospitals to care for patients even more challenging.

We support the position taken by the American Hospital Association and urge your consideration of this position to help ensure the viability of the community hospital.

Sincerely,



Operating Committee Member

**CMS-1533-P-171 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mr. David Cunningham

**Date & Time:** 06/07/2007

**Organization :** Stormont-Vail HealthCare, Inc.

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

GENERAL

GENERAL

See attachment

#171

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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.

**CMS-1533-P-172 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mrs. Janet Stanek

**Date & Time:** 06/07/2007

**Organization :** Stormont-Vail HealthCare

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

GENERAL

GENERAL

see attachment

#172

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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.

**CMS-1533-P-173 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mr. Ernest Schmid

**Date & Time:** 06/07/2007

**Organization :** Texas Hospital Association

**Category :** Hospital

**Issue Areas/Comments**

**GENERAL**

GENERAL

comment letter attached

CMS-1533-P-173-Attach-1.DOC

#173

June 7, 2007

Leslie Norwalk, Acting Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-1533-P  
P.O. Box 8010  
Baltimore, MD 21244-1850

Dear Ms. Norwalk:

On behalf of the Texas Hospital Association's 507 member-hospitals and health systems, please accept comments regarding the proposed Medicare hospital inpatient Prospective Payment System rules identified as CMS-1533-P.

Of great concern is a provision in the rules to prospectively reduce payment predicated upon anticipated coding behavior. Once again, CMS appears to be using the regulatory process to achieve policy objectives outside the legislative process. No data exist to support CMS' assumption of future coding behavior. THA encourages CMS to discontinue using the regulatory process to achieve policy goals; this behavior undermines CMS' credibility.

The following comments are offered on specific provisions of CMS-1533P.

**DRG Reclassifications**

The significant change caused by implementation of the Medicare-Severity-DRG system requires a transition period to permit hospitals to adjust to changes in payment, which will redistribute some \$800-\$900 million among the nation's hospitals. Dramatic changes to PPS require that fiscal intermediaries be well-prepared for efficient implementation. CMS has a responsibility to insure that systems function properly and that hospital payments are accurate and made without delay. Reasonable testing and assurance of system adequacy suggests use of a phased-implementation of the MS-DRG system beginning in 2009.

**Capital Update**

THA opposes the elimination of capital payment updates. This policy adversely will impact a growing state like Texas that requires increased hospital capacity to meet current and future needs. Congress has not directed CMS to eliminate capital payments. An action that will have such broad and far-reaching impact should be implemented only with congressional direction. Texas hospitals stand to lose \$25.6 million under this proposal in 2008.

**Behavioral Offset**

The CMS proposed behavioral offset is not supported by any data. CMS should address its concerns about coding through a comprehensive education program for fiscal intermediaries prior to implementing the new MS-DRG system. In addition, CMS should work with its FIs to identify coding problems and resolve them quickly, especially during the first year of implementation.

**Complications/Co-morbidity List**

Many common secondary diagnoses that justify use of increased resources were eliminated. This broad, indiscriminate policy is inappropriate since it will reduce DRG payments that are justified by the patient's medical condition. This provision should be revised to recognize the appropriate use of more resources and adjust payments accordingly.

**Recalibration of DRG Weights**

The hospital-specific relative value methodology is a flawed concept. Using cost reports to establish cost-based DRG weights appears to have caused unexpected distortions. Allowable flexibility in the development of cost reports requires increased FI and hospital training if cost reports are to be used appropriately to establish DRG weights.

**Occupational Mix Adjustment**

CMS is justified in seeking an approach to encourage all hospitals to provide required data. However, the inaction of one hospital within a community should not adversely impact other facilities that have submitted data. For FY 2008, the CMS proposal to use the average adjustment for non-responding hospitals is reasonable. However, for subsequent years, CMS should develop procedures to encourage hospital compliance without penalizing other community hospitals that have complied.

**Replacement Devices**

The CMS proposal to reduce DRG payments by the cost of recalled devices that are replaced at no cost to the hospital skews fundamental concepts inherent within PPS. The proposal artificially reduces the cost basis of how future payments are computed. Since the "free" replacement device is an anomaly, it should not be considered in computing future DRG values. This proposal should be withdrawn.

**New Technology**

CMS policies should encourage prompt implementation of new drugs, technology and services to the benefit of beneficiaries. Proposed policies do not support this goal. THA supports prompt implementation of ICD-10-CM with sufficient lead time for planning and execution.

Thank you for the opportunity to submit comments. Texas hospitals hope that CMS will modify this proposed rule, and refrain from using the regulatory process to achieve budget goals rather than focus on providing Medicare beneficiaries with appropriate, efficient care.

Respectfully submitted,

Ernie Schmid, FACHE  
Senior Director, Policy Analysis

cc: Members, Texas Congressional Delegation

**CMS-1533-P-174 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mr. Ernest Schmid

**Date & Time:** 06/07/2007

**Organization :** Texas Hospital Association

**Category :** Health Care Provider/Association

**Issue Areas/Comments**

**Impact--Overall Conclusion**

Impact--Overall Conclusion

On behalf of the Texas Hospital Association's 507 member-hospitals and health systems, please accept comments regarding the proposed Medicare hospital inpatient Prospective Payment System rules identified as CMS-1533-P.

CMS-1533-P-174-Attach-1.DOC

#174



TEXAS HOSPITAL ASSOCIATION

June 7, 2007

Leslie Norwalk, Acting Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-1533-P  
P.O. Box 8010  
Baltimore, MD 21244-1850

Dear Ms. Norwalk:

On behalf of the Texas Hospital Association's 507 member-hospitals and health systems, please accept comments regarding the proposed Medicare hospital inpatient Prospective Payment System rules identified as CMS-1533-P.

Of great concern is a provision in the rules to prospectively reduce payment predicated upon anticipated coding behavior. Once again, CMS appears to be using the regulatory process to achieve policy objectives outside the legislative process. No data exist to support CMS' assumption of future coding behavior. THA encourages CMS to discontinue using the regulatory process to achieve policy goals; this behavior undermines CMS' credibility.

The following comments are offered on specific provisions of CMS-1533P.

**DRG Reclassifications**

The significant change caused by implementation of the Medicare-Severity-DRG system requires a transition period to permit hospitals to adjust to changes in payment, which will redistribute some \$800-\$900 million among the nation's hospitals. Dramatic changes to PPS require that fiscal intermediaries be well-prepared for efficient implementation. CMS has a responsibility to insure that systems function properly and that hospital payments are accurate and made without delay. Reasonable testing and assurance of system adequacy suggests use of a phased-implementation of the MS-DRG system beginning in 2009.

**Capital Update**

THA opposes the elimination of capital payment updates. This policy adversely will impact a growing state like Texas that requires increased hospital capacity to meet current and future needs. Congress has not directed CMS to eliminate capital payments. An action that will have such broad and far-reaching impact should be implemented only with congressional direction. Texas hospitals stand to lose \$25.6 million under this proposal in 2008.

**Behavioral Offset**

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**Complications/Co-morbidity List**

Many common secondary diagnoses that justify use of increased resources were eliminated. This broad, indiscriminate policy is inappropriate since it will reduce DRG payments that are justified by the patient's medical condition. This provision should be revised to recognize the appropriate use of more resources and adjust payments accordingly.

**Recalibration of DRG Weights**

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**Occupational Mix Adjustment**

CMS is justified in seeking an approach to encourage all hospitals to provide required data. However, the inaction of one hospital within a community should not adversely impact other facilities that have submitted data. For FY 2008, the CMS proposal to use the average adjustment for non-responding hospitals is reasonable. However, for subsequent years, CMS should develop procedures to encourage hospital compliance without penalizing other community hospitals that have complied.

**Replacement Devices**

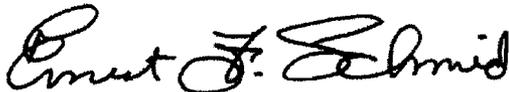
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**New Technology**

CMS policies should encourage prompt implementation of new drugs, technology and services to the benefit of beneficiaries. Proposed policies do not support this goal. THA supports prompt implementation of ICD-10-CM with sufficient lead time for planning and execution.

Thank you for the opportunity to submit comments. Texas hospitals hope that CMS will modify this proposed rule, and refrain from using the regulatory process to achieve budget goals rather than focus on providing Medicare beneficiaries with appropriate, efficient care.

Respectfully submitted,



Ernie Schmid, FACHE  
Senior Director, Policy Analysis

cc: Members, Texas Congressional Delegation

**CMS-1533-P-175 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mr. Arnold Thomas

**Date & Time:** 06/07/2007

**Organization :** North Dakota Healthcare Association

**Category :** Health Care Provider/Association

**Issue Areas/Comments**

GENERAL

GENERAL

See Attachment

#175

file:///T:/ELECTRONIC%20COMMENTS/ELECTRONIC%20COMMENTS/E-Comments/Active%20Files/Missing%20file1.txt

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.

**CMS-1533-P-176 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mrs. Valerie Rinkle

**Date & Time:** 06/07/2007

**Organization :** Asante Health System

**Category :** Hospital

**Issue Areas/Comments**

**Capital IPPS**

Capital IPPS

Asante does not support CMS's proposal to eliminate the capital payment update or the capital payment add-on for urban hospitals. CMS states that hospital margins have been positive and therefore these cuts are justified. We strongly disagree with the assumption that improved efficiency on the part of hospitals should result CMS making such broad based cuts, especially when hospitals are increasing capital investments for health information technology initiatives, a mandate that Congress and CMS support. Ultimately these reductions will impact beneficiary's access to newer technologies and equipment and the hospital's ability to invest in improving their facilities and in accelerating adoption of health information technology.

If CMS finalizes this proposal, it is essentially giving hospitals the signal that there is no reason to improve efficiency. In effect, hospitals are being penalized for being efficient. Capital payments are an important part of the funding mechanism and facilitate ongoing maintenance and improvement of our hospitals and enable us to continue advancing healthcare treatment through new and improved technologies. Therefore, Asante strongly urges CMS not to implement these proposed capital payment cuts.

**CMS-1533-P-177 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Stella Visaggio

**Date & Time:** 06/07/2007

**Organization :** Hackettstown Regional Medical Center

**Category :** Hospital

**Issue Areas/Comments**

**Imputed Floor**

Imputed Floor

Please see comments in the attached letter.

CMS-1533-P-177-Attach-1.DOC

#177

June 1, 2007

Ms. Leslie V. Norwalk, Esq.  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
**Attention: CMS-1533-P**

**Re: File Code CMS-1533-P**

Dear Ms. Norwalk:

Please note that the following comments correspond to the "Imputed Floor" section contained in the FFY 2008 proposed IPPS rule published in the May 3, 2007 Federal Register.

Hackettstown Community Hospital continues to support the Centers for Medicare and Medicaid Services (CMS) proposal related to "Special Circumstances of Hospitals in All-Urban States" set forth in the FFY 2005 proposed Inpatient Prospective Payment System (IPPS) rule published in the May 18, 2004 Federal Register. Conversely, Hackettstown Community Hospital objects to the proposed expiration of the imputed floor for the following reasons:

- CMS does not give any substantive rationale as to the reason the imputed floor should expire. For comparative purposes, please note the following quote from CMS in the FFY 2005 final rule:

We think it is also an anomaly that hospitals in all-urban States with predominant labor market areas do not have any type of protection, or "floor", from declines in their wage index. Therefore, we are adopting the logic similar to that articulated by Congress in the BBA and are adopting an imputed rural policy for a 3-year period.

- CMS does not provide in the FFY 2008 proposed rule any change in either the existence or effect of the aforementioned "anomaly"; therefore, CMS does not provide any substantive support for the elimination of the imputed floor.
- We believe that it would be improper for CMS to include in the final rule any empirical analysis regarding the imputed floor, as that would constitute avoidance of public commentary.
- CMS has contradicted itself by stating in the FFY 2008 proposed rule that "we believe the policy should apply only when required by statute." However, in the

*Ms. Norwalk*

*6/8/2007*

*Page 2 of 2*

FFY 2005 final rule, CMS responded to commenters' contention at that time that "any special provision for urban-only States should be subject to legislative action." Citing Social Security Act (SSA) section 1886(d)(3)(E) as the authoritative basis for establishing the imputed floor, CMS correctly noted that the agency "does have the discretion to adopt a policy that would adjust wage areas" in the manner established by CMS at that time; that is, the policy reflected in the imputed floor regulation.

- In addition, in the past CMS has repeatedly utilized SSA section 1886 (d)(5)(I)(i) to implement wage index adjustments absent specific statutory authority. Furthermore, CMS is currently relying on this section of the SSA for another proposed wage index matter in these proposed regulations.
- CMS notes in the proposed rule that "Urban providers in ... the Mid-Atlantic Region (NJ) will experience a decrease ... by 0.2 percent ... from the imputed rural floor no longer being applied" in New Jersey. We respectfully request that CMS provide the public, during the public comment period, with the rationale that supports the agency's conclusion in this regard. We request that the agency furnish this information during the public comment period so that interested parties will have due opportunity to review the rationale and comment, as they deem appropriate.
- On an individual hospital level the reduction in funds under the expiration of the imputed floor would result in a reduction in Medicare reimbursement of approximately \$1.4 million (or 8% of our total Medicare reimbursement). Such a reduction would impose a significant hardship on Hackettstown Community Hospital, resulting in a reduction in our workforce and potentially in eliminating needed services for our community.

As noted above, the expiration of the imputed floor would have a detrimental impact on Hackettstown Community Hospital. As such, Hackettstown Community Hospital does not support the expiration of the imputed floor due (among other things) to the fact that the rationale for implementing the imputed floor three years ago has not changed since the inception of the imputed floor regulation. Therefore, we urge CMS to extend the imputed floor regulation.

Thank you for considering these important comments and we look forward to your response.

Respectfully submitted,

Stella Visaggio  
Chief Financial Officer

**CMS-1533-P-178 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Dr. Liesl Cooper

**Date & Time:** 06/07/2007

**Organization :** Cordis, a Johnson

**Category :** Device Industry

**Issue Areas/Comments**

**DRG Reform and Proposed MS- DRGs**

DRG Reform and Proposed MS-DRGs

**A. Section II. D. 5. DRG Reform and Proposed MS-DRGs**

Cordis supports CMS's continued efforts to refine the current DRGs to better differentiate cases based on severity of illness and incremental resource consumption. Cordis acknowledges and appreciates CMS's response to FY 2007 IPPS comments urging the consideration of a DRG system based on the current CMS DRGs, as these DRGs include refinements made over many years to reflect advanced technologies and the most current medical practices. We also support the transparency and broad availability of a non-proprietary system. The proposed MS-DRG system is, in principle, a positive advancement and will create a more equitable and accurate payment system. We encourage CMS to implement the MS-DRGs, phased in over 3 years and to use the RAND analysis of alternative classification systems in considering future refinements to the MS-DRGs. We would not wish to see CMS switch to a completely different severity-based DRG system in FY 2009 or phase in a different system in subsequent years. Further, adopting a new DRG system in the following fiscal year may be premature since the benefit of the MS-DRGs cannot be fully assessed until FY 2010 due to the lag in reported claims data, e.g. FY 2006 data are the basis for proposed FY 2008 relative rates.

Additionally, we recognize the CC/MCC classification of diagnosis codes is fundamental to the integrity of the severity adjusted DRG framework. We want to acknowledge the significant effort and consideration CMS has given to developing both the mathematical and clinical judgment criteria in determining severity classifications. However, in reviewing the CC/MCC list it was not possible to fully assess the assignment of diagnosis codes in the severity classification because there was an incomplete description of the process in the NPRM.

**Recommendations**

- 1) Implement the MS-DRGs effective October 1, 2007, with a three year phase-in approach.
- 2) Refrain from implementing an entirely new DRG system in FY 2009. Rather, continue to refine the MS-DRGs introduced in FY 2008.
- 3) Provide full disclosure regarding the data used, the mathematical criteria and clinical judgment for determination of the CCs and MCCs and provide complete results of the analysis for all codes.

**B. Section II. D. 6. Changes to Case-Mix Index (CMI) From Proposed MS-DRGs (standardized amount adjustment)**

While Cordis maintains the proposed MS-DRGs are a significant improvement to the current CMS DRGs, the accompanying 2.4% standard amount adjustment in FY 2008 and the additional 2.4% in FY 2009 are significant and potentially detrimental to hospitals. We are concerned about the budgetary burden for hospitals should the adjustment exceed the realized impact of coding changes that do not reflect real changes in the case-mix. We believe that the potential for "up-coding" has been minimized by the reduction in the number of comorbidities and complications that have been included in the Proposed Rule and hence such an across the board adjustment is unwarranted. We also believe a three-year phase-in approach to MS-DRG implementation will minimize and potentially eliminate the need for the prospective adjustment.

**Recommendations**

1. Any adjustment for coding behavior should be applied retrospectively once the actual FY 2008 data are available on which to determine the necessary adjustment.

**DRGs: Relative Weight Calculations**

**DRGs: Relative Weight Calculations**

**C. Section II. E. "DRG-Relative Weight Calculation" (Charge Compression)**

Cordis supports the recommendations provided in the Research Triangle Institute's (RTI) Report entitled "A Study of Charge Compression in Calculating DRG Relative Weights" dated January 2007. The recommendations provided in this report will allow CMS to better align payments with estimated costs by reducing or eliminating the distorting effects of charge compression. We advocate implementation of the changes effective FY 2008 to further CMS' goal of increasing payment accuracy. Specifically, we strongly support the following recommendations.

**Recommendations**

1. As CMS did last year when it moved forward with cost-based weights to correct distortions in the DRG weights, it should move forward with implementing a regression-based charge compression adjustment to ensure its payments to hospitals are accurate and do not create disincentives to hospitals as they make choices regarding the most appropriate care for each patient.
2. Increase the number of distinct hospital departments used to calculate cost-to-charge ratios (CCRs) from 13 to 19 and disaggregate "Emergency Room" and "Blood and Blood Products" from the "Other Services" cost center. Using the proposed MS-DRG structure, our internally modeled impact of these changes produces modest adjustments to the estimated relative weights that are consistent with those reported in Exhibit 31 of the RTI Report. We support the initiative to place greater scrutiny on those hospitals reporting extreme CCRs but appreciate CMS' comments that limited resources are typically allocated to those issues impacting payments to individual providers.
3. Encourage providers to use existing cost centers and establish new cost centers for implantable devices and prosthetics in the cost report.
4. Collaborate with hospitals to generate accurate cost reports and standardize the manner in which implantable medical devices are assigned to hospital cost centers.
5. Refrain from implementing a payment adjustment on hospital specific relative values (HSRV), in conjunction with charge compression. HSRV does not align payment with costs and may eliminate real cost differences between hospitals leading to greater variance and less accurate payments.

**GENERAL**

GENERAL

June 8, 2007

Via Federal Express

Honorable Leslie V. Norwalk, Esquire  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health & Human Services

Attention: CMS-1533-P  
Baltimore, MD 21244-1850

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

Dear Ms. Norwalk:

Cordis Corporation is pleased to submit comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule on the Medicare Hospital Inpatient Prospective Payment System (PPS) and Fiscal Year 2008 Rates published on May 3, 2007 in the Federal Register. Cordis Corporation is a member of the Johnson & Johnson family of companies and a leading manufacturer of cardiovascular, endovascular, electrophysiology and neurovascular advanced medical technologies.

Johnson & Johnson has also submitted extensive comments discussing CMS' proposed changes with respect to the (1) DRG Reform and Proposed Medicare Severity DRGs (MS-DRGs), (2) Changes to Case-Mix Index (CMI) from Proposed MS-DRGs (standardized amount adjustment) and (3) DRG-Relative Weight Calculation (charge compression). Cordis' comments will provide additional perspective on the impact of these proposed changes.

In conclusion, we support CMS' efforts to implement a DRG system that provides a more accurate and equitable payment system to hospitals, reflecting severity and resource consumption. We appreciate the opportunity to comment on the proposed rule and look forward to continuing to work with you.

Sincerely,

Liesl M. Cooper RPh, MBA, PhD  
Vice President, Health Economics and Reimbursement  
Cordis Corporation, a Johnson & Johnson Company.

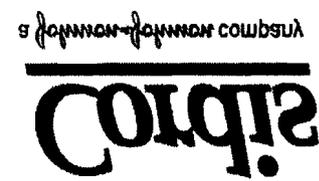
Cc: Leslie Norwalk, Deputy Director of the Division of Acute Care (sent electronically)  
cc. Brian G Firth, Worldwide Vice President Medical Affairs and Health Economics, Cordis.  
cc. Kathy Buto, Vice President Health Policy, Johnson & Johnson.

CMS-1533-P-178-Attach-1.DOC

CMS-1533-P-178-Attach-1.DOC

CMS-1533-P-178-Attach-1.DOC

\*178



June 8, 2007

**Via Federal Express**

Honorable Leslie V. Norwalk, Esquire  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health & Human Services  
Attention: CMS-1533-P  
Baltimore, MD 21244-1850

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**A. Section II. D. 'DRG Reform and Proposed MS-DRGs'**

Cordis supports CMS' continued efforts to refine the current DRGs to better differentiate cases based on severity of illness and incremental resource consumption. Cordis acknowledges and appreciates CMS' response to FY 2007 IPPS comments urging the consideration of a DRG system based on the current CMS DRGs, as these DRGs include refinements made over many years to reflect advanced technologies and the most current medical practices. We also support the transparency and broad availability of a non-proprietary system. The proposed MS-DRG system is, in principle, a positive advancement and will create a more equitable and accurate payment system. We encourage CMS to implement the MS-DRGs, phased in over 3 years and to use the RAND analysis of alternative classification systems in considering future refinements to the MS-DRGs. We would not wish to see CMS

switch to a completely different severity-based DRG system in FY 2009 or phase in a different system in subsequent years. Further, adopting a new DRG system in the following fiscal year may be premature since the benefit of the MS-DRGs cannot be fully assessed until FY 2010 due to the lag in reported claims data, e.g. FY 2006 data are the basis for proposed FY 2008 relative rates.

Additionally, we recognize the CC/MCC classification of diagnosis codes is fundamental to the integrity of the severity adjusted DRG framework. We want to acknowledge the significant effort and consideration CMS has given to developing both the mathematical and clinical judgment criteria in determining severity classifications. However, in reviewing the CC/MCC list it was not possible to fully assess the assignment of diagnosis codes in the severity classification because there was an incomplete description of the process in the NPRM.

#### **Recommendations**

- 1) Implement the MS-DRGs effective October 1, 2007, with a three year phase-in approach.
- 2) Refrain from implementing an entirely new DRG system in FY 2009. Rather, continue to refine the MS-DRGs introduced in FY 2008.
- 3) Provide full disclosure regarding the data used, the mathematical criteria and clinical judgment for determination of the CCs and MCCs and provide complete results of the analysis for all codes.

#### **B. Section II. D. 6. Changes to Case-Mix Index (CMI) From Proposed MS-DRGs (standardized amount adjustment)**

While Cordis maintains the proposed MS-DRGs are a significant improvement to the current CMS DRGs, the accompanying 2.4% standard amount adjustment in FY 2008 and the additional 2.4% in FY 2009 are significant and potentially detrimental to hospitals. We are concerned about the budgetary burden for hospitals should the adjustment exceed the realized impact of coding changes that do not reflect real changes in the case-mix. We believe that the potential for “up-coding” has been minimized by the reduction in the number of comorbidities and complications that have been included in the Proposed Rule and hence such an across the board adjustment is unwarranted. We also believe a three-year phase-in approach to MS-DRG implementation will minimize and potentially eliminate the need for the prospective adjustment.

#### **Recommendations**

1. Any adjustment for coding behavior should be applied retrospectively once the actual FY 2008 data are available on which to determine the necessary adjustment.

#### **C. Section II. E. ‘DRG-Relative Weight Calculation’ (Charge Compression)**

Cordis supports the recommendations provided in the Research Triangle Institute’s (RTI) Report entitled “A Study of Charge Compression in Calculating DRG Relative Weights”<sup>1</sup> dated January 2007. The recommendations provided in this report will allow CMS to better align payments with estimated costs by reducing or eliminating the distorting effects of charge compression. We advocate implementation of the

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<sup>1</sup> A Study of Charge Compression in Calculating DRG Relative Weights – Dalton, Kathleen RTI International January 2007. <http://www.cms.hhs.gov/reports/downloads/Dalton.pdf>.

changes effective FY 2008 to further CMS' goal of increasing payment accuracy. Specifically, we strongly support the following recommendations.

**Recommendations**

1. As CMS did last year when it moved forward with cost-based weights to correct distortions in the DRG weights, it should move forward with implementing a regression-based charge compression adjustment to ensure its payments to hospitals are accurate and do not create disincentives to hospitals as they make choices regarding the most appropriate care for each patient.
2. Increase the number of distinct hospital departments used to calculate cost-to-charge ratios (CCRs) from 13 to 19 and disaggregate "Emergency Room" and "Blood and Blood Products" from the "Other Services" cost center. Using the proposed MS-DRG structure, our internally modeled impact of these changes produces modest adjustments to the estimated relative weights that are consistent with those reported in Exhibit 31 of the RTI Report. We support the initiative to place greater scrutiny on those hospitals reporting extreme CCRs but appreciate CMS's comments that limited resources are typically allocated to those issues impacting payments to individual providers.
3. Encourage providers to use existing cost centers and establish new cost centers for implantable devices and prosthetics in the cost report.
4. Collaborate with hospitals to generate accurate cost reports and standardize the manner in which implantable medical devices are assigned to hospital cost centers.
5. Refrain from implementing a payment adjustment on hospital specific relative values (HSRV), in conjunction with charge compression. HSRV does not align payment with costs and may eliminate real cost differences between hospitals leading to greater variance and less accurate payments.

In conclusion, we support CMS's efforts to implement a DRG system that provides a more accurate and equitable payment system to hospitals, reflecting severity and resource consumption. We appreciate the opportunity to comment on the proposed rule and look forward to continuing to work with you.

Sincerely,



Liesl M. Cooper RPh, MBA, PhD  
Vice President, Health Economics and Reimbursement  
Cordis Corporation, a Johnson & Johnson Company.

Cc: Leslie Norwalk, Deputy Director of the Division of Acute Care (sent electronically)  
cc. Brian G Firth, Worldwide Vice President Medical Affairs and Health Economics, Cordis.  
cc. Kathy Buto, Vice President Health Policy, Johnson & Johnson.

**CMS-1533-P-179 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mr. David Knocke

**Date & Time:** 06/07/2007

**Organization :** Stormont-Vail HealthCare, Inc.

**Category :** Health Care Provider/Association

**Issue Areas/Comments**

GENERAL

GENERAL

see attachment

#179

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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.

**CMS-1533-P-180 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mr. Keith Forshee

**Date & Time:** 06/07/2007

**Organization :** Mr. Keith Forshee

**Category :** Individual

**Issue Areas/Comments**

**DRG Reform and Proposed  
MS- DRGs**

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a family member of a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

**Rationale:** The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

**CMS-1533-P-181 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mr. Michael Tona

**Date & Time:** 06/07/2007

**Organization :** Mr. Michael Tona

**Category :** Individual

**Issue Areas/Comments**

**DRG Reform and Proposed MS- DRGs**

DRG Reform and Proposed MS-DRGs

I am the son a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

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The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

**CMS-1533-P-182 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mrs. Valerie Rinkle

**Date & Time:** 06/07/2007

**Organization :** Asante Health System

**Category :** Hospital

**Issue Areas/Comments**

**DRGs: Relative Weight Calculations**

DRGs: Relative Weight Calculations

Another issue that is significant to cost apportionment for cost weighted DRGs is hospital charge practices. Asante requests that CMS explicitly state whether hospitals should be charging the same rates for the same services to both inpatients and outpatients. Existing Medicare regulations on cost apportionment contained in the Provider Reimbursement Manual: (1) (Publication 15, Part I, Chapter 22, ?2203) which states: "so that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient" and (2) (Publication 15, Part I, Chapter 22, ?2204) which states: "Medicare charges refer to the regular rates for various covered services which are charged to beneficiaries for inpatient or outpatient services. The Medicare charge for a specific service must be the same as the charge made to non-Medicare patients (including Medicaid, CHAMPUS, private, etc.), must be recorded in the respective income accounts of the facility, and must be related to the cost of the service. (See ?2202.4.)"

If CMS breaks out a cost center for blood, Asante cautions CMS not to include charges under revenue code 391 as blood charges. This revenue code is for the administration of blood products. The administration of blood products is a nursing service. The costs of administration is not in the blood bank cost center, but rather routine or specialty care cost groupings.

**Recalibration of DRG Weights**

Recalibration of DRG Weights

Asante is concerned with the significant data integrity problem CMS has created with cost-weighted DRGs. There is a mismatch between the two data sources used in establishing the cost-based weights, namely the charges from the MedPAR files (an accumulation of Medicare patient claims filed by each hospital) and the cost-to-charge ratios (CCRs) from the hospital Medicare cost reports. First, the method used by CMS to group hospital charges for the MedPAR files (i.e., by revenue code) differs from that used by hospitals to group Medicare charges, total charges and overall costs on the cost report (i.e., by general ledger). Second, hospitals group their Medicare charges, total charges and overall costs in different departments on their cost reports for various reasons. Third, hospitals across the country complete their cost reports in different ways, as allowed by CMS. This mismatch between MedPAR charges and cost report CCRs can distort the resulting DRG weights.

Currently, cost report instructions included with the CMS Form-339 allow for three methods of reporting Medicare charges. The method selected by each hospital is specific to its information systems and based on the method that most accurately aligns Medicare program charges on Cost Report Worksheet D-4 (inpatient) and/or Worksheet D, Part IV (outpatient) with the overall cost and charges reported on Worksheets A and C. Many hospitals elect to allocate some or all of the Medicare program charges from the Medicare Provider Statistical and Reimbursement data

(PS&R) to various lines in the cost report based on hospital-specific financial system needs. Under this scenario, total hospital CCRs are aligned with program charges, but will not match the charge groupings used in MedPAR. This mismatching may distort the resulting DRG weights under the methodology developed by CMS. Increased edits or cost report rejections would not provide a solution to a problem that is caused by cost report instructions that allow for multiple approaches. CMS should support and delay further transition to cost-weighted DRGs until the AHA, AAMC and FAH, along with the Healthcare Financial Management Association, are launch an educational campaign to help hospitals report costs and charges, particularly for supplies, in a way that is consistent with how MedPAR groups charges. CMS should communicate with its fiscal intermediaries (FIs) that such action is appropriate and encouraged.

CMS is considering whether it would be appropriate to expand the cost center groupings to 19 in order to separate services that have substantially different CCRs from other services currently in the same cost center. Specifically, CMS is considering the following refinements recommended by RTI: a) Separating the emergency department and blood from other services; b) Splitting medical supplies into devices/implants/prosthetics and other medical supplies; c) Distinguishing between CT, MRI and other radiology; and d) Splitting drugs into IV solutions and other drugs. Using existing cost report data, changes can be made to emergency departments and blood to separate them from other services. But further breaking out supplies, radiology and pharmacy would require either changes to the structure of the cost report or the application of a regression-based adjustment. Asante is concerned that this proposed new approach for categorizing all charges and costs into 13 specific categories may not yield the most appropriate CCR for each cost category. As a result, we support the AHA and their recommended short-term educational efforts to resolve the mismatched data and CMS' long-term review of the cost report.

**CMS-1533-P-183 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Ms. Jean Prater

**Date & Time:** 06/07/2007

**Organization :** Avera Sacred Heart Hospital

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**DRG Reform and Proposed MS- DRGs**

DRG Reform and Proposed MS-DRGs

As a HIM Coding manager I wish to comment on the CMS 2007 Proposed Rule. I am writing to express concern over the proposed changes for FY2008.

Although I am in favor of a severity adjusted payment system, I am concerned that you proposed to adopt the MS-DRG for FY2008 while the RAND Corporation is deciding this year between your methodology and five other vendors for subsequent adoption that probably would take place in FY2009.

Health care dollars in hospitals are already being stretched. With the rapid implementation of the proposal you suggested hospitals will incur enormous costs as they gear up for this system and then in the next year potentially will be faced with the same situation. With the timing of the rule there will be very limited time to get this training done which will put a burden on hospitals as they train not only the employees but also physicians. There will be a learning curve for coders and billers and coding backlogs will occur.

I hope that my comments and those of many others in the healthcare field will make you study the larger picture before finalizing the implementation of a system that will further increase the cost of healthcare and will pose a hardship on many hospitals as they try to comply.

Thank you for allowing me to comment on this rule.

**CMS-1533-P-184 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Submitter :

Date & Time: 06/07/2007

Organization :

Category : Speech-Language Therapist

Issue Areas/Comments

DRG Reform and Proposed MS- DRGs

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a caregiver of brain tumor patients, and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

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Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

**CMS-1533-P-185 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mrs. Valerie Rinkle

**Date & Time:** 06/07/2007

**Organization :** Asante Health System

**Category :** Hospital

**Issue Areas/Comments**

**Hospital Quality Data**

Hospital Quality Data

For the foreseeable future, Asante believes that only three of the six conditions represent serious preventable events and are appropriate conditions to include for FY 2009: object left in during surgery, air embolism and blood incompatibility. Because these conditions are identified by discrete ICD-9 codes, they can be coded by hospitals. Asante has serious concerns regarding the other proposed conditions. Implementing a present-on-admission coding indicator will be a major challenge for hospitals, ours included. Furthermore, the most appropriate documentation regarding these conditions comes from nursing and coding personnel, under present coding rules, may not rely upon nursing documentation for coding. Asante believes that CMS should align physician and hospital documentation and coding incentives in this arena. Hospitals are dependent upon physician documentation for coding. One way for CMS to begin this process is to use its considerable influence to education physicians on documentation practices and coding.

Asante strongly urges CMS to review the definitions of some of these conditions and update them before they can be successfully used in a hospital reporting program. Asante is particularly concerned with ulcers. It is difficult to detect stage I pressure ulcers on admission, as the skin is not yet broken, even though the tissue is damaged. The National Pressure Ulcer Advisory Panel recently released revised guidelines for staging pressure ulcers and included a new definition for a suspected deep tissue injury. Although difficult to detect initially, this condition may rapidly evolve into an advanced pressure ulcer, and it is especially difficult to detect in individuals with darker skin tones. We also are concerned that the present-on-admission coding of pressure ulcers will rely solely on physicians' notes and diagnoses, per Medicare coding rules, and cannot make use of additional notes from nurses and other practitioners. Certain patients, including those at the end of life, may be exceptionally prone to developing pressure ulcers, despite receiving appropriate care. There also is evidence of an increased risk of pressure ulcer reoccurrence after a patient has had at least one stage IV ulcer. If CMS decides to include pressure ulcers under the hospital-acquired conditions policy, the agency should exclude patients with certain diagnoses, for example, malnutrition which make them more highly prone to pressure ulcers because, in these cases, the condition may not be reasonably prevented.

**CMS-1533-P-186 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Amelia Hirsch

**Date & Time:** 06/07/2007

**Organization :** Amelia Hirsch

**Category :** Individual

**Issue Areas/Comments**

**DRG Reform and Proposed MS- DRGs**

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am the wife of a brain tumor patient, and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

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Thank you for your consideration of this important matter!

**CMS-1533-P-187 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Dr. Hans Gritsch

**Date & Time:** 06/07/2007

**Organization :** Univ. of California, Los Angeles

**Category :** Physician

**Issue Areas/Comments**

**Capital Payment Rate**

Capital Payment Rate

HRSA has a goal to increase the number of renal transplants. This has occurred primarily by using deceased donor kidneys from older donors (extended criteria donors -ECD) and donors who are pronounced dead on the basis of cardiac criteria (instead of neurologic criteria -DCD). Both of these types of donors allow for renal transplantation that extends the life of the patient, however the cost of these transplants is much higher to delayed graft function requiring more extensive post transplant dialysis and immunosuppression.

The cost of using these donors in transplantation needs to be accounted for to reduce the burden of dialysis on the population of older recipients.

**CMS-1533-P-188 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Ms. Debbie Shaffer

**Date & Time:** 06/07/2007

**Organization :** Ms. Debbie Shaffer

**Category :** Individual

**Issue Areas/Comments**

**DRG Reform and Proposed MS- DRGs**

DRG Reform and Proposed MS-DRGs

-----  
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**CMS-1533-P-189 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Dr. henry friedman

**Date & Time:** 06/07/2007

**Organization :** preston robert tisch bran tumor center

**Category :** Physician

**Issue Areas/Comments**

**DRG Reclassifications**

DRG Reclassifications

what in the world is cms thinking? if you change the drg for gliadel, the only fda approved implantable chemotherapeutic agent for malignant brain tumors, then the very population that needs it for glioblastoma multiforme, who are primarily in the medicare age group, will not get it because the new proposed drgs(replacing the current 543) will provide inadequate financial support and hospitals will stop using it. this is an immoral and crazy consideration--and i am emailing this to the appropriate oncology societies such as acs, asco and sno. i am also emailing this to the public domain who presumably has more sense than cms at this time--specifically 60 minutes---who will certainly take a very strong interest in this ridiculous plan. if you must change the drg, change to ms-drg 23 or 24---craniotomy with acute complex cns principal diagnosis with mcc or major device implant(23) or craniotomy with acute complex cns principal diagnosis without mcc. but know this--the current cms administration, from the top down, will forever in the oncology and public domain be linked with this decision. choose wisely. try hard and do the right thing

**CMS-1533-P-190 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Keith Armitage

**Date & Time:** 06/08/2007

**Organization :** Case Medical School/APDIM

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

June 8, 2007

Leslie V. Norwalk  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Room 445-G  
Washington, DC 20201

File Code: CMS-1533-P

Re: Payment for Direct Graduate Medical Education

Dear Ms. Norwalk:

I write regarding the proposal for removing vacation and sick leave in the FTE resident count for purposes payment for direct graduate medical education. I would like to bring to your attention the increased administrative burden that compliance with your proposal would cause for residency and fellowship programs.

There are 150 number of residents in the internal medicine residency/fellowship programs in three hospitals at Case Western. To track their time on an hour by hour basis will cost the programs several thousand dollars per month for the program. This is not a negligible effect. CMS must consider the local effect before it proposes these rules. I encourage CMS to finalize a rule that eliminates the local costs of complying with yet another regulation. In addition, the costs and overhead of running a training program do not go away when residents are on vacation. Thanks for your consideration

Keith Armitage

**CMS-1533-P-191 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mr. Charles Privalsky

**Date & Time:** 06/08/2007

**Organization :** Mr. Charles Privalsky

**Category :** Individual

**Issue Areas/Comments**

**DRG Reform and Proposed MS- DRGs**

DRG Reform and Proposed MS-DRGs

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a close friend of a brain tumor patient, and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

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The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

**CMS-1533-P-192 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Kay Marsyla

**Date & Time:** 06/08/2007

**Organization :** Trinith Health West MI Shared Services

**Category :** Hospital

**Issue Areas/Comments**

GENERAL

GENERAL

See Attachment

CMS-1533-P-192-Attach-1.DOC

#192



June 7, 2007

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

West Michigan Finance Shared  
Services  
1820 44<sup>th</sup> Street SE  
Kentwood, MI 49508

**Re: FY 2008 Medicare Inpatient Prospective Payment System Proposed Rule  
CMS-1533-P**

Dear Ms. Norwalk:

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 proposed rule to update the Inpatient Prospective Payment System for FY 2008.

WMFSS has several key concerns regarding the Medicare Inpatient Prospective Payment System Proposed Rule as summarized below:

**2.4 Percent "Behavioral Offset"**

*(Federal Register Pages 24708-24711)*

A provision in the Benefits Improvement and Protection Act (BIPA) of 2000, provides the CMS authority to adjust the standardized amount to eliminate the effect of changes in coding or classification of discharges that do not reflect real changes in case-mix. WMSS is strongly opposed to the proposed adjustment based on the assumption that the case-mix index of hospitals will automatically increase. The CMS does not have any compelling evidence for this proposed change.

**The CMS is assuming providers will have higher case mixes based on Maryland's transition to AP-DRGs. Within the three providers represented by WMSS, after the changes to the DRGs, co-morbidity and complications last fiscal year, it took our coding staff six months to one year to capture everything correctly. The changes that are currently being proposed for FY 2008 are more drastic. It is realistic to expect that it will take at least a year for coding to adapt to the changes proposed. Therefore, WMSS recommends that the CMS eliminated this reduction and provide hospitals with the full 3.3 percent market basket increase. Until the MS-DRGs are fully implemented and the CMS can document and demonstrate that any increase in the case-mix results from changes in coding practices rather than actual changes in patient severity there should be no "behavioral offset."**

**Medicare Severity (MS) DRGs**

*(Federal Register pages 24691 – 24712)*

For FY 2008, the CMS is proposing to adopt Medicare Severity (MS) DRGs, which are the result of modifications to the current CMS DRGs to better account for patient severity. While the CMS proposes to implement the MS-DRGs on October 1, 2007, they also believe that the MS-DRGs should be evaluated by RAND and have instructed RAND to evaluate the proposed MS-DRGs using the same criteria that it is applying to the other DRG systems.

The proposed MS-DRGs would increase the number of DRGs from 538 to 745. While the current CMS DRGs include 115 DRGs that are split based upon the presence or absence of a complication or co-morbidity (CC), the MS-DRGs include 152 DRGs that subdivide into three major tiers: major CC, CC and non-CC and another 106 DRGs that subdivide into two severity levels.

**Currently, the billing system used by WMSS has one grouper for all payors. The CMS DRGs are used by our two other major payors (Blue Cross and Medicaid) with a few variances. By moving Medicare to the MS-DRG system, the DRG grouper will be incompatible with our other major payors. Initially, this will cause an increase in billing costs and time from patient discharge to the bill going out the door. Second, significant money would have to be invested into the software to accommodate multiple grouper systems. Third, WMSS and the individual hospitals use the DRGs for various reports and analytical tools. This drastic change between the CMS DRGs and the MS-DRGs would make year to year analysis very difficult. Again, causing more time and money to be spent by the hospitals. Therefore, WMSS supports the American Hospital Association and Michigan Hospital Association's proposal for a four-year transition.**

### **Hospital-Acquired Conditions**

*(Federal Register page 24716 - 24726)*

Complications such as infections acquired in the hospital can trigger higher payments in the form of outlier payments and/or higher DRG payments due to the presence of a complication or comorbidity (CC). The Debt Reduction Act of 1999 (DRA) requires the CMS to identify, by October 1, 2007 (FY 2008), at least two CC secondary diagnoses that:

- Are high cost, high volume, or both;
- Result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis; and
- Could reasonably have been prevented through the application of evidence-based guidelines

For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases where one of the selected conditions was not present. The law states that the CMS can revise the list from time to time, as long as the list contains at least two conditions. Additionally, the DRA requires hospitals to report the secondary diagnoses that are present at admission when reporting payment information for discharges on or after October 1, 2007.

The CMS selected 13 conditions as possible candidates to satisfy the DRA provision for hospital-acquired conditions. According to the CMS' selection method, the conditions at the top of the list best meet the statutory selection criteria, while the conditions lower on the list may meet the selection criteria but could present a particular challenge (that is, they may be preventable only in some circumstances, but not in others) and therefore, the first conditions listed should receive the highest consideration of selection among the initial group of hospital acquired conditions.

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

**WMFSS believes that three of the top six conditions representing the serious preventable events identified by the CMS – object left in during surgery, air embolism and blood incompatibility – are appropriate conditions to include for FY 2009. Because these conditions**

are identified by discrete ICD-9 codes, they can be coded by hospitals. More importantly, these are events that can cause great harm to patients and for which there are known methods of prevention. WMFSS also recommends that the CMS expand demonstration projects such as the MHA Keystone Center in Michigan to truly improve patient safety and quality for Medicare and all patients.

### **Recalibration of DRG Weights**

*(Federal Register pages 24746 – 24754)*

For FY 2008, CMS has not proposed any changes to the methodology adopted in FY 2007 for calculating cost-based DRG weights. The three-year transition from charge-based DRG weights to cost-based weights would continue, with two-thirds of each weight based on an estimation of costs and one-third based on charges.

The AHA identified several reasons for why this recalibration of weights is flawed. **Additionally, WMSS has first hand knowledge that the cost based information on the cost reports has not been audited with any depth by the Fiscal Intermediaries in several years. Due to budget cuts at the FI, looking at cost groupings, charge groupings and statistical allocations is not done. The audit time is spent on areas of the cost report that results in cost savings to Medicare (bad debt, disproportionate share, interns and residents, transplant, and settlement data). To base DRG weights on a cost basis that has not been audited is in itself flawed.**

### **Rural Floor**

*(Federal Register pages 24787 – 24792)*

The CMS proposes applying the budget-neutrality adjustment associated with the rural floor to the wage index rather than the standardized amount in FY 2008. While it considered both an iterative process and a uniform reduction, the agency said the uniform is operationally easier and results in the same wage indices.

**WMSS supports this move assuming that it removes the compounding effect of applying the budget-neutrality adjustment for the rural floor to the standardized amount annually since 1998. WMSS believes this was an unintended error to repeatedly apply the rural floor budget-neutrality adjustment without first reversing the prior year's adjustment as is done with the outlier calculation each year. WMSS also suggests that the CMS remove the effects of the adjustments made from 1999 through 2006 by increasing the positive budget-neutrality adjustment proposed to the standardized amount intended to just reverse the 2007 adjustment.**

### **Revision of the Wage Index Adjustment – FY 2009 Proposed Rule**

*(Federal Register page 24802)*

Section 106(b)(1) of the Tax Relief and Health Care Act of 2006 requires MedPac to review the current Medicare wage index classification system and recommend alternatives to the method of computing the wage index. MedPac is required to submit a report to Congress on the findings by June 30, 2007.

**WMSS agrees that the current wage index system does not work well. The inconsistencies on how hospitals file the data, how the fiscal intermediaries interpret the regulations (different treatment of items from various offices of a single fiscal intermediary), and the effect of the occupational mix on the wage index all culminate in a wage index that no one**

can be assured is correct. Nor does WMSS agree that using the Bureau of Labor Statistics (BLS) data is the answer. As it is not a requirement to file the information with the BLS, fringe benefit data is not included (hospitals tend to have higher fringe benefits) and the data captured is only for two weeks a year, using the BLS data as it currently stands will not necessarily correct the wage index issue. WMSS is requesting that the wage index issue be reviewed further before making any changes but acknowledging that changes do need to be made.

### Hospital Quality Data

(Federal Register pages 24802 – 24809)

The Medicare Modernization Act (MMA) required hospitals to submit data on quality measures to the CMS, which this provision applied for three years (FY 2005-07). Participating hospitals were required to submit data on a set of ten quality measures and for their data to meet certain validation requirements. Hospitals that withdrew from the program or failed to submit valid data received the marketbasket increase minus 0.4 percent for FFYs 2005 and 2006.

The DRA extended and expanded this program, giving the CMS greater authority. In the FFY 2007 IPPS final rule, the penalty for withdrawal from the program or failure to comply with its requirements was increased to 2.0 percent; some procedural changes were effected; and the set of quality measures was expanded to a total of twenty-one. For FY 2009, the CMS is proposing to add one outcome measure and four process measures to the existing 27 measure set to establish a new set of 32 quality measures to be used for the FY 2009 annual payment determination.

**WMSS does not believe that quality improvement has been addressed with the first set of 27 measures. Also, the data collection of the current 27 and the five additional proposed for FY 2009 have not been addressed. Not every provider has all of this documentation electronically. To gather this data requires more time and cost. WMSS is requesting that the CMS evaluate if the quality has been improved with the current measures before adding additional measures that may or may not improve quality.**

### IME Adjustment

(Federal Register pages 24812 – 24815)

In the FY 2007 final rule, the CMS finalized a policy to exclude residents' time spent in non-patient care activities from the resident count for purposes of IME (in all settings) and direct graduate medical education (in non-hospital settings) payments. Since that time, the agency has received questions about the treatment of vacation or sick leave and orientations. While recognizing that this time is neither devoted to patient care or non-patient care, but rather a third category, the proposed rule would treat vacation and sick time differently than it would treat orientation time. Orientation time would continue to be included as part of the full-time equivalent (FTE) count, as it always has.

Under the proposed rule, vacation and sick time would be removed from the total time considered to constitute an FTE resident. Thus, it would be removed from both the numerator and the denominator of the FTE calculation. The CMS acknowledges that this would result in lower FTE counts for some hospitals and higher counts for other hospitals, solely because of this regulatory change.

WMSS appreciates the CMS' efforts to clarify its policies, and its attempt to not penalize hospitals for offering sick and vacation leave for its residents. However, the CMS' proposal is operationally impractical. Hospitals would not only have to keep track of the leave for each resident, but then somehow apportion the leave to each of the hospitals the residents' rotate through. **For example, one of our facilities has over 200 residents that make up the 60 or so FTEs that are claimed. All of these residents rotate to at least two different hospitals. The magnitude of the administrative**

burden is very large. Additionally, the IRIS software is not set up to accommodate modifying the denominator for each resident. WMSS recommends that the CMS treat vacation and sick leave similarly to how it proposes to treat orientation time as part of the FTE count.

### **IPPS Capital Payments**

(Federal Register pages 24818 – 24823)

Reimbursement for capital-related costs was implemented in FY 1992. Over a ten-year period, payments for capital were transitioned from a reasonable cost-based methodology to a prospective methodology. Beginning in FY 2002, all hospitals were paid based on 100 percent of the capital Federal rate, which is updated based on changes in a capital input price index (CIPI) and several other policy adjustment factors. Since inception of the capital IPPS, urban and rural hospitals have received the same update to the capital Federal rate. For FY 2008, the CMS is proposing to give rural hospitals the full 0.8 percent update but no update for urban hospitals. WMSS opposes the CMS proposal to freeze urban capital rates and the CMS application of the 2.4 percent “behavioral offset” to capital rates. **Hospitals have already committed funds toward various capital projects (The Hauenstein Center for Neurological Services at Saint Mary’s Health Care; Center for Cancer Care at Mercy General Health Partners; and privatization bed project and PACS at Battle Creek Health System) 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 WMSS hospitals are embracing all of these movements but they are very expensive. For the CMS to recommend no increase in capital payments and the offset for possible increased case mix is not comprehensible at this time. WMSS recommends that the CMS eliminate the 2.4 percent “behavioral offset” and provide all hospitals with the full 0.8 percent capital update.**

### **Capital IME and DSH Adjustments – Potential Elimination**

(Federal Register pages 24818 – 24823)

Under current law, the CMS has “*broad authority in establishing and implementing the IPPS for acute care hospital inpatient capital-related costs.*” In the proposed rule, the CMS considers and seeks comment on eliminating the special payment adjustments provider under the capital IPPS.

Based on the CMS’ analysis of capital IPPS margins in the proposed rule, the CMS is considering further reductions to certain classes of hospitals that have sustained positive margins. These reductions could be focused on the payment adjustments received by teaching hospitals and disproportionate share hospitals. Because these adjustments are not required by law, the CMS is considering proposals that would reduce or eliminate the IME and DSH capital adjustments. The CMS is also determining whether these potential changes to the capital IPPS should be made in a budget neutral manner or should instead result in savings to the Medicare program. The hospitals receiving these adjustments are providing teaching opportunities for future physicians (of which there is becoming a severe shortage) and provide services to a significant number of patients that are indigent. **The hospitals receiving these adjustments have already budgeted for receipt of these payments to operate (to the WMSS hospitals these adjustments are worth over \$1.1 million) and are already being paid less than cost for the Medicare and indigent patients that they treat. WMSS opposes the potential elimination of these payments.**

### **Cost Outliers**

(Federal Register pages 24836 – 24838)

The CMS provides payments for outlier cases involving extraordinarily high costs when compared to average cases in the same DRG. To qualify as a cost outlier, a hospital's cost for the case must exceed the payment rate for the DRG plus a specified amount called the fixed-loss threshold. The outlier payment is equal to 80% of the difference between the hospital's cost for the stay and the threshold amount. The threshold is adjusted every year based on the CMS' projections of total outlier payments to make outlier reimbursement equal 5.1 percent of total payments.

Although a 5.1 percent pool was set-aside for each year for outlier payments, the CMS estimates that only spent 4.1 percent in FY 2005, 4.7 percent in FY 2006 and only 4.9 percent will be spent in FY 2007. The proposed decrease in the fixed-loss threshold of 6 percent is not enough. The hospitals have suffered a loss each year that the CMS has not paid out 100 percent of the outlier pool. This is money that is not recoverable by the hospitals as the difference was never reallocated to another portion of the Medicare pool or split amongst those with outlier payments for any given year.

**WMSS is requesting a further cut in the fixed-loss threshold that will ensure the 5.1 percent outlier pool is paid to the hospitals. WMSS also requests that language be added that in case the outlier pool is not paid out in one fiscal year, the remaining money will be carried forward to be paid in the next fiscal year by either increasing the outlier pool or adding it to the standardized amount.**

Again, WMFSS appreciates this opportunity to provide comments to the CMS regarding this proposed inpatient rule and urge you to please take them into consideration. We believe our suggested modifications will result in positive changes for hospitals and the Medicare beneficiaries they serve. If you have questions on this comment letter, please contact me at (616) 643-3569 or [marsylkp@trinity-health.org](mailto:marsylkp@trinity-health.org).

Sincerely,

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

**CMS-1533-P-193 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mrs. Katherine Perry

**Date & Time:** 06/08/2007

**Organization :** SUNY Upstate Medical University

**Category :** Health Care Professional or Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1533-P-193-Attach-1.PDF

#193

June 8, 2007

Leslie V. Norwalk  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Room 445-G  
Washington, DC 20201

File Code: CMS-1533-P  
Re: Payment for Direct Graduate Medical Education

Dear Ms. Norwalk:

I write regarding the proposal for removing vacation and sick leave in the FTE resident count for purposes payment for direct graduate medical education. I would like to bring to your attention the increased administrative burden that compliance with your proposal would cause for residency and fellowship programs.

There are 114 residents and fellows in the internal medicine residency/fellowship program at SUNY Upstate Medical University. To track their time on an hour by hour basis will cost the program a minimum of \$2,500 per month, as it would require an additional staff member to devote to this task full time in a program this large. This is not a negligible effect. CMS must consider the local effect before it proposes these rules. I encourage CMS to finalize a rule that eliminates the local costs of complying with yet another regulation.

Katherine E. Perry

Educational Programs Administrator  
Department of Medicine

SUNY Upstate Medical University

**CMS-1533-P-194 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mr. Charles Cataline

**Date & Time:** 06/08/2007

**Organization :** The Ohio Hospital Association

**Category :** Hospital

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attachment

CMS-1533-P-194-Attach-1.PDF



June 8, 2007

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Blvd.  
Baltimore, Maryland 21244-1850

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

**Sent Via Electronic Mail**

To whom it may concern:

On behalf of its 170+ hospital and health system members, the Ohio Hospital Association is commenting on CMS' *Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates*, published in the May 3, 2007, *Federal Register*.

The proposed rule would set inpatient hospital payment rates for federal fiscal year 2008, includes significant changes to the methodology for assigning Medicare discharges to Inpatient Hospital Prospective Payment System (IHPPS) diagnosis-related groups (DRGs), and establishes a policy and process by which hospitals will be held accountable for alleged hospital-acquired conditions.

OHA joins the American Hospital Association (AHA) in its support of improvements to the Medicare IHPPS that create an equal opportunity for return across DRGs and provides incentives for hospitals to treat all types of patients and conditions. However, OHA also agrees with AHA that CMS is moving too quickly on a comprehensive change in DRG assignment that has the potential to shift nearly a billion dollars of Medicare reimbursement between hospitals overnight, and violates core principles of the IHPPS, namely that Medicare payments be stable, predictable and based on proven data.

**DRG REFORM AND PROPOSED MS-DRGS**

OHA has always supported CMS' efforts to refine coding and DRG assignment when it leads to appropriate payments for medically necessary services. Further, OHA in previous years has applauded CMS' efforts to level the reimbursement playing field by eliminating incentives for facilities to specialize in more profitable diagnoses and conditions.

June 8, 2007  
Centers for Medicare & Medicaid Services  
Attention: CMS 1533-P  
Page Two

OHA believes CMS' proposed MS-DRG classification system is reasonable and OHA supports its phased-in adoption. There are three qualifications to OHA's support of MS-DRGs.

- **Other Systems to Severity-Adjust DRGs**

Regardless of its potential, the adoption of MS-DRGs and the revised list of complications and co-morbidities (CCs) will be difficult and expensive for hospitals—and CMS—to undertake. And, if it is not very carefully implemented, the change will cause abrupt and unbudgeted shifts in Medicare payments to hospitals. As such, OHA is concerned that CMS could extend and worsen those problems indefinitely if it readopts any other system for severity-adjusting DRGs in the near future. **OHA recommends CMS delay the implementation of MS-DRGs if there is any possibility it might adopt one of the alternate systems under study at the RAND Corporation.**

- **Payment Phase-in**

At no time since the start of the IHPHS has CMS adopted such a major change in payment policy without at least a three-year transition from the old to the new payment rates. Further, OHA agrees with AHA that the industry needs time to review other systems for severity adjusting DRGs, budget for changes in reimbursement, and refine the revised lists of CCs. **OHA supports a four-year transition to the MS-DRGs, with year one devoted to refining, testing and budgeting for whichever system CMS adopts, and years two through four used to phase in the payment differences from the old Grouper to the new, in increments of one third each year.**

- **Behavioral Offset**

**OHA takes its strongest objection to the proposed 2.4 percent cut in the updates to the IHPHS standardized amounts for both FFY 2008 and 2009.** CMS' proposal to severity adjust DRGs is, in essence, the continuation of a 20+ year process to refine the IHPHS. Hospitals have already maximized their ability to affect payments by better medical documentation and coding and CMS has already taken that into effect in adjustments to past updates to the IHPHS standardized amounts. CMS has not demonstrated hospitals would—or even could—manipulate the order and coding of diagnoses and procedures in 2008 and 2009 sufficient to warrant a budget-neutralizing cut of this magnitude. Further, CMS has not indicated that if it is proved wrong it would return the underpayments in 2008 and 2009 to hospitals in the form of higher updates in later years. As such, **OHA strongly objects to any proposal to cut Medicare payments to account for unsubstantiated allegations of “coding creep.” The proposal is wrong and must be eliminated.**

June 8, 2007  
Centers for Medicare & Medicaid Services  
Attention: CMS 1533-P  
Page Three

### **CAPITAL IPPS**

OHA also believes CMS is wrong in its proposal to cut payments to urban hospitals in order to offset what it alone believes to be unacceptable margins in the Capital inpatient prospective payment system. CMS' unilateral decision to cut capital payments will severely disrupt urban hospitals' ability to secure and finance long-term capital at precisely the same time that CMS is pressing for significant policy and procedural changes that will require substantial capital investment in information technology, ICD.10, quality assurance and patient protection programs and systems. **OHA joins the AHA in strongly opposing CMS' unnecessary and unauthorized cuts in Medicare capital payments to urban hospitals.**

### **DRGS: HOSPITAL ACQUIRED CONDITIONS**

As directed by Congress, CMS is proposing to create a process whereby hospitals are financially penalized for the presence upon discharge of specific conditions and injuries not present at admission, which could reasonably have been prevented through the application of evidence-based guidelines. The penalty, as proposed, is that the discharge will be paid under the Medicare DRG that would be assigned if the ICD code for the "hospital acquired" condition was not on the bill. CMS considered 13 conditions and is asking for comments on six of them.

**OHA is still debating whether the conditions CMS identified are appropriate for inclusion and it appreciates CMS' decision to hold back any payment penalties for at least a year while the data is reviewed.**

However, while that debate continues CMS must consider several points about how the process is being developed and the final procedures are established.

- **OHA is concerned CMS is setting a wrong precedent by establishing a system that is punitive, rather than one that encourages process improvement through cultural change.** There is no data to suggest these conditions are always preventable, evidence-based guidelines or not. Yet CMS is taking the approach that the hospital is to be blamed for the "acquired" condition regardless of the circumstance, and without any clear direction about how the decisions will be translated into proactive, educational activities to ensure a problem is not repeated.

June 8, 2007  
Centers for Medicare & Medicaid Services  
Attention: CMS 1533-P  
Page Four

- **OHA is also concerned that CMS is considering including conditions that have not been identified or recommended by nationally recognized quality organizations.** It is important, as this policy is developed for the Medicare IHPPS and potentially expanded to scores of other payers, that the conditions included are mutually agreeable, data-driven and established by an independent third-party that has no bias or goals regarding Medicare payments or the federal budget.
- Finally, **OHA does not think CMS has considered or accounted for all the unintended financial consequences of the “hospital-acquired condition” policy.** Plainly put, this is an enormous unfunded mandate on American hospitals to change the way they admit, record, code, bill and follow-up on Medicare claims.

**OHA specifically objects to CMS requiring hospitals to code and include a *Present on Admission Indicator* for all diagnoses,** not just those conditions identified as part of the policy (see CMS CR 5499). This requirement is not sanctioned by the Deficit Reduction Act, nor will it assist the process OHA has outlined above. It is nothing more than CMS’ attempt to create a huge, expensive and unnecessary pool of data that it can mine for future updates.

OHA is also concerned about the potential for a large increase in cost to cover hospital-based appeals of unfavorable decisions, fund the increase in the number of pre-admission tests necessary to determine whether the identified conditions are actually present on admission, and undertake the necessary work to ensure medical records are complete and appropriately coded.

OHA appreciates the opportunity to comment. You may feel free to contact the association at any time if you have any questions or concerns at 614.221.7614 or electronically at [charlesc@ohanet.org](mailto:charlesc@ohanet.org).

Sincerely,

Charles Cataline  
Senior Director, Health Policy  
/cc

**CMS-1533-P-195 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Dr. Alwin Steinmann

**Date & Time:** 06/08/2007

**Organization :** Albany Medical College

**Category :** Physician

**Issue Areas/Comments**

**Impact--Overall Conclusion**

Impact--Overall Conclusion

June 8, 2007

Leslie V. Norwalk  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Room 445-G  
Washington, DC 20201  
File Code: CMS-1533-P  
Re: Payment for Direct Graduate Medical Education

Dear Ms. Norwalk:

I write regarding the proposal for removing vacation and sick leave in the FTE resident count for purposes of payment for direct graduate medical education. I would like to bring to your attention the increased administrative burden that compliance with your proposal would cause for residency and fellowship programs.

There are approximately 100 residents and fellows in the Department of Medicine here at Albany Medical College. To track their time on an hour by hour basis will add significant administrative work and considerable cost to our programs. CMS should consider the local effect before it enacts these rules. I encourage CMS to finalize a rule that eliminates the local costs of complying with yet another regulation.

Sincerely,

Alwin F. Steinmann, MD, FACP  
Director, Internal medicine Residency  
Vice-Chair for Academic Affairs  
Albany Medical College

**CMS-1533-P-196 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Dr. Virginia Wood

**Date & Time:** 06/08/2007

**Organization :** Wright State University internal medicine

**Category :** Physician

**Issue Areas/Comments**

**IME Adjustment**

IME Adjustment

I am very concerned about the proposal for removing vacation and sick leave from the FTE resident count for purposes of payment for IME and/or DME. This would significantly increase the administrative burden for our residency and fellowship programs.

There are 110 residents and fellows in the internal medicine programs at Wright State University. To track and report their time on an hour by hour basis will require the time equivalent of a 0.2 coordinator FTE and could cost the program at least three thousand dollars per month. In fact, it is unlikely that additional staff would be added for this task, but rather that current personnel would have to take time away from other required duties to complete this tracking.

While understanding that CMS does not think it should be financially responsible for off duty residents and fellows, one must consider the local effects before continuing with implementation of this proposed rule. I encourage CMS to finalize a rule that eliminates the local costs of complying with this additional regulation. Although we don't like to see any reduction in reimbursement, it would be much simpler (and less susceptible to error) to reduce all payments by a decrement that would allow for estimated average time of vacation and sick days.

Thank you for your consideration of this request.

Virginia C. Wood, M.D.  
Program Director, Internal Medicine

**CMS-1533-P-197 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mr. Dan Rode

**Date & Time:** 06/08/2007

**Organization :** American Health Information Management Association

**Category :** Other Health Care Professional

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1533-P-197-Attach-1.DOC

# 197



American Health Information  
Management Association®

June 7, 2007

Leslie Norwalk, Esq.  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: **CMS-1533-P**  
PO Box 8011  
Baltimore, Maryland 21244-1850

Dear Ms. Norwalk:

The American Health Information Management Association (AHIMA) is pleased to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the Medicare Hospital Inpatient Prospective Payment Systems (IP-PPS) and fiscal year 2008 Rates, as published in the May 3, 2007 *Federal Register* (CMS-1533-P).

AHIMA is a professional association representing more than 51,000 health information management (HIM) professionals who work throughout the healthcare industry and whose work is closely engaged with the diagnosis and procedure classification systems that serve to create the diagnosis related groups (DRG) discussed in this proposed rule. As part of our effort to promote consistent coding practices, AHIMA is one of the Cooperating Parties, along with CMS, the Department of Health and Human Services' (HHS) National Center for Health Statistics (NCHS), and the American Hospital Association (AHA). The Cooperating Parties oversee correct coding rules associated with the *International Classification of Diseases Ninth Revision, Clinical Modification* (ICD-9-CM). AHIMA members are also deeply involved with the development and analysis of healthcare secondary reporting data including that associated with quality measurement and in the development, planning, implementation and management of electronic health records.

CMS is proposing adoption of a new severity-adjusted DRG system, MS-DRGs, for FY 2008. However, **AHIMA recommends that implementation of a severity-adjusted DRG system be delayed until FY 2009, when the Rand report is final, the most appropriate severity-adjusted DRG system can be selected, and ample time exists for implementation.**

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In previous years, AHIMA's recognition of the industry's need for consistency in medical coding, improved data integrity, and more precise and contemporary data reflecting 21<sup>st</sup> century medicine has led AHIMA to advocate for adoption and coordinated implementation of ICD-10-CM and ICD-10-PCS in our comments on the IP-PPS. It is unfortunate that, as new initiatives that rely heavily on coded data gain momentum (such as present on admission reporting, pay-for-performance, and DRG refinements to better recognize severity of illness), ICD-10-CM and ICD-10-PCS still have not been implemented as replacements for ICD-9-CM.

If the obsolete ICD-9-CM coding system had been replaced earlier, claims data that would significantly add to the knowledge needed to measure severity, quality, and other factors under consideration would now be available. The proposed MS-DRG system and other proposals in this year's proposed rule are excellent examples of how ICD-10-CM and ICD-10-PCS could improve the ability to refine reimbursement systems in order to better reflect severity of illness. We will point out these examples throughout our comments and we urge CMS and the Department of Health and Human Services (HHS) to take immediate action to secure the adoption and implementation of these two classification systems, and supporting transaction standards as early as possible.

Our detailed comments and rationale are below.

## **II-D: DRG Reform and Proposed MS-DRGs (72FR24691)**

### **II-D-1 – Evaluation of Alternative Severity-Adjusted DRG Systems (72FR24691)**

AHIMA agrees that RAND should evaluate the proposed MS-DRGs using the same criteria it applies to the other DRG systems; however, we are concerned that CMS is proposing adoption of the MS-DRG system without completion of this evaluation. Since RAND is engaged to evaluate alternative DRG systems that may better recognize severity than the current CMS DRGs, it is premature to select and implement a severity-adjusted DRG system before completion of the evaluation and without having your decisions based on this analysis.

The MS-DRG system was not included in the draft interim report, and how it measures up against the other systems being evaluated is still unknown. The potential that implementation of MS-DRGs for fiscal year 2008 could be a one-year stopgap measure, should CMS choose to select an alternative system for implementation next year (as a result of RAND's final report of their evaluation of alternative DRG systems), is problematic and costly. Implementing a new DRG system is a major change that involves significant investment in education and systems changes. Also, comparability of DRG data will be impacted each time a new system is implemented.

**AHIMA recommends that CMS delay implementation of a severity-adjusted DRG system until RAND's final report is available and a thoughtful decision, based on RAND's evaluation, can be made.**

### **II-D-2 – Development of Proposed Medicare Severity DRGs (72FR24697)**

**AHIMA opposes the re-use of the current CMS DRG numbers in the MS-DRG system.** Although we acknowledge the advantages of maintaining the current three-digit numerical scheme, we believe the

use of the same DRG numbers in both the current CMS DRG and MS-DRG systems will create confusion when analyzing longitudinal data, given the same DRG number will have a different meaning in the two systems. Delaying implementation of a severity-adjusted DRG system until FY 2009 would allow additional time for making more extensive systems modifications, such as adopting an alphanumeric or four-digit numerical structure for the new DRG system.

We commend CMS for undertaking a long-overdue comprehensive review and revision of the CC list. However, **AHIMA believes more industry input is needed regarding the revised CC and the CC and MCC designation in the MS-DRG system.** The brevity of the public comment period in combination with insufficient detail associated with the process and rationale for categorization of diagnoses as MCCs, CCs, and non-CCs made it very difficult to conduct a thorough analysis of all of the codes on the MCC and CC lists. However, we have identified a few concerns regarding the CC/MCC lists:

- **AHIMA disagrees with the decision to designate code 428.0, Congestive heart failure, unspecified, a non-CC.** The proposed rule incorrectly characterized the diastolic and systolic heart failure codes as congestive heart failure codes. Per the Fourth Quarter 2002 issue of *Coding Clinic for ICD-9-CM*, congestive heart failure is not an inherent component of the codes in category 428 for systolic and diastolic heart failure. According to *Coding Clinic*, code 428.0 should be assigned as an additional code when the patient has systolic or diastolic congestive heart failure. Also, code 428.0 may appropriately be assigned by itself when congestive heart failure is documented, but there is no documentation of systolic or diastolic heart failure. In ICD-9-CM, there is no distinction between an acute exacerbation of congestive heart failure and chronic congestive heart failure. Code 428.0 is assigned for both. Also, codes 402.11 (benign hypertensive heart disease with congestive heart failure) and 402.91 (unspecified hypertensive heart disease with congestive heart failure) are on the CC list. We believe **code 428.0 should be included on the revised CC list as well.**
- **There are unexplained inconsistencies within the designation of non-CC, CC, and MCC.** For example:
  - While congestive heart failure (code 428.0) and benign and unspecified essential hypertension (401.1 and 401.9) individually have been designated as a non-CC, combination codes 402.11 (benign hypertensive heart disease with congestive heart failure) and 402.91 (unspecified hypertensive heart disease with congestive heart failure) are listed as CCs.
  - Other protein-calorie malnutrition and unspecified protein-calorie malnutrition (codes 263.8 and 263.9) are on the CC list, but mild and moderate malnutrition (codes 263.1 and 263.0) are not.
- Based on input from our members regarding the resources required to treat these conditions, we believe **the following codes should be retained on the CC list:**
  - 285.1, Acute posthemorrhagic anemia
  - 413.9, Other and unspecified angina pectoris
  - 427.31, Atrial fibrillation
  - 492.8, Other emphysema
  - 496, Chronic airway obstruction NEC
  - 599.7, Hematuria
  - 780.39, Other convulsions
  - 786.03, Apnea

- 799.02, Hypoxemia
- In some cases, the current ICD-9-CM classification system does not adequately distinguish between acute and chronic forms of a condition. In the MS-DRG system, this distinction appears to be critical in predicting resources utilized at the patient level. **AHIMA recommends that CMS work with the National Center for Health Statistics (NCHS) to make ICD-9-CM code modifications to improve this acute and chronic distinction.** Additionally, CMS and HHS should take immediate steps for the adoption of ICD-10-CM, as this system is much better than ICD-9-CM at distinguishing clinical severity, which is a key aspect of any severity-adjusted DRG system. Continued use of ICD-9-CM severely limits the ability of a severity-adjusted DRG system to recognize severity of illness.

#### **II-D-4 – Conclusion (72FR24706)**

AHIMA commends CMS' responsiveness to last year's PPS public comments in the development of a severity-adjusted DRG system. Clearly, the MS-DRG system does a better job than last year's proposed CS-DRGs of reflecting medical technology and other improvements, made over the years, in the current CMS DRG system. However, **AHIMA believes implementation of a severity-adjusted DRG system should be delayed until FY 2009, when the Rand report is final, the most appropriate severity-adjusted DRG system can be selected, and ample time exists for implementation.**

AHIMA believes there is insufficient implementation time – essentially 61 calendar days – between the publication of the final rule at the beginning of August and proposed implementation of MS-DRGs on October 1. Although the MS-DRG system is based on the current CMS DRG system:

- The structure, grouping logic, and CC list are quite different.
- Systems changes will need to be made, such as creating a new data element for the MS-DRG.
- Systems edits or analytic reports based on DRGs will need to be modified.
- Encoding and grouping software will need to be modified.
- Hospital staff and physicians must be educated.

It is not clear if software vendors will be ready in time. Also, a grouper and definitions manual are not yet available, and without these resources, it is not possible to fully understand, evaluate, or analyze the specifics related to the assignment of an MS-DRG at a case or even an aggregate DRG level.

Use of ICD-10-CM and ICD-10-PCS would provide a much better foundation for a severity-adjusted DRG system than ICD-9-CM. The value of MS-DRGs or any other severity-adjusted DRG system that relies on claims data will be limited by the continued use of an obsolete, non-specific classification system. ICD-10-CM and ICD-10-PCS would provide greater clinical detail, and up-to-date clinical information for capturing information on disease severity, including complications, co-morbidities and risk factors, as well as more detailed information on the use of medical technology and its impact on resource utilization and outcomes. The longer adoptions of contemporary classifications are delayed, the more CMS must develop alternatives that become costly to administer and for providers costly to continually implement.

#### **II-D-5 – Impact of the Proposed MS-DRGs (72FR24707)**

**AHIMA opposes CMS' proposal to reduce the IPPS standardized payment amounts by 2.4 percent each year for FY 2008 and FY 2009 to eliminate the suggested effect of changes in coding or classification that do not reflect real changes in case mix. This proposed behavioral offset has no basis in actual data or research pertaining to inpatient hospital coding practices.**

AHIMA has long been an advocate of consistent coding practices and serves as one of the four Cooperating Parties responsible for development of the *ICD-9-CM Official Guidelines for Coding and Reporting* and the content of the American Hospital Association's *Coding Clinic for ICD-9-CM*. These publications provide official industry guidance on complete, accurate ICD-9-CM coding, without regard to the impact of code assignment on reimbursement. AHIMA's Standards of Ethical Coding stipulate that "coding professionals are expected to support the importance of accurate, complete, and consistent coding practices for the production of quality healthcare data." Therefore, AHIMA believes that all diagnoses and procedure should be coded and reported in accordance with the official coding rules and guidelines and does not advocate the practice of only coding enough diagnoses and procedures for correct DRG assignment.

We acknowledge that at the time the prospective payment system was first introduced in the early 1980s, coding accuracy was not at the level it should have been. However, much has changed since then. Increased attention to the quality of coding and documentation as a result of the role coding plays in DRG assignment has led to much-improved coding practices. And hospitals began to realize that in order for CMS to make DRG modifications that would recognize the resource-intensiveness of a diagnosis or procedure, that diagnosis or procedure must be included in the reported codes so that it would be included in CMS' data.

It is unknown how many hospitals, if any, code only the diagnoses and procedures that affect reimbursement rather than coding all reportable diagnoses and procedures. Further, since CMS only processes nine diagnosis and six procedure codes, CMS has no way of knowing how many codes that currently do not affect the CMS DRG assignment, but would affect the MS-DRG, are being reported beyond the ninth diagnosis and sixth procedure codes.

The Maryland experience with APR-DRG implementation is used as a basis for projecting behavioral changes in the wider national hospital population. AHIMA believes the Maryland experience is not an appropriate basis for projecting changes in coding as a result of MS-DRG implementation. Prior to APR-DRG implementation, Maryland hospitals were not paid using a DRG system. DRG data was collected for statistical purposes, but DRGs were not used for reimbursement. Unlike the rest of US hospitals, Maryland hospitals did not have prior experience coding under a DRG system, and therefore, we do not believe their experience with APR-DRG implementation is at all similar to the rest of the country's experience with MS-DRG implementation. Coding practices under APR-DRGs are not necessarily comparable to that under MS-DRGs. For example, since APR-DRGs were not designed for reimbursement purposes, we have found that the system logic is not always consistent with nationally recognized coding rules and guidelines, resulting in possible changes in coding practices that do not necessarily represent improved coding. Since MS-DRGs are based on a DRG system designed for reimbursement, we are not aware of similar conflicts with nationally recognized coding practices in the MS-DRG system.

Although RAND Corporation acknowledged in its interim report on alternative DRG systems that changes in coding patterns or behavior could improve payments with each severity adjusted DRG system,

the interim report also noted that coding behaviors are expected to vary under alternative systems. RAND compared the potential for coding improvements among the various systems they evaluated, based on the logic of each DRG system. However, an evaluation of MS-DRGs is not included in RAND's interim report and is not expected until the final report. RAND noted, that without having the opportunity to observe actual changes in coding behavior when a DRG system is used for payment, it was not able to empirically assess the relative risk the alternative severity-adjusted systems pose for case mix increases attributable to coding improvement.

**AHIMA does not believe any payment adjustment to account for case mix increases, which are attributable to coding improvements, should be made until CMS has conducted appropriate research to determine the extent to which this would become an issue under the proposed MS-DRG system.** While the design of the MS-DRG system may encourage an increased level of coding specificity, it is unknown what effect, if any, this might have on the case mix index. As noted earlier, we believe most hospitals are already coding all diagnoses and procedures in accordance with official coding rules and guidelines.

**AHIMA continues to recommend that CMS process all reported diagnoses and procedures.** CMS' failure to process more than nine diagnoses and six procedures is one of the most common complaints from our members. A complete picture of the patient's diagnoses and procedures is needed to fully represent the severity of illness and accurately calculate the DRG in any severity-adjusted DRG system. The development of the MS-DRG system was based on incomplete data due to Medicare's failure to process more than nine diagnoses and six procedures. The severity of illness of hospital inpatients has increased over the last decade, due to shifts in the provision of care from the inpatient to outpatient setting. This has led to an increase in the number of comorbidities per hospital admission. Demands for greater coding specificity have also led to an increase in the number of reported diagnosis and procedure codes. Given this situation, **AHIMA recommends that hospitals report all codes that are reportable according to the ICD-9-CM Official Guidelines for Coding and Reporting and that CMS accept and use all submitted codes in the DRG calculation.**

If there is variability in the completeness of hospital coding practices, AHIMA agrees with RAND that the amount of coding improvement is likely to vary across hospitals, depending on how strong their current coding practices are and the resources they are able to devote to improving them. Therefore, we also agree with RAND that CMS' practice of making an across-the-board adjustment to PPS payments to address case mix increases attributable to coding improvements raises an equity issue that CMS needs to consider.

## **II-F: Hospital-Acquired Conditions, Including Infections (72FR24717)**

Since the Deficit Reduction Act only requires the selection of two hospital-acquired conditions, **AHIMA recommends that for fiscal year 2008, CMS adopt only two conditions that would not result in the higher-weighted DRG assignment when they are not present on admission.** Since this is a new concept for both hospitals and CMS, we believe it would be best to start out slow in order to ensure accurate data collection and to ensure that payment reduction is limited to conditions that are the most likely to be preventable.

Again, we urge CMS to adopt ICD-10-CM and ICD-10-PCS, as these improved classification systems would greatly enhance the quality of present on admission data and the identification of hospital-acquired conditions.

Specific comments on proposed hospital-acquired conditions:

- Catheter-associated urinary tract infection: Although identification of this condition is complicated by the need to assign two codes to fully capture the condition, there are ICD-9-CM codes that clearly describe this condition. Our members indicate that documentation will be an issue, as the physician documentation must link the urinary tract infection with the catheter in order to assign code 996.64, Infection and inflammatory reaction due to indwelling urinary catheter.
- Pressure ulcers: This is an excellent example of why ICD-10-CM would be a much better system for reporting hospital-acquired conditions than ICD-9-CM. ICD-10-CM distinguishes the various stages of pressure ulcers, whereas ICD-9-CM does not. If pressure ulcer is selected as one of the hospital-acquired conditions, CMS will need to provide both a clinical definition of a pressure ulcer and instructions regarding the reporting of a pressure ulcer that progresses during the hospital stay (for example, clarification as to the reporting of an early stage, or pre-ulcer stage, at the time of admission that progresses to a full-blown pressure ulcer, or a more severe stage, during the hospitalization is needed).
- Serious Preventable Event–Object Left in During Surgery: There is a specific code to identify this circumstance. However, we believe several issues will need to be clarified prior to implementing this circumstance as one of the hospital-acquired infections. Clarification is needed as to whether code 998.4 should be assigned when a foreign body is discovered and removed prior to the patient leaving the operating room. Situations whereby the original surgery was performed during a previous encounter or at a different hospital also need to be clarified. In other words, code 998.4 may be reported for a different encounter or by a different hospital than the one where the original surgery was performed.
- Serious Preventable Event–Air Embolism: There is a specific code to identify this condition.
- Serious Preventable Event–Blood Incompatibility: There is a specific code to identify this condition.
- Staphylococcus Aureus Bloodstream Infection/Septicemia: **We oppose adopting septicemia as one of the hospital-acquired conditions.** Although there are specific codes to identify this condition, it is very difficult to determine whether it truly developed after admission or is a progression of an infection the patient had at the time of admission. We do not believe that creating an exclusion list would entirely resolve this problem. For example, the causal organism for an infection present at the time of admission, such as pneumonia, might not be determined, but that doesn't mean it is not related to the septicemia that develops later. In this case, the code for pneumonia, organism unspecified, would be assigned instead of the code for Staphylococcus aureus pneumonia.
- Ventilator Associated Pneumonia: We agree with CMS that ventilator-associated pneumonia should not be selected as one of the hospital-acquired conditions at this time because there is no unique ICD-9-CM code and there is no clear definition as to what constitutes ventilator-associated pneumonia.
- Vascular Catheter-Associated Infections: We agree with CMS that vascular catheter-associated infections should not be selected as one of the hospital-acquired conditions at this time because there is no unique ICD-9-CM code. CMS noted in the proposed rule that the associated specific infection codes would have to be identified so that they would not count as a CC. In the case of sepsis due to a vascular catheter, the code for sepsis (995.91) or severe sepsis (995.92) would be

assigned in addition to the codes for vascular catheter-associated infections and the specific infection, and these codes are also CCs.

- Clostridium Difficile-Associated Disease: While there is a specific ICD-9-CM code for this condition, we agree with CMS that it should not be selected as one of the hospital-acquired conditions because of the lack of prevention guidelines.
- Methicillin-Resistant Staphylococcus Aureus (MRSA): We agree that it would be difficult to clearly identify MRSA infections. Using a combination of code V09.0 and specific codes for infections due to Staphylococcus aureus would be problematic because not all infection codes identify the responsible organism (for example, code 998.59, other postoperative infection).
- Surgical Site Infections: As CMS indicated, there is currently no ICD-9-CM code that uniquely identifies surgical site infections.
- Serious Preventable Event-Surgery on Wrong Body Part, Patient, or Wrong Surgery: We agree with CMS' decision not to select this circumstance as one of the hospital-acquired conditions for all of the reasons stated in the proposed rule.
- Falls: Even if a unique code existed to identify falls occurring in the hospital, a fall does not necessarily mean any injury has occurred. To include falls as one of the hospital-acquired conditions, CMS would need to link the occurrence of a fall with an injury.

## **II-G: Proposed Changes to Specific DRG Classifications (72FR24726)**

Unless otherwise noted, AHIMA supports CMS' proposed changes to specific DRG classifications.

### **II-G-4b – Spinal Fusions (72FR24731)**

We support the reassignment of spinal fusion cases with a principal diagnosis of tuberculosis or osteomyelitis to DRGs that better account for resource utilization. However, to classify patients with these diagnoses to the proposed MS-DRGs 456, 457, and 458 would require a modification of the DRG titles. MS-DRGs 456, 457, and 458 are defined as patients with diagnoses of spinal curvature and malignancies, whereas tuberculosis and osteomyelitis are infectious processes and do not fit into this description.

## **IV-A: Reporting of Hospital Quality Data for Annual Hospital Payment Update**

### **IV-A-1 – Background (72FR24802)**

As stated in our previous comment letters, AHIMA remains concerned that even though there is an active program under way to develop standard measurements for quality, the lack of detailed diagnoses and procedure data, that could be available with the use of ICD-10-CM and ICD-10-PCS, will make the information gathered incomplete and inconsistent when it comes to using it for the measurement of quality and other factors.

As CMS continues to develop and require implementation of quality measures, the additional measures increase the burden on hospitals to report on the defined measures. Although it is imperative to measure the quality of treatment and patient care, the cost of increasing burdens of reporting may cause programs to collapse under the weight of trying to meet CMS' requirements. Additionally, the cost of reporting on the required measures will eventually outpace the bonus payments whether voluntary reporting or not.

**AHIMA recommends providing additional information regarding the criteria and process by which the Secretary will retire and/or replace quality measures.** Providing information such as timelines and the decision process will allow the healthcare providers and vendors to prepare and plan resources, should the replacement measures be implemented.

AHIMA applauds CMS' efforts to reflect consensus in the healthcare quality sector and looks forward to reviewing the measures incorporated into the future quality efforts. AHIMA recommends that CMS identify what organizations will be selected to set forth the recommended measures for acceptance. By identifying the organizations, it will make the process more transparent and allow the industry to understand and review the measure development and selection process.

#### **IV-A-2 – FY 2008 Quality Measures (72FR24804)**

The Value-Based Purchasing (VBP) program that CMS is implementing beginning FY 2009 identifies the measure for percutaneous coronary intervention for acute myocardial infarction as being within 90 minutes of hospital arrival (see page 23 of the CMS Medicare Value Based Purchasing (VBP) Options Paper dated April 12, 2007 AMI-8a). There is a discrepancy in the information provided in the proposed rule versus the CMS VBP Options Paper (120 minutes of hospital arrival in the proposed rule versus 90 minutes in the Options Paper). Because the VBP is being implemented beginning FY 2009, AHIMA recommends that CMS clarify and/or correct the information so it is consistent and reduces confusion for the industry.

The measures identified in the proposed rule indicate that measures identified in the FY 2008 Quality Measures table will remain in effect up to and beyond FY 2009. The measures referred to are the following:

- AMI (Beta blocker at arrival)
- HF (Left ventricular function assessment)
- PNE (Initial antibiotic received within four hours of hospital arrival)
- PNE (oxygenation assessment)
- SCIP (Prophylactic antibiotic selection for surgical patients)

The CMS VBP program to be implemented beginning FY 2009 indicates that these measures will be phased out and not included in the set for consideration under a financial-based incentive. This information is confusing to the reader as there is no indication in the *Federal Register* for the RHQDAPU program that these measures are expected to be phased out. **AHIMA recommends reconciling this information as quickly as possible so the industry has an appropriate amount of time to prepare their resources.**

#### **IV-A-3a – Proposed New Quality Measures for FY 2009 and Subsequent Years (72FR24805)**

CMS is proposing to add several quality measures for the FY 2009 RHQDAPU program. The CMS VBP Options Paper does not define these measures as being introduced during the implementation of the VBP program for FY 2009. AHIMA recommends reconciling this information as quickly as possible so that the industry has an appropriate amount of time to prepare their resources.

Using claims data as a basis for the development of measures does not provide a strong and comprehensive review of the clinical care received by a patient. Claims data provides only a cursory view into the care received and is not a complete picture by which measures should be developed. AHIMA strongly recommends that CMS reconsider using claims data as the basis for the measure development.

To which facility will the 30-day mortality measures be attributed if the patient has been hospitalized in multiple facilities (for example, patient transfers)?

#### **IV-A-3b – Data Submission (72FR24806)**

In order to be eligible for the full FY 2009 market basket update, we are proposing that hospitals will be required to submit data on 32 measures (the 27 existing measures plus the 5 proposed new measures). The CMS VBP Options Paper indicates that the organization will be phasing out five measures for FY 2009 during its implementation. AHIMA is requesting that CMS clarify how this will impact the market basket update.

#### **IV-A-4 – Retiring or Replacing RHODAPU Program Quality Measures (72FR24807)**

**AHIMA strongly recommends that CMS clearly define and communicate the process by which measures will be retired and/or replaced.** By providing this information to the health care community, it will allow for the appropriate planning and preparing of resources for these changes. This is especially true as the CMS VBP program is implemented during the FY 2009.

#### **IV-A-6 – Electronic Medical Records (72FR24809)**

Stating that hospitals should conform to both industry and Federal Health Architecture (FHA) standards is confusing. Due to the strong and positive work that the Certification Commission for Health Information Technology (CCHIT) is executing, it would be beneficial for the community to have a better and clearer understanding of what CMS is referring to. **AHIMA recommends that CMS provide more detailed information in regards to “industry standards” to better guide hospitals. In addition, CMS should be sure to utilize standards that have been endorsed by HITSP and are part of the CCHIT inpatient electronic health record (EHR) certification criteria.**

#### **IV-B: Development of the Medicare Hospital Value-Based Purchasing Plan (72FR24809)**

The information presented in this section regarding the CMS VBP is outdated and does not reflect the current activities occurring since the last meeting on April 12, 2007. AHIMA recommends that CMS reconcile the information presented in the Options Paper against the information currently being presented in the IPPS proposed rule with regards to the FY 2009. By reconciling this information, it will enable hospitals and vendors to better prepare and plan for the upcoming changes expected during the implementation of such a large program as the VBP.

## Conclusion

AHIMA appreciates the opportunity to comment on the proposed modifications to the Medicare Hospital Inpatient PPS program for FY 2008. AHIMA supports CMS' goal of refining and developing a severity-adjusted DRG system. However, **we recommend that implementation of a severity-adjusted DRG system be delayed until FY 2009** in order to make an informed decision regarding selection of a DRG system based on RAND's final report of their evaluation of severity DRG systems. This will also allow the healthcare industry sufficient time to prepare for implementation of a new DRG system, and avoid the administrative burden of potentially implementing a different severity-adjusted DRG system one year after implementation of MS-DRGs.

**AHIMA further recommend that CMS not make any payment adjustment to account for case mix increases attributable to coding improvements until appropriate research is conducted to determine the extent to which this would become an issue under the proposed MS-DRG system.**

**AHIMA urges CMS to actively promote HHS' adoption and implementation of the ICD-10-CM and ICD-10-PCS coding systems** in order to ensure the availability of appropriate, consistent, and accurate clinical information reflective of patients' medical conditions and care provided. This will allow us to measure quality, implement value-based purchasing, identify hospital-acquired conditions, and adopt a DRG system that improves recognition of variances in severity of illness. With this proposed rule, we face the prospect of a rapidly changed reimbursement system without having first improved the 30-year-old classification system on which it is based, and the transaction standards necessary to carry such data. If CMS and HHS fail to meet the need for 21<sup>st</sup> century classification systems and up-to-date transaction standards, we believe the goals set out by CMS, and required by Congress, to improve the DRG system and the collection and use of quality monitoring data will fail.

**AHIMA continues to recommend that CMS process all reported diagnoses and procedures.** Until CMS has a full picture of the severity and services received by its Medicare patients, any system will result in inaccurate data and flawed decisions based on this data.

AHIMA stands ready to work with CMS and the healthcare industry to see that all these goals, including those of CMS for accurate payment, are met. If AHIMA can provide any further information, or if there are any questions or concerns in regard to this letter and its recommendations, please contact Sue Bowman, RHIA, CCS, AHIMA's director of coding policy and compliance at (312) 233-1115 or [sue.bowman@ahima.org](mailto:sue.bowman@ahima.org), or myself at (202) 659-9440 or [dan.rode@ahima.org](mailto:dan.rode@ahima.org).

Sincerely,



Dan Rode, MBA, FHFMA  
Vice President, Policy and Government Relations

cc: Sue Bowman, RHIA, CCS

**CMS-1533-P-198 Medicare Program; Proposed Changes to the Hospital Inpatient  
Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Mr. Tom Fisher

**Date & Time:** 06/08/2007

**Organization :** University of Tennessee Medical Center

**Category :** Hospital

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1533-P-198-Attach-1.PDF



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

June 8, 2007

Ms. Leslie Norwalk  
Acting Administrator  
Department of Health and Human Services  
Attention: CMS-1533-P  
P.O. Box 8011  
Baltimore, MD 21244-1850

**RE: CMS-1533-P; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

Dear Ms. Norwalk,

University Health System is the parent company of the University of Tennessee Medical Center, an academic medical center and Level I trauma center in Knoxville, Tennessee. We at University Health System appreciate the opportunity to comment on the inpatient proposed regulations for FY 2008. We are concerned that, at a time when the Medicare population and the costs of serving that population are increasing, CMS has proposed to weaken the position of the hospitals that provide services to seniors and the disabled and we ask that you reconsider the proposed changes. Our specific comments follow.

**DRG Reform and Proposed MS-DRGs**

**Adoption of MS-DRGs**

On September 1, 2006, CMS awarded a contract to RAND Corporation to perform an evaluation of alternative severity-adjusted DRG classification systems. RAND is currently evaluating several alternative DRG systems based on how well they are suited to classifying and making payment for inpatient hospital services provided to Medicare patients. Each system is being assessed based on its ability to differentiate among severity of illness. A final report is due on or before September 1, 2007.

Rather than wait for RAND's conclusions, CMS is proposing to adopt MS-DRGs and then have RAND include them as an additional system not in the preliminary RAND report. This report will include further analysis of the five original alternative systems plus additional evaluation of the MS-DRGs and, after receiving it, CMS will "have the necessary information to decide the next steps in the reform of the IP PPS."

CMS, itself, recognizes in its Impact Analysis of Proposed Changes for FY 2008 that the change to MS-DRGs will impact the amount of reimbursement received by hospitals. Given that CMS may (based on the RAND findings) choose a method other than the MS-DRGs in FY 2009, hospitals can expect not just fluctuations in reimbursement between 2007 and 2008, but a second year of variation before reimbursement levels presumably steady in 2010. Since Medicare is the largest payor for the industry, reimbursement uncertainty makes budgeting and capital planning extremely difficult.

In light of the potential for unexpected variation in DRG reimbursement, we ask that CMS delay making any changes to the DRG system in the current year until RAND has completed its comparison and one, single, final solution can be implemented regarding how to modify DRGs to better reflect severity.

#### 2.4% Cut for "Behavioral Changes"

Based on the premise that hospitals do not currently code as completely and accurately as possible, CMS believes the new severity-adjusted DRGs "create a risk of increased aggregate levels of payment as a result of increased documentation and coding."

This premise is a misapprehension. As pointed out in the proposed rule, based on coding using the current CC list, 77.6% of patients have at least one complicating condition present. This supports the assertion that hospitals already do their utmost to code accurately. Additionally, MS-DRGs do not comprise a new system – they are, instead, built on the Medicare DRG system which has been in use for over 20 years. Hospitals already have experience in coding effectively and efficiently under the system and the new MS-DRG system, based as it is on the prior DRGs, will not provide an opportunity for new coding changes.

There is no mandate in the law to impose the proposed regulation. The precedent, as stated in the proposed regulation, was the transition of the Maryland hospitals to All Patient Refined (APR) DRGs. This, however, was an example of moving from a system where coding did not greatly effect reimbursement to a system where more exact coding was incentivized. There is no reason to presume moving to the MS-DRGs will have the same effect. We request, therefore, that if CMS does go forward with implementing the MS-DRGs in FY 2008, that this "behavioral change" reduction be eliminated as it will reduce reimbursement for Medicare services which are being properly provided to needy beneficiaries.

#### Capital IPPS

Medicare is required to pay for the capital-related costs of inpatient hospital services to help fund Medicare's share of expenses for new facilities, renovations, clinical equipment and the increasingly important (and costly) clinical IT systems. With the 2.4% "behavioral change" reduction, CMS has already reduced both operating and capital DRG payments. In addition, CMS plans to eliminate the annual update for capital payments for urban hospitals.

The elimination of the update for capital payment will make it more difficult to purchase the advanced technology, equipment and clinical information systems that consumers now expect and could have the effect of slowing clinical innovation. The capital cuts also have the potential to disrupt the ability of hospitals to make payments on their long-term capital obligations.

As the senior population grows and the price of technology continues to rise, hospitals will be forced to spend larger and larger sums on capital-related costs. We request that CMS not hinder the hospitals' ability to meet these challenges by reducing the funds available to provide needed expansions and improve clinical processes and outcomes for our patients. We ask that the capital payment update for urban hospitals be restored.

Thank you for your consideration of these comments on the important issue of inpatient PPS reimbursement.

Sincerely,

A handwritten signature in black ink, appearing to read 'T. M. Fisher', written over a horizontal line.

Thomas M. Fisher  
Sr. Vice President & CFO  
University Health System, Inc.

**CMS-1533-P-199 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Dr. Lloyd Rucker

**Date & Time:** 06/08/2007

**Organization :** University of California

**Category :** Physician

**Issue Areas/Comments**

**Impact--Overall Conclusion**

Impact--Overall Conclusion

The proposal to not count vacation time for reimbursement would add another paperwork burden to an already overburdened graduate medical education system. The paperwork burden would be enormous for large programs such as mine that has 90 residents who work at 3 major teaching hospitals. In addition, if the GME dollars are conceived as paying for the cost of graduate medical education, then vacation is a part of that cost. Reform the system fundamentally or do away with it by providing a legislative alternative to GME funding. But don't nickel and dime us with these constant, invasive proposals. For a program our size, we would need to hire additional staff just to track and report this proposed new requirement.

**CMS-1533-P-200 Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates**

**Submitter :** Dr. John Buckley

**Date & Time:** 06/08/2007

**Organization :** Henry Ford Hospital

**Category :** Physician

**Issue Areas/Comments**

**GENERAL**

GENERAL

Decreasing Medicare support for Graduate Medical Education by eliminating payments to support residents/fellows on vacation suggests that CMS is interested in supporting their role on an hourly basis. If this is the case, hospitals should be able to include all after-hours, weekend and holiday time residents spend with patients. If we truly go to an hourly basis, I would expect a net increase in GME financial support because of the long hours (up to 80 per week) of resident related patient care.