32-0

SIERRA VISTA HOSPITAL

RECEIVED (17)
JUN 02 2005
BY:.....

CAH/RFC

Hefler
Molley Smith

May 25, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-1500-P
PO Box 8011
Baltimore, Maryland 21244-1850

RE: Oppose Medicare's Proposed Construction Ban on Critical Access Hospitals

To Whom It May Concern:

After years of struggle Sierra Vista Hospital in Truth or Consequences, Sierra County, New Mexico now sees the possibility, the very real necessity of replacing a fifty-year old facility with an updated, more proficient and cost-effective facility to serve the needs of the citizens of our State. As a member of the Governing Board of that facility I would ask that the arbitrary deadline on Critical Access Hospital replacement or relocation in the Inpatient Prospective Payment System be ***deleted.***

Sierra Vista Hospital is a Sole Provider, Critical Access Hospital located in Sierra County New Mexico ***seventy miles from the nearest facility***. It is located on I-25; a major heavily used Interstate Highway. Elephant Butte and Caballo Lakes make this a tourist and recreation area with State Parks that draw well over 100,000 visitors annually, as many as 100,000 on a holiday weekend, making Sierra Vista Hospital the only facility within 70 miles that is available to these visitors and citizens in a critical emergency, to stabilize, treat and if need be transfer to a tertiary facility 70 to 150 miles away. When the Critical Access Program came into being this was precisely what it was intended for.

The date restriction (construction plans that began before December 8, 2003) puts Sierra Vista Hospital at risk to lose its CAH designation if plans proceed to update or construct a new facility.

It was clearly not the intent of Congress in the Medicare Modernization Act that a Critical Access Hospital designated as a Sole Provider, be perpetually prohibited from replacing or relocating their facility. This is especially true of those that are, as Sierra Vista Hospital, fifty years old. Ironically, the CMS proposal to ban a local community's ability to rebuild on an adjacent or nearby location will cost Medicare more over time. The higher costs of operating in an outdated, retrofitted building far exceed the slightly higher cost of rebuilding. In the case of Sierra Vista Hospital, a facility built in the early fifties, the cost of maintenance alone is staggering let alone the cost of meeting current safety codes in an aged building. We are currently operating on a Waiver from the Life Safety Code Program of the

800 East Ninth Avenue Truth or Consequences, NM 87901 Phone: (505) 894-2111 Fax: (505) 894-7659

New Mexico Health Facility Licensing and Certification Bureau for five years due to Life Safety Code violations. Upgrading this facility to Code is impossible.

A ban on major construction projects developed after 12/03/03, is clearly an over-reaction to the rule that would require assurance that after construction the Critical Access Hospital (SVH) will be serving the same community, operating essentially the same services with essentially the same staff. There is no basis in law for the assertion that relocation of a Critical Access Hospital with Sole Provider Status within a community constitutes a cessation of business and loss of its Provider Number and Agreement.

A Critical Access Hospital with Sole Provider designation is associated with its current Medicare Provider Agreement, which should remain intact unless there is a fundamental change in business. It is a long-standing policy that the provider agreement describes the legal entity (SVH) and services provided, ***not the physical structure or location.***

This might even suggest that CMS investigate once again the original intent of the CAH Program, what it was originally intended to achieve before, as is often the case, there were those that took advantage of the programs intent. If a critical access facility is abiding by the standards set forth, there should be no reason for them to lose the important local control especially regarding the construction and upkeep plans for the facility.

Sierra Vista Hospital in Truth or Consequences, New Mexico ***respectfully calls for the deletion of the arbitrary deadline on Critical Access Hospital replacement/relocation in the Inpatient Prospective Payment System Final Rule.***

Yours very truly,

Terry Taylor, Member
Sierra Vista Hospital Governing Board

cc: Senator Pete Domenici
Senator Jeff Bingaman
Representative Steven Pearce
Representative Heather Wilson
Representative Tom Udall
Senator John Arthur Smith
Senator Leonard Lee Rawson
Representative Diane Hamilton

33

May 13, 2005

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

Re: CMS-1500-P
Funding for Pharmacy Residency Programs

Dear Center for Medicare and Medicaid Services,
Subject: CMS-1500-P

It was recently brought to my attention that restoration of funding for second year specialized pharmacy residency programs has been denied. I would like for you to reconsider the restoration of this funding as the pharmacy residency programs provide invaluable structured training for pharmacists. These programs offer comprehensive, structured training that enhances the ability of a pharmacist to interact clinically with patients and improve patient outcomes. These programs are especially important as pharmacists are now able to implement medication management programs for Medicare recipients as part of the new Medicare drug benefit. It will be essential to have adequately trained individuals providing those services to Medicare beneficiaries.

There are many second year specialized training programs which educate pharmacists in geriatric care, transplantation services, infectious diseases, psychiatry, and ambulatory care, just to name a few. As pharmacists are considered the drug experts, wouldn't you wish to have an expertly, specialized trained pharmacists helping you to manage your diabetes or your kidney transplant?

The American Society for Health System Pharmacists submitted to you in a timely fashion, survey data in 2004 and 2005 demonstrating that most hospitals require or prefer to employ clinical pharmacy specialists who have completed second year specialized residency training.

At our institution, all of our clinical pharmacy specialist positions **require** second year specialty residency training. It is imperative that these residency programs are once again funded externally if we are to provide the same quality of care to our patient populations. I am certain that once you are aware of the extent of the services that pharmacists provide for which they are trained in their residency programs you will conclude that it is vital to continue to provide funding for these programs. Should you have further questions, please do not hesitate to contact me at 302-733-6361.

Cordially,

Kimberly Couch, PharmD
Clinical Pharmacy Specialist, Infectious Diseases
Christiana Care Health Services

cc: Gary C. Stein, PhD
The Honorable Barbara Mikulski
The Honorable Paul Sarbanes
The Honorable Wayne Gilchrest

39

Sacred Heart-Saint Mary's Hospitals
MINISTRY HEALTH CARE
Sponsored by Sisters of the Sorrowful Mother
KEVIN J. O'DONNELL
PRESIDENT & CEO

May 25, 2005

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

Reference: CMS-1500-P

Dear Sirs:

The purpose of this letter is to appose the provision in the Centers for Medicare and Medicaid Services (CMS) Inpatient Prospective Payment System (IPPS) final rule that has a deadline date of December 8, 2003 for the start of any replacement or relocation of a Critical Access Hospital (CAH) in a local community.

We request this provision be removed from the final rule for the following reasons:

1. The Proposed Regulation transfers to CMS control over the basic structure of local rural health care, a loss of local control never before seen, and if allowed to stand, a precedent that threatens all hospitals and all communities.

2. It was clearly not the intent of Congress in the Medicare Modernization Act that a CAH designated as a Necessary Provider be perpetually prohibited from replacing or relocating their facility, facilities that are often 40 to 50 years old.

3. Many rural hospitals are located on a small campus in the middle of residential neighborhoods with relocation being the most appropriate, and sometimes only, alternative. This was the case for Sacred Heart Hospital in Tomahawk, Wisconsin.

4. Ironically, the CMS proposal to ban a local community's ability to rebuild on an adjacent or nearby location will cost Medicare over time, more, not less. The higher labor costs of operating in a retrofitted building more than offset the slightly higher cost of rebuilding.

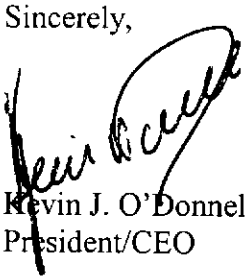
5. A ban on major construction projects developed after December 8, 2003 is an over reaction against a potential problem that can be appropriately managed by a portion of CMS's proposed rule that would require assurance that, after the construction, "the CAH will be servicing the same community and will be operating essentially the same services with essentially the same staff."

6. The CMS ban is based on the misguided belief, not tested in law and a break with CMS's past policy, that the relocation of a CAH can be treated differently than for any other hospital. There is no basis in law that the relocation within a community of a CAH with Necessary Provider status constitutes a cessation of business and loss of its provider agreement and number.

7. A CAH's Necessary Provider designation is associated with its current Medicare provider agreement that should remain intact unless the CAH fundamentally changes its business (e.g., ceases its current operations) or is terminated by Medicare. It is a longstanding policy that the provider agreement describes the legal entity and services provided, not the physical structure or location.

By including a copy of this letter to our State and Federal Representatives, I'm requesting their assistance, and direct intervention in striking out this provision in the IPPS final rule.

Sincerely,



Kevin J. O'Donnell
President/CEO

KJOD/kah

cc: Senator Roger Breske
Senator Russ Feingold
Representative Don Friske
Senator Herb Kohl
Congressman David Obey

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(85)

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Hefton
Harkien
Tribal
Walk

Submitter : Miss. Anne Ferrell **Date:** 06/10/2005

Organization : na

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

As a person who struggles with chronic pain and inadequate resources to help, I feel that the research is clearly supporting the disabling effects of untreated or undertreated pain on an individual's mental and physical health. I believe it is to our collective societal benefit to do all that is possible to help us who suffer to have our needs met so we may remain functioning citizens. While my pain definitely limits me, I believe strongly that I have gifts to contribute and due to inadequate pain relief there are days I am unable to contribute to my community. I would love these days to be fewer, and if we are truly a humane country as we say we are, then I believe it is a human right to have our medical needs, including pain relief, met. And part of this is to provide us with as many options as possible, and insurance companies would be prudent to cover pain management tools, since research is showing there are long-term health effects of un/undertreated pain. In the end, un/undertreated pain will drive up health care costs and social service costs. Sincerely,

Anne Ferrell

CATHOLIC HEALTH INITIATIVES

Marymount Medical Center

May 16, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: Comments on **WAGE DATA CORRECTIONS**

Dear Dr. McClellan:

We appreciate the opportunity to comment on the Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates, published in the Federal Register on May 4, 2005. We are commenting on the policy discussed at page 23384 of the May 4, 2005 Federal Register regarding retroactive changes to the federal fiscal year 2005 (FY 2005) wage index.

The policy discussed at page 23384 states that, pursuant to section 903(a)(1) of Pub. L. 108-173, which allows the Secretary to make retroactive changes to items and services if failure to apply such changes would be contrary to the public interest, the Centers for Medicare and Medicaid Services (CMS) is proposing a retroactive correction to the wage data used to compute the FY 2005 wage index for hospitals that meet certain criteria. The criteria are: 1) the fiscal intermediary or CMS made an error in tabulating a hospital's FY 2005 wage index data; 2) the hospital informed the fiscal intermediary or CMS, or both, about the error, following the established schedule and process for requesting corrections to the FY 2005 wage index data; and 3) CMS agreed before October 1 that the fiscal intermediary or CMS made an error in tabulating the hospital's wage data and the wage index should be corrected by the beginning of FY 2005, but CMS was unable to publish the correction by that date. The discussion at page 23384 also states that CMS published a correction to its FY 2005 inpatient prospective payment final rule on December 30, 2004 that included the corrected wage data for four hospitals that meet the above criteria and that the corrections were effective January 1, 2005.

We very much agree that a retroactive correction to the FY 2005 wage index is appropriate and appreciate the Secretary exercising his authority to make that retroactive correction. For reasons discussed below, however, we request that the policy be amended

to delete the requirement that CMS must have agreed before October 1, 2004 that it or the intermediary made an error in tabulating a hospital's data.

St. Joseph Hospital (provider no. 18-0010) and St. Joseph East (provider no. 18-0143) are both located in the Lexington, KY core-based statistical area ("CBSA"). For both hospitals, the fiscal intermediary made an error in tabulating the hospital's FY 2005 wage index data (based on the hospitals cost reports ending June 30, 2002), and the hospitals informed the fiscal intermediary and CMS of this error following the established schedule and process for requesting corrections to the FY 2005 wage data. Accordingly, both hospitals meet the first two criteria proposed by CMS for a retroactive correction to the FY 2005 wage index data.

The hospitals received a letter dated October 15, 2004 from James Hart, Deputy Director of the Division of Acute Care for CMS, stating that CMS had reviewed this wage data matter and that it agreed that it was necessary to correct the hospitals' wage data. The letter also states,"[t]he corrected wage data will be retroactive to October 1, 2004, and will be published in an upcoming correction notice and/or joint signature letter." Because this letter is dated October 15, 2004, it does not technically meet the third criteria proposed by CMS at page 23382. (Although, as a practical matter, we believe that CMS had determined that the wage data for provider nos. 18-0010 and 18-0043 should be corrected prior to October 1, 2004, but did not issue its letter stating so until October 15, 2004.)

We believe, however, that the circumstances described above justify a retroactive correction to the FY 2005 wage data pursuant to section 903(a)(1) of Pub. L. 108-173, because the failure to apply such changes would be contrary to the public interest. The fact that CMS agreed to make the wage data change retroactive to October 1, 2004 is sufficient reason to implement the change as of that date. Moreover, these wage data corrections should have been implemented as part of the established process for requesting corrections to the wage index data, which would have made them effective October 1, 2004. Accordingly, we suggest that the criteria published at page 23384 of the Federal Register be amended to delete the requirement that CMS must have agreed before October 1, 2004 to correct the wage data.

We also want to confirm our understanding that the wage data correction for provider nos. 18-0010 and 18-0143 will result in a retroactive wage index correction to October 1, 2004 for all acute-care hospitals in the Lexington, KY CBSA. In our opinion, a change to the wage data for provider nos. 18-0010 and 18-0143 that did not affect the wage index for the entire CBSA would be inequitable and contrary to the public interest.

Again, we very much appreciate the opportunity to comment on the proposed policy and CMS's effort to make retroactive corrections to the FY 2005 wage index when those corrections are in the public interest.

Sincerely,

Robert Brock
Chief Financial Officer

cc: Scott Raab, Office of Senator Mitch McConnell

NT

37

STANFORD UNIVERSITY SCHOOL of MEDICINE
DEPARTMENT OF CARDIOTHORACIC SURGERY
FALK CARDIOVASCULAR RESEARCH CENTER
STANFORD, CALIFORNIA 94305-5407

R. SCOTT MITCHELL, M.D.
PROFESSOR OF CARDIOVASCULAR SURGERY

TELEPHONE (650) 723-5823
FACSIMILE (650) 725-3846

Hefte, Hartstein, Troell Nat L

May 25, 2005

Centers for Medicare and Medicaid Services
Attention: CMS-1500-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: "New Technology" status for endovascular grafting of the thoracic aorta

Dear Sirs:

As a surgeon with a longstanding interest in disease of the thoracic aorta, I have enjoyed a long involvement with devices designed for less invasive repair of thoracic aortic pathology. The new TAG device from W.L. Gore is a major advance in the treatment of thoracic aortic pathology, as it allows repair in a much less invasive manner, dramatically reducing both morbidity and mortality from the open repair, and allowing patients to return to an active lifestyle much more quickly. These observations have been verified by the multi-center control trial submitted to the FDA for TAG graft approval.

From a patient's perspective, the TAG device is even more dramatic. Patients are very apprehensive and fearful of a possible rupture of their thoracic aneurysm, but they are even more fearful of the open surgical repair and the possibility of dreaded complications, including paraplegia. They view this new device as a lifesaving device, have researched it on their own, and frequently present to the physician's office requesting a stent graft repair.

From my perspective, this stent graft will dramatically impact appropriate patients with thoracic aortic pathology, simplify the operating procedure, shorten their hospital stay, and hasten their return to mobility and daily living. Granting "New Technology" status will facilitate this process.

Thank you very much for your consideration.

Yours sincerely,

R. Scott Mitchell, M.D.

RSM:ep

cc: Don Goffena
Elizabeth Hoff

Nurs/AH/Manne

CMS-1500-P-42 **Changes to the Hospital Inpatient Prospective Payment Systems and FY 2006 Rates**

Heller
Hornstein
Trueus
Lefkowitz
Ruiz

Submitter : **Dr. R Donald Harvey III** **Date & Time:** **05/05/2005**

Organization : **UNC Health System**

Category : **Pharmacist**

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-1500-P
Funding for Pharmacy Residency Programs

CMS-1500-P-42-Attach-1.DOC

Attachment #42
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: CMS-1500-P
Funding for Pharmacy Residency Programs

Dear CMS:

I am a pharmacist in the specialty area of hematology and oncology at the University of North Carolina Health Systems. We are a state-funded, 700 bed hospital and provide care to all residents. Our cancer care is given in a multi-disciplinary model through the Lineberger Comprehensive Cancer Center, an NIH-designated center of excellence for the institution. Many of our patients rely on Medicare and Medicaid insurance for the provision of their health care.

I am writing to urge CMS to restore funding for second-year, specialized pharmacy residency programs. As a graduate of one of the hematology/oncology residency at UNC, I am extremely disappointed that CMS has neglected to fund these very important training programs. Without specialty training, I would not have been able to achieve the professional satisfaction of clinical specialization that I enjoy today. The expertise that is gained is similar in nature to specialized physician training, and serves to elevate the level of care of all patients in a particular disease area. Funding is particularly important as the pharmacy community is preparing to implement medication therapy management programs as part of the new Medicare drug benefit. Failure to restore funding will limit Medicare beneficiaries' access to the expertise of clinical pharmacy specialists and will lead to increased Medicare spending for health care.

Physicians, nurses, administrators, and other pharmacists view our program and its trainees as essential to the care of all our patients with malignant disorders. We have trained a total of 15 residents over the years and each has gone on to provide superb patient care at exemplary institutions across the country. Without CMS funding, our program will likely be eliminated.

We require all clinical specialists to have completed a second-year, specialty residency program in order to be hired at our institution. Without this training, we will no longer be able to hire and provide

Sincerely,

R. Donald Harvey, III, PharmD, BCPS, BCOP
Senior Clinical Specialist in Hematology, Oncology and Coagulation
Department of Pharmacy
Clinical Assistant Professor
University of North Carolina
107 Old Cooper Square
Chapel Hill, NC 27517
dharvey@unch.unc.edu

Senator Richard Burr

217 Russell Senate Office Building
Washington, DC 20510
Senator Elizabeth Dole
555 Dirksen Senate Office Building
Washington, DC 20510
to your Representative:
Congressman David Price
2162 Rayburn House Office Building
Washington, DC 20515

Nurs/AH/Pharm

CMS-1500-P-47 **Changes to the Hospital Inpatient Prospective Payment Systems and FY 2006 Rates**

Hefler
Horstein
Travis
Lefkowitz
Ruiz

Submitter : **Dr. Pamela Lada** **Date & Time:** **05/06/2005**

Organization : **Boston Medical Center**

Category : **Pharmacist**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1500-P-47-Attach-1.DOC

Attachment #47

Funding for Pharmacy Residency Programs

Dear CMS:

I am the Clinical Pharmacy Specialist for Emergency Medicine at Boston Medical Center in Boston, MA. We are a Level 1 trauma center and our Emergency Department has approximately 130,000 adult and pediatric patient visits combined per year. Patients utilize our ED for many different issues; traumas, assaults, acute MIs, status epilepticus, strokes, and drug misadventures to name a few. This is a very unique practice area and requires those to be highly trained with a specialty residency program having a strong emphasis on critical care and emergency management. Pharmacists in these specialty positions have documented increased patient satisfaction, decreased adverse drug events and decreased length of stay for admitted patients. For patients discharged from the ED, there are decreased revisits due to more appropriate empiric therapies and the availability of the clinical pharmacist to spend time with the patient before discharge. Areas for the pharmacist include correct dosing/choice of medications due to comorbid conditions, assisting patients by answering any questions and explaining appropriate administration techniques in the setting of complicated medication regimens along with assisting nurse in calculating emergency drip rates, and medication compatibilities.

I understand the value of the specialty learning experience, as I would not have my current position without additional training. This position required emergency medicine specialty training. Our Human Resource department informed me that there was no other candidate out there currently with my expertise and level of training. In fact, most clinical specialists received their current hospital position due to specialty residency training with more programs demanding specialty training. I feel to continue developing highly effective pharmacist it is crucial for CMS to restore funding for second-year, specialized pharmacy residency programs. In my current practice I am able to train both Pharm.D. candidates as well as first-year residents. Since emergency medicine is such a unique area the necessary skill set is not currently taught in most colleges of pharmacy.

My goal is to develop a second-year program to teach others how to care for patients in the ED. Currently in the US there are approximately 60 EM pharmacists with varying practices. Looking at the vast number of EDs in the US, the availability of clinically trained EM pharmacists is a drop in the bucket. With more and more literature stressing the overcrowding of the ED and medication errors it is imperative to train more pharmacist in this area. This is not a discipline that can be learned in a one month rotation but it needs to be learned over a residency year. Topics such as toxicology, rapid sequence intubations, infectious diseases require the constant exposure to new cases to see the patient variations, for example geriatric patients require different agents/dosages for sedation and neuromuscular blockade than pediatric patients. Boston Medical Center is an ideal learning environment for the specialized training of pharmacy residents in all aspects of emergency medicine.

Sincerely,

Pamela L. Lada, Pharm.D.

Clinical Specialist - Emergency Medicine
Boston Medical Center
88 E. Newton, Atrium H2606
Boston, MA 02118-2393
Office (617) 414-5389

NUSHAH/Pharm

CMS-1500-P-50 **Changes to the Hospital Inpatient Prospective Payment Systems and FY 2006 Rates**

Hattie Hartstein Towne Lefkowitz Luiz

Submitter : Dr. Krystal Edwards **Date & Time:** 05/06/2005

Organization : Dr. Krystal Edwards

Category : Pharmacist

Issue Areas/Comments

GENERAL

GENERAL

see attachment

Issues

Issues

CMS-1500-P

CMS-1500-P-50-Attach-1.DOC

CMS-1500-P-50-Attach-1.DOC

Attachment #50
May 6, 2005

Center for Medicare & Medicaid Services
ATTN: CMS-1500-P
P.O. Box 8010
Baltimore, MD 21244-1850

RE: CMS-1470-P

Dear Sir or Madam:

I am writing to express my request restore funding for pharmacy residency programs policy change for: CMS-1500-P. I am a pharmacist who graduated with my Bachelor of Science in Pharmacy and my Doctor of Pharmacy degree and then completed two years of post-graduate residency training in pharmacy practice and primary care specialty pharmacy practice. I then went on to accept a faculty position as an assistant professor and have been practicing for 1 year.

Residencies are mandatory for pharmacists who plan on pursuing an academic career. As the number of pharmacy schools opening in the country continues to grow, we are in dire need of qualified professors to adequately teach pharmacy students. One of the requirements for pharmacy practice instructors is to complete specialty residency training. If residency programs were no longer funded under Medicare, it would directly decrease the numbers of qualified applicants for professor positions. The profession of pharmacy as a whole would suffer. Patients would also suffer as a result of decreased training of pharmacists by qualified people.

Residencies are also mandatory for pharmacists practicing in clinical roles directly with physicians on teams in hospitals and outpatient clinical settings. In addition, they are preferred in community pharmacy settings where pharmacists are providing immunizations, bone screening for osteoporosis, and diabetes blood glucose monitoring, and other clinical disease state monitoring as providers. Residency programs are a formal, structured learning process for individuals to obtain more intensive training in therapeutics once they have completed their Doctor of Pharmacy degree. As with medical residencies, pharmacy residency training allows pharmacists to more thoroughly extrapolate book knowledge into clinical real-life situations. These programs go through a rigorous, peer-reviewed accreditation process upon initiation and subsequently every three years to make sure certain training standards are met.

In the outpatient clinic setting where I now practice and in the outpatient settings and hospitals where I completed training, residents take on significant responsibilities that directly affect the care of patients and their clinical outcomes. In the outpatient clinical setting pharmacists have direct patient contact, often managing long-term disease states such as diabetes, hypertension, anticoagulation, asthma, COPD, and hyperlipidemia under protocols with physicians. Residents also provide on-site drug information and recommendations to physicians to optimize therapy and decrease side effects and drug interactions. Patients' s charts with multiple medications (polypharmacy) are reviewed to decrease the number of medications needed, optimize drug therapy, prevent drug interactions and potential side effects, and recommend adequate drug monitoring laboratories. Pharmacy residents also provide patient education and counseling on medications and disease states that physicians often do not have time to provide to patients due

to the pressure to see as many patients per day as possible. Nurses are often asked to provide this education but are understaffed and overworked thereby not having adequate time to provide discharge counseling in this setting. During my residency training one of my projects was to set up a multidisciplinary heart failure clinic. This education taught me how to set up my own clinic once I finished the residency program. This level of training is not taught in pharmacy school and often cannot be taught "on-the-job" since it is the job one is brought in to do alone. In the hospital, residents have an in-house, on-call program. They respond to phone calls for drug information from physicians and nurses. They provide discharge medication counseling for all patients who are discharged from the hospital. Residents are also responsible for clinical rounding coverage with medical teams on the weekends. This is the only "clinical" coverage that is done during the weekends, as the rest of the pharmacy staff functions with fewer people. They are able to catch significant errors, as they see these patients first-hand and interact directly with physicians to hear their plans for the patients. Often, there is not time for pharmacy staff to check renal or hepatic function and drug dosing appropriateness for these disease states, & residents are there to ensure safety for the patients. Residents in the hospital and in outpatient clinical settings are also involved in quality improvement (QI) projects to minimize patient errors. Residents provide physician and nursing inservices on drug therapy topics as well. These inservices are usually focused on a particular area of need where there have been errors in the past or where there is a lack of understanding of drug action. The knowledge gained by physicians and nurses as a result of these processes directly reduces the number of prescribing and administration errors in our patient population.

Although pharmacy residencies are learning experiences for residents, it should be obvious from my comments above that they provide us with a tremendous amount of benefit and clinical application far beyond any "continuing education" program. Residents are paid for their work, but it is the equivalent of 3-5 years of training for every one year of residency completed. I personally feel that the wide variety of activities offered for residents to participate in during a residency program far exceeds the opportunities for learning they would have received in general practice in 3-5 years. These activities allow them to function as a well-rounded practitioner who has the problem-solving skills to aide in highly complex medical issues. If Medicare eliminated residency reimbursement, it would greatly impact my institution, as well as the institution where I trained, in addition to many others. Patients simply would not receive the same level of care, as there is not enough pharmacist manpower alone in typical pharmacy budgets to successfully offer the breadth of services we can with residents. As the number of elderly patients continues to rise and number of prescriptions taken continues to rise, the problem will only be more acute in the future.

I sincerely appreciate the opportunity to comment on the proposed policy change. As an individual who personally benefited from Medicare pass-through funds, I feel adamant about this issue. I can testify that I would not be able to provide the level of care that I do today without my residency training.

Sincerely,

Krystal L Edwards, Pharm.D., BCPS
Assistant Professor & Clinical Pharmacy Specialist
Texas Tech University Health Science Center – School of Pharmacy

41

Original.

CMS-1500-P-63 **Changes to the Hospital Inpatient Prospective Payment Systems and FY 2006 Rates**

Hefter
Hartstein
Bucks
Fagan
Erwin
Kelly

Mady Hare

Submitter : Mr. Murray Clark **Date & Time:** 05/16/2005

Organization : University of Kentucky Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-63-Attach-1.DOC

Debra A. Ellis, RHIT, CCS
Nosologist
Solucient, LLC
5400 Data Court, Suite 100
Ann Arbor, MI 48108

June 1, 2005

Attachment #63

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

Dear Sir or Madam:

These comments are regarding typographical errors found in the Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates. [CMS-1500-P] published May 4, 2005. The following typographical errors were found in Table 5 - List of Diagnosis R elated G roups (DRGs), R elative Weighting F actors, G eometric a nd A rithmetic mean Length of Stay.

Printed in table 5,

DRG	DRG Title Printed	Correct DRG Title
14	Intracranial hemorrhage or stroke with infarct	Intracranial hemorrhage or cerebral infarction
276	Non-maligant breast disorders	Non-malignant breast disorders

Also, DRG 315, Other kidney & urinary tract O.R. procedures has been modified to include non-OR procedures in the past several years. The DRG Definitions Manual, Version 22, published by 3M lists the title of this DRG as "Other kidney & urinary tract procedures". We suggest that this change be made to the title of this DRG in the Federal Register as well.

Sincerely,

Debra A. Ellis, RHIT, CCS
Nosologist

42
CAH/RECC

CMS-1500-P-71 **Changes to the Hospital Inpatient Prospective Payment Systems and FY 2006 Rates**

Heather
Hart
Collins
Neva
Molley Smith

Submitter : Mr. Thomas Hudgins **Date & Time:** 05/18/2005

Organization : Pinckneyville Community Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1500-P-71-Attach-1.DOC

Attachment #71

June 1, 2005

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attn: CMS-1500-P

I am forwarding my comments to express my deep concern about the impact of the proposed changes outlined in CMS-1500-P on Critical Access Hospitals created under the Necessary Provider option that are considering the construction of a new facility to ensure their ability to serve their community in the future.

Rural Hospitals are the first line of contact for millions of Americans who require healthcare. Those of us in rural areas recognize that we cannot be all things to all people at all times. We do understand our role of providing high quality, personalized care to all who come through our doors. Those we cannot help for their entire scope of needs, we arrange to transport to facilities and physicians with that ability. Without the immediate attention to life-threatening situations by qualified professionals, many lives would be needlessly lost or reduced in quality.

Each of the facilities, some predating the Hill Burton Program, has served its community with often-unrecognized distinction. Changes in how care is provided and safety codes have placed operational stresses on these facilities. In many cases, patients are receiving optimal care delivered by the professional skills of caregivers in sub-optimal settings.

The proposed rule would defeat the purpose of strengthening rural hospitals to maintain their presence in their communities. The reimbursement methodology for Critical Access Hospitals provides a sound financial footing for the future of these key elements of healthcare in rural America. Establishing a financial track record to approach funding sources for replacement facilities does not happen overnight. Given the strained financial conditions that existed in most of the hospitals that converted to Critical Access status, the focus at these hospitals was more on survival than thinking about what the future might hold in terms of a new facility. With an improving financial position, comes acquisition of new equipment, recruitment of new physicians and thoughts of providing a modern facility, designed to meet the future needs of the community, become a reality. In my experience in building a replacement hospital, having a five-year track record with a positive financial performance was critical. This provided the groundwork for those considering funding this project to see that the future was strong enough to ensure repayment of the funds to be extended.

With the restrictive provisions that would apply to Critical Access Hospitals who obtained their status through the necessary provider program, over 700 Critical Access Hospitals nationwide stand potentially affected by this proposed rule. In the state of Illinois, the almost 50 Critical Access Hospitals in the state would all fall under this proposed rule and be in a position not to

replace their facilities should the need arise in the future without the loss of cost based reimbursement which is a key to obtaining the necessary financing.

The requirement that documentation demonstrate that plans to r ebuild p redated December 8, 2003 would prevent most Critical Access Hospitals in the country that came into existence as a necessary provider from being able to place a new facility into service even if the need warranted such an action and the finances of the organization could support it. Absent this ability, many communities over time would lose their local healthcare provider and all of the benefits that accrue with the presence of a viable and vibrant hospital.

Being assigned to a sub class of hospitals by a rule that predated conversion under the allowed necessary provider process is an injustice to those who work at rural hospitals, those who serve on their Boards and the communities these hospitals serve.

In many cases, necessary providers who have become Critical Access Hospitals are located in areas that do not lend themselves new replacement onsite or on contiguous property. In these cases, the cost of attempting these projects would likely exceed the cost of building a replacement facility in a new location. This is a choice that should be driven by the needs of an area and the associated costs.

I feel that any Critical Access Hospital that is relocating to construct a new hospital, should be required to demonstrate that it will continue to provide service to the same population that it had served in its prior location and its services and staffing should be commensurate with the services that were provided in the replaced facility. If this can be demonstrated, any Critical Access Hospital should be allowed to maintain their status at the new location.

I would encourage a serious revisiting of these proposed rules to ensure that those of use who provide care in rural America have the ability to continue to do so and to lay the groundwork so that our children and our children' children will continue to have access to quality, cost effective care in their home communities.

Sincerely,

Thomas J. Hudgins, FACHE
Administrator/CEO
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Arturo J. Echeverri MD Nicholas J. Okon DO Lowell R. Quenemoen MD Roger S. Williams MD

May 15, 2005

CMS
DHHS
Attn: CMS-1500-P
PO Box 8011
Washington, D.C. 21244-1850

Re:

Dear Folks,

First, let us introduce ourselves. We are neurologists with special expertise in the management of cerebrovascular diseases. We have worked with colleagues at both hospitals in Billings, and in surrounding communities, to develop multi-disciplinary teams for the rapid and most effective treatment of people with acute stroke or "brain attack". Early, well coordinated therapy is essential to minimize permanent brain damage and maximize functional recovery. *Time is brain!* Our Billings stroke programs recently were evaluated and accredited by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO).

At St. Vincent Hospital, we also have interventional radiologists who are capable of performing cervical and intracranial angiography, angioplasty, and intra-arterial thrombolysis ("clot-busting therapy"). When we can treat people early, within the first hours of stroke, we can be thrilled to witness the resolution of severe neurological impairments within minutes, impairments that surely would have been permanent without this specialized intervention. Now that we have teams and programs in place, our challenge is to increase public awareness, and increase the numbers of people who present as early as possible for therapy. With our excellent ground, fixed-wing and helicopter ambulance systems, we can effectively treat people within a radius of about 150 miles, if only we can get to them in time.

As you might imagine, this type of intervention is highly resource intensive. We need specially trained people who are committed and well coordinated, and we require special equipment and facilities. We must be willing, and able, to drop every thing to provide this service, *immediately*! Patients with regularly scheduled appointments are sent away.

Every thing is put on hold until the stroke patient has completed the course of therapy, which typically takes three to six hours of sustained intervention by a team of experts.

There is a major threat to the vitality of programs like ours, and the threat is primarily financial. In our heavily managed and regulated system of reimbursement for health care, there currently is no adequate mechanism to cover the costs of a successful service like ours. We are strapped with diagnosis-related groups (DRGs), procedure codes (CPTs), and relative value units (RVUs) that predate the era of these more effective interventions. In the current Medicare structure, for example, reimbursement to hospitals is the same for all stroke patients, whether or not these specialized, brain-saving services are provided.

In March 2005, several nationally recognized experts in cerebrovascular disease met with staff of the Center for Medicare-Medicaid Services (CMS), and presented a proposal for changes in the current regulations. CMS agreed to receive comments on the new Rule ("Medicare program: proposed changes to the hospital inpatient prospective payment systems and fiscal year 2006 rates.").

On behalf of the nearly 300,000 people in our service area, we enthusiastically endorse the Proposed Rule.

Thank you,

Nicholas J. Okon, DO

Roger S. Williams, MD

Arturo J, Echeverri, MD

Lowell R. Quenemoen, MD

44

INTEGRIS
Bass Baptist
HEALTH CENTER

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580.233.2300 • (f) 580.233.8802

DSH
Hosp. Rates
WE Kansas/Update

May 23, 2005

Dr. Mark McClellan, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8011
Baltimore, MD 21244–1850

File Code: CMS–1500–P

Dear Dr. McClellan:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled *Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Proposed Rule*, 70 Fed. Reg. 85 (May 4, 2005). We appreciate your staff's work on this prospective payment system, particularly given the competing demands on the agency.

Unfortunately, this rule carries out implementation changes included in the fiscal year (FY) 2005 final rule for the inpatient hospital prospective payment system (PPS) that have a devastating effect on INTEGRIS Bass Baptist Health Center in Enid, Oklahoma. INTEGRIS Bass Baptist Health Center is in one of only two single-county Metropolitan Statistical Areas (MSAs) that is now treated as rural under the new Core Based Statistical Area designations, as adopted by CMS.

As a result of the new rural designation, the hospital will receive the rural wage index at the end of the hold harmless period, and adjustments to our rates under the disproportionate share hospital payment will be reduced from about 32 percent to 12 percent pursuant to the cap applied to hospitals in rural areas. In combination, those changes eliminate approximately **$4 Million** in annual revenue when fully implemented; **$1.1 Million** is the result of the wage index change and **$2.9 Million** is related to the DSH cap applied to our hospital. The cumulative effect of these changes for the period from FFY 2006 to FFY 2009 is approximately $11.8 Million. Absent reconsideration of our treatment as rural, we have no option but to reduce or eliminate certain services.

This letter briefly summarizes the decisions made in the FY 2005 final rule, the impact on our organization and the communities we serve, and our comments related to the FY 2006 proposed rule. Specifically, we address the following concerns:

- Garfield County was designated by the Office of Management and Budget (OMB) as Micropolitan, but CMS should look at the characteristics of the area when determining whether it should be considered urban or rural. We believe an examination of the data supports treatment of Garfield County as urban.
- The hospital's wage index, DSH percent, and case mix index are more similar to its urban counterparts than other rural hospitals in the state.
- INTEGRIS Bass Baptist Health Center provides many services characteristic of urban hospitals and should be treated as urban. In its area, the city of Enid and the hospital are the "hub" or core of where services in the county are provided. If the hospital eliminates certain services, the nearest alternative provider is in the neighboring MSA almost 80 miles away.
- The FY 2006 proposed rule offers no recourse for INTEGRIS Bass Baptist Health Center or similarly situated hospitals through reclassification (for wage index purposes) or other means by which the hospital can recoup DSH revenue otherwise payable to the institution if it were considered urban.

Garfield County is more similar to other single-county MSAs than rural areas

OMB adopted new standards for defining Metropolitan and Micropolitan Statistical Areas December 27, 2000. They applied these definitions to Census 2000 data in June 2003, and announced the new areas. The revised standards resulted in Garfield County (previously a Metropolitan Statistical Area) being classified as a Micropolitan Statistical Area because of changes to the standards for defining MSAs. The Micropolitan Area is a new category that did not exist in previous definitions (e.g. the 1990 standards), and CMS chose to treat micropolitan areas as rural for purposes of the wage index and DSH adjustment. We believe the agency's decision to treat all Micropolitan Statistical Areas as rural failed to differentiate between two important circumstances:

1. Areas losing population and becoming more rural
2. Areas whose population is unchanged, but whose designation changed simply due to revised OMB standards for defining MSAs.

Garfield County fits the second situation described above. The county is no less metropolitan in character than it was in 1990. In fact, its population increased 2 percent between the 1990 and 2000 Census.

Chart 1. Population of Garfield County, OK, 1990 and 2000

Metro/ Micro Area Code	Micropolitan Statistical Area County or equivalent	Legal/Statistical Area Description	Population		Change 1990 to 2000	
			April 1, 2000	April 1, 1990	Number	Percent
21420	Enid, OK	Micropolitan Statistical Area	57,813	56,735	1,078	1.9

Source: U.S. Census Bureau, Census 2000 and 1990.

The urban core of the county, the city of Enid, has more than 45,000 residents – just shy of the requisite 50,000 required for designation as a metropolitan area. Further pointing to the similarity to an MSA where services are intrinsically tied to the central city, more than 75 percent of the county population resides in this urban core. The relationship between the city of Enid and Garfield county is similar to the population patterns observed in several single-county MSAs recognized by CMS and OMB shown in Chart 2. Conversely, most of the new micropolitan areas have several small urban areas with populations of 10 – 20 thousand people, rather than a large, central city such as Enid.

Chart 2. Population of Enid, OK Micropolitan Area and Selected MSAs

Urban Area Name, Census 2000	Urbanized Area Population, Census 2000	Geography	Total County Population, Census 2000
Micropolitan Statistical Area			
Enid, OK Urban Cluster	45654	Garfield County, Oklahoma	57813
Metropolitan Statistical Areas			
Fond du Lac, WI Urbanized Area	50058	Fond du Lac County, Wisconsin	97296
Columbus, IN Urbanized Area	50227	Bartholomew County, Indiana	71435
Ames, IA Urbanized Area	50726	Story County, Iowa	79981
Auburn, AL Urbanized Area	60137	Lee County, Alabama	115092

Source: U.S. Census Bureau, Census 2000 Summary File 1 (SF 1) 100-Percent Data

In addition, the commuting patterns of workers within and into the county remain virtually unchanged according to Census Bureau's "Journey to Work" data. Ninety-two percent of workers lived and worked in Garfield County in 2000; 93 percent lived and worked there in 1990. However, the Census data used by OMB to determine whether the county is metropolitan do not mirror the commuting patterns of hospital workers employed by INTEGRIS. Nearly 20 percent of INTEGRIS Bass employees commute from other counties to work at the hospital, compared to only 8 percent of all Garfield County workers. A complete breakdown of hospital and county employees' county of residence is provided in Attachment A. Not only is the hospital a large employer in the community, but they draw employees from a much larger geographic area than is represented by the county-level data OMB relies on for metropolitan determinations.

When OMB issued the revised statistical area definitions, they were cautious in their advice to agencies about the use of these definitions by programs such as Medicare, and rightfully so. In their December 27, 2000, *Federal Register* notice implementing the new standards, they acknowledge the risks associated with making policy decisions using these definitions, stating that:

> "The success [of the MSA definitions] is evident in the use of statistics for Metropolitan Areas to inform the debate and development of public policies and in the use of Metropolitan Area definitions to implement and administer a variety of nonstatistical Federal Programs. These last uses, however, raise concerns about the distinction between appropriate uses—collecting, tabulating, and

> publishing statistics as well as informing policy—and inappropriate uses—implementing nonstatistical programs and determining program eligibility... [OMB] cautions that Metropolitan Statistical Area and Micropolitan Statistical Area definitions should not be used to develop and implement Federal, state, and local nonstatistical programs and policies *without full consideration of the effects of using these definitions for such purposes*."

As OMB recognized, discretion is very important in the implementation of these criteria. Because CMS had the authority to use or disregard the micropolitan area definitions in their application of the wage index, we believe the agency also has the authority to exercise discretion in the application of the urban and rural designations assigned to individual counties classified as micropolitan. We urge the agency to look closely at the hospital and county-level data, recognize the similarity between Enid, OK and other single-county metropolitan statistical areas with only slightly larger populations, and designate Garfield County as urban for purposes of the disproportionate share hospital adjustment.

INTEGRIS Bass is more similar to urban hospitals than rural ones on many levels

Using CMS administrative data, we compared INTEGRIS Bass to other Oklahoma hospitals. Bass compares favorably on many dimensions. Oklahoma has just over 80 hospitals paid under the inpatient prospective payment system (PPS). After excluding specialty hospitals, whose service mix is not comparable to INTEGRIS or other community hospitals in the state because of their intense focus on the performance of profitable procedures, the state has 79 other PPS hospitals. The complete data comparison is provided in Attachment B.

- We used the DSH percent as a proxy for the hospital's commitment to uninsured and under-insured patients. Bass has the 6th *highest* DSH percent in the entire state. All of the hospitals above it on the list are in MSAs, and are therefore able to access the full amount entitled to under the applicable formulas. There are 27 other hospitals *in MSAs* with lower DSH percentages. Bass is above *all* rural hospitals in the state.

- We used the case-mix index as a proxy for the complexity of services provided by the facility. By this measure, Bass has the 12th *highest* complexity of cases. Again, it falls below only 10 of the 27 Oklahoma hospitals in MSAs. The 11th hospital is a neighboring Garfield County hospital. Its CMI is higher than *all* rural PPS hospitals in the state.

- We used the average hourly wages for FY 2006 and the 3-year AHW to illustrate how competitive Bass is in recruiting and retaining a talented workforce to provide the many specialized services in its community. In FY 2006, Bass had the 8th *highest* AHW in the state, and its wages have risen in each of the last three

years. When compared by the 3-year AHW, Bass is the 13th best hospital employer in the state.

Even though the DSH reductions have already cost the hospital $700,000 this year, these losses pale in comparison to the revenue that will be lost after the DSH cap is fully implemented and the wage index drops to the rural rate. Not only will these changes affect the services offered by the hospital, but there is no way the hospital can continue to recruit and retain skilled labor as the administrative data currently reflect.

Looking beyond administrative data, INTEGRIS services are more similar to urban hospitals than other rural providers. INTEGRIS Bass Baptist Health Center has repeatedly responded to the needs of the growing community it serves. Often, the services the community and surrounding area needs draw a large number of uninsured and under-insured patients. In particular, INTEGRIS Bass provides a variety of inpatient psychiatric services, including acute and RTC inpatient treatment for children, adolescents, and adolescents with a dual diagnosis of mental retardation and mental illness. The hospital is recognized as the primary non-government provider of inpatient psychiatric services in the entire region of the state. In 2004 alone, INTEGRIS Bass received over 3,000 referrals to its behavioral health services.

Like the behavioral health services, Bass offers the only radiation oncology services in the area. Without the hospital's commitment to provide oncology services, patients in the community would have to drive about 70 miles to the nearest provider.

In addition, INTEGRIS Bass has responded to an acute shortage of OB physicians which drew nationwide attention from the news media. Bass implemented an aggressive recruitment campaign that resulted in the addition of three OB physicians to serve the needs of the Vance Air Force Base population as well as the Enid community and outlying areas.

INTEGRIS Bass also provides many state-of-the-art services common to large urban hospitals, including offering the only fully digital combined catheterization and special procedures lab in Northwest Oklahoma. The hospital's heliport receives referrals from many surrounding hospitals. In addition, the Bass emergency department is the busiest in Northwest Oklahoma, seeing about 20,000 patients per year.

The provision of these services are not required for the hospital to operate, but as the primary—and often only—provider of these services, the hospital urges CMS to make every effort to restore its urban DSH adjustment to ensure that Bass can meet the needs of its community.

The Proposed Rule Offers No Recourse for the Loss of DSH or Wage Index Funds

The proposed FY 2006 inpatient PPS rule continues to implement policies that are already having a devastating effect on INTEGRIS Bass Baptist Health Center.

Wage Index. Timing denied Bass one reclassification opportunity. The CBSA definitions were implemented in FY 2005 *after* the one-time opportunity for wage index appeals provided by Section 508 of the Medicare Modernization Act. As a result, the hospital was denied an opportunity for wage index reclassification designed specifically to address reclassifications for hospitals unable to meet the standard criteria.

In the FY 2005 Final Rule, you included a provision that would essentially allow a hospital in a county that was "dropped" from an MSA and is now designated as its own metropolitan area to reclassify to the old MSA by allowing the use of the old and new definitions of CSAs and CBSAs to reclassify as a county group. Several urban county groups have taken advantage of this criterion. This provision recognized that these counties no longer meet OMB's criteria for outlying to the MSA but that the underlying relationship between them is unchanged.

A parallel process was not included for rural groups, but this recognition of the impact of new CBSA definitions should be extended to Garfield County. However, Garfield County was a single-county MSA that is now classified as micropolitan: there are no counties remaining in the MSA to which it can reclassify. Two options exist to address this:
1. Single-county MSAs that were dissolved due to the new CBSA definitions should be treated as metropolitan and a wage index assigned to it.
2. Hospitals whose entire MSA was dissolved should be able to reclassify to an adjacent MSA.

Either of the options outlined above will affect a very small number of hospitals and provide relief similar to urban hospitals in counties that were removed from multi-county MSAs by the new CBSA definitions. As you can see in Attachment B, hospitals with far lower average hourly wages than INTEGRIS Bass have been able to reclassify to Oklahoma MSAs, yet Bass will be denied that opportunity absent a change in the final rule.

Disproportionate Share Hospital Adjustment. The loss of Garfield County's status as urban and subsequent cap on DSH payments will have an even more profound impact on the organization, our employees, and the community we serve than the wage index changes. As the primary provider of specialized services in a multi-county area, Bass attracts a diverse patient population and relies heavily on the disproportionate share hospital payments to provide many services. Patients receiving specialized services like those in our psychiatric unit would not have reasonable access to these services if Bass closed the unit. The nearest providers are over 70 miles away.

The loss of funds as a result of the DSH cap applied to rural hospitals will result in access problems for both the Medicare population and the community at-large. Bass' problem is circular – the presence of DSH funds allows the hospital to provide these services, but without these services the hospital would be unable to draw much of the patient population that triggers significant DSH payments.

We believe there is ample evidence and administrative authority to consider the data as it relates to the treatment of a particular micropolitan area (and former MSA) as urban or rural. Given the characteristics of the county and the hospital, recognition of INTEGRIS Bass as urban is reasonable and appropriate. To our facility, it is critical.

We urge you to include changes in the final rule that would restore the urban designation to INTEGRIS Bass and provide an opportunity for wage index reclassification if Garfield County will not be recognized as an MSA and assigned a wage index.

Please do not hesitate to call me or Strawn Steele at (580) 548-1100 if you have any questions or need additional information.

Sincerely,

Oscar K. Weinmeister, Jr.
Administrator

Enclosures:
Attachment A - Garfield County Employees, By County of Residence
Attachment B - Oklahoma Hospital Comparison by

Integris Bass Baptist Health Center
Enid, OK
Provider number 370016

Attachment A
Garfield County Employees,
by County of Residence

Table 1. Garfield County Employees, by County of Residence compared to INTEGRIS Bass Employees

	Number of		Percent of	
	Garfield County Workers (2000)	Integris Employees	Garfield County Workers	Integris Bass Employees
Alfalfa Co. OK	204	18	0.75%	2.45%
Beaver Co. OK	9		0.03%	0.00%
Blaine Co. OK	46	4	0.17%	0.54%
Caddo Co. OK	5		0.02%	0.14%
Canadian Co. OK	4	2	0.01%	0.27%
Cleveland Co. OK	15		0.06%	0.14%
Comanche Co. OK	5		0.02%	0.14%
Creek Co. OK	21		0.08%	0.14%
Custer Co. OK	50		0.18%	0.14%
Dewey Co. OK	2	1	0.01%	0.14%
Garfield Co. OK	**24,961**	**590**	**92.05%**	**80.38%**
Garvin Co. OK	9	1	0.03%	0.14%
Grady Co. OK	12		0.04%	0.14%
Grant Co. OK	372	23	1.37%	3.13%
Haskell Co. OK	2		0.01%	0.14%
Kay Co. OK	62	14	0.23%	1.91%
Kingfisher Co. OK	369	29	1.36%	3.95%
Le Flore Co. OK	2		0.01%	0.14%
Logan Co. OK	70	3	0.26%	0.41%
Major Co. OK	504	21	1.86%	2.86%
McClain Co. OK	2		0.01%	0.14%
Murray Co. OK	2		0.01%	0.14%
Noble Co. OK	72	6	0.27%	0.82%
Nowata Co. OK	4		0.01%	0.14%
Oklahoma Co. OK	56	3	0.21%	0.41%
Okmulgee Co. OK	10		0.04%	0.14%
Osage Co. OK	4		0.01%	0.14%
Osage Co. OK	7		0.03%	0.14%
Pawnee Co. OK	10		0.04%	0.14%
Payne Co. OK	98	3	0.36%	0.41%
Pontotoc Co. OK	4		0.01%	0.14%
Pottawatomie	2	1	0.01%	0.14%
Rogers Co. OK	8		0.03%	0.14%
Sumner	0	9	0.00%	1.23%
Texas Co. OK	2		0.01%	0.14%
Tulsa Co. OK	37		0.14%	0.14%
Washita Co. OK	3		0.01%	0.14%
Woods Co. OK	48	6	0.18%	0.82%
Woodward Co. OK	23		0.08%	0.14%
Total	27,116	734		

INTEGRIS Bass Baptist Health Center
Enid, OK
Provider number 370016

Attachment B
Oklahoma Hospital Comparison

Table 2. Oklahoma Hospitals*: Hospital DSH Percent From FY05 Final Rule Impact File; Case-Mix Indexes for Discharges Occurring in Federal FY 2004; Hospital Wage Indexes for Federal FY 2006; Hospital Average Hourly Wages for Federal FY 2006 (2002 Wage Data); 3-Year Average of Hospital Average Hourly Wages

Provider Number	DSH Percent[2]	Case-Mix Index	FY 2006 Proposed Wage Index	Average hourly wage FY 2006[1]	Average hourly wage (3 years)**	Provider Name	County	In an MSA?
370093	0.63958	1.6152	0.9043	26.9774	25.3740	OU MEDICAL CENTER	OKLAHOMA	Y
370078	0.61872	1.6061	0.8313	25.4161	23.9078	TULSA REGIONAL MEDICAL CENTER	TULSA	Y
370097	0.52458	1.2850	0.7916	22.3267	21.5064	SOUTHWESTERN MEDICAL CENTER	COMANCHE	Y
370001	0.50039	1.6782	0.8313	27.7549	26.5495	HILLCREST MEDICAL CENTER	TULSA	Y
370037	0.48894	1.6563	0.9043	23.9685	22.7803	ST. ANTHONY HOSPITAL	OKLAHOMA	Y
370016	**0.46424**	**1.4747**	**0.8682**	**25.4062**	**23.3330**	**INTEGRIS BASS BAPTIST HEALTH CENTER**	**GARFIELD**	
370048	0.44851	1.0975	0.7615	19.2464	17.4431	MCCURTAIN MEMORIAL HOSPITAL	MCCURTAIN	
370057	0.44674	0.9425	0.8313	19.7284	18.3749	OKMULGEE MEMORIAL HOSPITAL	OKMULGEE	Y
370166	0.44288	0.9772	0.8313	23.1681	22.1327	WAGONER COMMUNITY HOSPITAL	WAGONER	Y
370178	0.44081	0.8922	0.7615	14.6070	14.1857	ADAIR COUNTY HEALTH CENTER	ADAIR	
370014	*0.43166*	*1.0403*	*0.8971*	*25.3576*	*24.0194*	*MED. CTR. OF SOUTHEASTERN OKLAHOMA*	*BRYAN*	
370040	0.43090	1.0053	0.8231	22.4048	20.8291	EASTERN OKLAHOMA MEDICAL CENTER	LEFLORE	Y
370103	*0.38996*	*0.9494*	*0.8038*	*17.8018*	*16.5505*	*SAYRE MEMORIAL HOSPITAL*	*BECKHAM*	
370099	*0.38563*	*1.0065*	*0.8313*	*20.5075*	*20.4227*	*CUSHING REGIONAL HOSPITAL*	*PAYNE*	
370015	*0.36444*	*0.9737*	*0.8313*	*23.6693*	*21.7009*	*MAYES COUNTY MEDICAL CENTER*	*MAYES*	
370095	0.35009	0.8800	0.7615	*	15.4277	ARBUCKLE MEMORIAL HOSPITAL	MURRAY	
370100	0.33636	0.9736	0.7615	14.7712	14.0181	CHOCTAW MEMORIAL HOSPITAL	CHOCTAW	
370056	0.31131	1.6060	0.7916	22.0312	21.4507	COMMANCHE COUNTY MEMORIAL HOSPITAL	COMANCHE	Y
370089	0.30227	1.0714	0.7615	20.4699	19.4850	TAHLEQUAH CITY HOSPITAL	CHEROKEE	
370060	0.28636	0.9342	0.8313	18.7592	21.7395	PAWNEE MUNICIPAL HOSPITAL	PAWNEE	Y
370034	*0.27625*	*1.1924*	*0.7986*	*18.2341*	*17.3349*	*MCALESTER REG L HEALTH CENTER*	*PITTSBURG*	
370149	0.26813	1.2033	0.9399	22.3537	20.7832	UNITY HEALTH CENTER	POTTAWATOMIE	Y
370153	0.26796	1.0423	0.7615	19.8349	18.7951	ELKVIEW GENERAL HOSPITAL	KIOWA	
370200	0.26524	1.1666	0.7615	17.6317	17.5059	SEMINOLE MEDICAL CENTER	SEMINOLE	
370004	*0.26373*	*1.0932*	*0.8458*	*25.3919*	*23.7972*	*INTEGRIS BAPT. REGIONAL HEALTH CTR.*	*OTTAWA*	
370025	*0.26242*	*1.2545*	*0.8313*	*23.5659*	*21.9757*	*MUSKOGEE REGIONAL MEDICAL CENTER*	*MUSKOGEE*	
370047	*0.26108*	*1.4244*	*0.8971*	*20.4657*	*19.9082*	*MERCY MEMORIAL HEALTH CENTER*	*CARTER*	
370072	0.25702	0.7985	0.7615	9.9616	11.8723	LATIMER COUNTY HOSPITAL	LATIMER	
370007	0.25354	1.0399	0.7615	17.6547	17.2160	NEWMAN MEMORIAL HOSPITAL	ELLIS	
370106	0.25252	1.3329	0.9043	26.5867	25.0105	INTEGRIS SOUTHWEST MEDICAL CENTER	OKLAHOMA COUNT	Y
370179	*0.25114*	*0.9231*	*0.8313*	*23.5794*	*22.6918*	*CREEK NATION COMMUNITY HOSPITAL*	*OKFUSKEE*	
370028	0.24612	1.8453	0.9043	26.6153	25.1976	INTEGRIS BAPTIST MEDICAL CENTER	OKLAHOMA	Y
370022	*0.24366*	*1.1976*	*0.7673*	*19.6495*	*19.4375*	*JACKSON COUNTY MEMORIAL HOSPITAL*	*JACKSON*	
370020	0.23987	1.2243	0.7615	18.5046	17.6368	VALLEY VIEW REGIONAL HOSPITAL	PONTOTOC	
370019	0.23131	1.2184	0.7615	21.4474	19.7475	GREAT PLAINS REGIONAL MEDICAL CTR.	BECKHAM	

INTEGRIS Bass Baptist Health Center
Enid, OK
Provider number 370016

Attachment B
Oklahoma Hospital Comparison

Provider Number	DSH Percent[2]	Case-Mix Index	FY 2006 Proposed Wage Index	Average hourly wage FY 2006[1]	Average hourly wage (3 years)**	Provider Name	County	In an MSA?
370065	0.22990	1.0179	0.7736	20.0226	19.6691	CRAIG GENERAL HOSPITAL	CRAIG	
370029	0.22955	1.0293	0.7615	23.9956	21.8559	INTEGRIS CLINTON HOSPITAL	CUSTER	
370064	0.22815	0.8954	0.7615	14.2053	13.4809	CARNEGIE TRI-CTY MUNICIPAL HOSPT.	CADDO	
370113	*0.22422*	*1.1317*	*0.8615*	*25.3565*	*23.3322*	*INTEGRIS GROVE GENERAL HOSPITAL*	*DELWARE*	
370045	0.22280	0.9116	0.7615	*	13.6711	OKEENE MUNICIPAL HOSPITAL	BLAINE	
370023	0.22149	1.2396	0.7699	21.5762	20.5441	DUNCAN REGIONAL HOSPITAL	STEPHENS	
370091	0.22100	1.6980	0.8313	20.8950	22.6316	SAINT FRANCIS HOSPITAL	TULSA	Y
370051	0.22090	1.0467	0.7615	17.2618	14.4702	TILLMAN MEMORIAL HOSPITAL	TILLMAN	
370006	0.21867	1.2069	0.7615	20.1063	17.6384	VIA CHRISTI OKLAHOMA REG MED CENTER	OSAGE	Y
370183	0.21042	1.0143	0.8313	21.8147	20.0076	HENRYETTA MEDICAL CENTER	OKMULGEE	Y
370039	0.20808	1.0902	0.8313	21.8220	21.0783	CLAREMORE REGIONAL HOSPITAL	RODGERS	Y
370054	0.20724	1.2568	0.7615	21.5043	21.1653	GRADY MEMORIAL HOSPITAL	GRADY	Y
370114	0.19223	1.5494	0.8313	21.7880	20.8230	ST. JOHN MEDICAL CENTER	TULSA	Y
370125	0.19175	0.8500	0.7615	17.1361	17.4038	MANGUM CITY HOSPITAL	GREER	
370084	0.18862	0.9685	0.7615	16.6514	16.7384	HASKELL COUNTY HOSPITAL	HASKELL	
370202	0.18515	1.5326	0.8313	25.1181	24.5965	SOUTHCREST HOSPITAL	TULSA	Y
370138	0.18419	1.0187	0.7688	18.3113	19.0435	MEMORIAL HOSPITAL OF TEXAS COUNTY	TEXAS	
370049	*0.17938*	*1.2985*	*0.9043*	*23.2171*	*21.8100*	*STILLWATER MEDICAL CENTER*	*PAYNE*	
370036	0.17917	1.0216	0.7615	17.7576	17.1504	HARMON MEMORIAL HOSPITAL	HARMON	
370041	0.17561	0.8812	0.8313	22.3496	21.1267	BRISTOW MEDICAL CENTER	CREEK	Y
370158	0.17152	1.0192	0.9043	18.5578	17.7592	PURCELL MUNICIPAL HOSPITAL	MCCLAIN	Y
370026	0.16064	1.5077	0.8682	23.0848	22.5236	ST MARYS REGIONAL MEDICAL CENTER	GARFIELD	
370094	0.14931	1.3966	0.9043	23.1191	21.9907	MIDWEST REGIONAL MEDICAL CENTER	OKLAHOMA	Y
370008	0.14731	1.3885	0.9043	24.2978	23.1423	NORMAN REGIONAL HOSPITAL	CLEVELAND	Y
370169	0.14303	0.8969	0.7615	15.8002	16.0704	COMMUNITY HOSPITAL LAKEVIEW	MCINTOSH	
370042	0.13591	0.9473	0.7615	*	14.7180	FAIRVIEW HOSPITAL	MAJOR	
370030	0.12881	1.0428	0.7615	23.3037	20.7201	BLACKWELL REGIONAL HOSPITAL	KAY	
370011	0.12817	1.0810	0.9043	19.7821	18.6737	PARK VIEW HOSPITAL	CANADIAN	Y
370018	*0.11759*	*1.4098*	*0.8313*	*23.5336*	*22.5984*	*JANE PHILLIPS MEDICAL CENTER*	*WASHINGTON*	
370002	0.11246	1.1821	0.7615	20.1479	19.6308	WOODWARD REGIONAL HOSPITAL	WOODWARD	
370196	0.11120	1.0758	0.9043	22.6824	25.4359	RENAISSANCE WOMEN S CTR OF EDMOND	OKLAHOMA	Y
370032	0.10909	1.4479	0.9043	23.4843	21.7536	DEACONESS HOSPITAL	OKLAHOMA	Y
370203	0.08203	1.3678	0.9043	23.5190	21.5182	PHYSICIANS HOSPITAL OF OKLAHOMA	OKLAHOMA	Y
370013	0.07488	1.5187	0.9043	24.9295	22.9792	MERCY HEALTH CENTER	OKLAHOMA	Y
370177	0.06063	1.0170	0.7615	14.7193	14.7923	SEILING MUNICIPAL HOSPITAL	DEWEY	
370139	0.05867	0.9394	0.7615	18.5225	17.5400	PERRY MEMORIAL HOSPITAL	NOBLE	
370176	0.04957	1.1057	0.8313	25.0509	23.4362	SAINT FRANCIS HOSPITAL AT BROKEN ARR	TULSA	Y
370080	0.04559	0.9012	0.7615	18.0665	17.2314	SHARE MEDICAL CENTER	WOODS	

INTEGRIS Bass Baptist Health Center
Enid, OK
Provider number 370016

Attachment B
Oklahoma Hospital Comparison

Provider Number	DSH Percent[2]	Case-Mix Index	FY 2006 Proposed Wage Index	Average hourly wage FY 2006[1]	Average hourly wage (3 years)**	Provider Name	County	In an MSA?
370211	0.04200	0.9454	0.9043	26.5344	26.5344	INTEGRIS CANADIAN VALLEY HOSPITAL	CANADIAN	Y
370199	0.00460	0.9440	0.9043	26.0451	23.4652	LAKESIDE WOMEN S HOSPITAL	OKLAHOMA	Y
370043	****	0.9286	0.7615	*	20.9707	MARSHALL MEMORIAL HOSPITAL	MARSHALL	
370186	****	0.9064	0.7615	*	16.3879	CORDELL MEMORIAL HOSPITAL	WASHITA	

1 Based on salaries adjusted for Occupational Mix, according to the calculation in section III F.
2 DSH percent as determined from cost report data & SSA data from the FY2005 Final Rule Impact File -as republished in the Dec 30, 2004 Fed Reg correction notice
* Denotes wage data not available for the provider for that year.
**Based on the sum of the salaries and hours computed for Federal FYs 2004, 2005, and 2006.
*** Denotes MedPAR data not available for the provider for FY 2004.
**** Data not available
Italics indicate Hospitals reclassified and redesignated according to Table 9B of the proposed FY06 IPPS rule
Note: Table excludes specialty hospitals, as their CMI is distorted due to a higher proportion of procedures

#45

CMS-1500-P-78

Submitter : Mrs. Marilyn Musgrave **Date:** 05/20/2005

Organization : United States House of Representatives

Category : Congressional

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1500-P-78-Attach-1.DOC

45

CAH/Reloc

Hefter
Feinstein
Collins
Mercy
Molley Smith

May 20, 2005

Attachment #78
Dr. Mark McClellan
CMS Administrator
Centers for Medicaid and Medicare Services
PO Box 8011
Baltimore, MD 21244-1850

Dear Dr. McClellan,

RE: Critical Access Hospitals
CMS-1500-P

I am writing regarding a proposed CMS rule that will impact two **Critical Access Hospitals** in northeastern Colorado.

It has come to my attention that the Medicare Modernization Act, passed by Congress and signed into law in December 2003, eliminated the "Necessary Provider" provision of the Critical Access Hospital (CAH) regulations, effective January 1, 2006. As I understand it, a proposed CMS rule would grandfather any CAH licensed under the Necessary Provider provision prior to January 1, 2006, allowing them to maintain licensure as a CAH. However, if a hospital builds a replacement facility in a different location and construction is complete after January 1, 2006, the hospital may lose its CAH designation.

These proposed regulations have implications for two hospitals within my district. Both of these hospitals are planning to build new facilities to replace their current facilities. By providing efficient, high-quality healthcare, these hospitals have seen growth and increased utilization that demand greater space to better serve the community.

- **Yuma District Hospital (Yuma, CO)** – Has plans to build a new site within **850 yards** of current site.

- **Melissa Memorial Hospital (Holyoke, CO)** – Has been preparing to build a new facility since April 2004, being very careful to ensure that finances, plans, and community perceptions are being considered in all details. The proposed sites are within **one mile** of the existing CAH facility.

According to the proposal, as stated in the Federal Register, the decision whether to continue to consider the hospitals Critical Access Hospitals may be determined on a case-by-case basis. *"The regulations...(do) not address the situation where the CAH is no*

longer the same facility due to relocation, cessation of business, or a replacement facility. Currently, CMS Regional Offices make the decision for continued certification following relocation of a certified facility on a case-by-case basis."

The proposed rule states that a "replacement" facility is one in which construction is undertaken within 250 yards of current building. *"We will consider a construction of the CAH to be a replacement if construction was undertaken within 250 yards of the current building, as set by prior precedence in defining a hospital campus."*

As representative of these two facilities, I consider it my responsibility to ensure that these facilities have every opportunity to serve the growing community. **I recommend that this distance be changed to three miles or within the same zip code.** There are many factors that could prevent a hospital from replacing itself on the exact location – lack of parking, lack of land availability, resistant community. However, a facility built within three miles or within the same zip code will most certainly serve the same population and continue to operate as the same entity.

Whether deemed to be a "replacement" or "relocation", I urge you to ensure that both Yuma District Hospital and Melissa Memorial Hospital receive continued CAH status and are enabled to continue serving their rural communities.

I am sure it was not the intent of Congress or CMS regulators to punish rural hospitals for their efficiency and success nor to hinder them from growth and expansion. It is my recommendation that you modify these regulations to ensure that hospitals such as these are able to continue to serve rural populations.

Please notify both of these hospitals regarding the steps they must take to ensure continued CAH status and please keep me informed as to the progression of these regulatory decisions.

Thank you for your prompt attention to this matter.

Sincerely,

Congresswoman Marilyn Musgrave (CO-04)

CMS-1500-P-108 **Changes to the Hospital Inpatient Prospective Payment Systems and FY 2006 Rates**

Submitter : Mr. Chris Shoup **Date & Time:** 05/27/2005

Organization : The Spine Hospital of South Texas

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-108-Attach-1.DOC

46

NT
DRAFT

Reiter
Hartstein
Bmbls
Fagan
Gruber
Kelly
Treitel
Walz

Attachment #108

May 27, 2005

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1500-P
P.O. Box 8011 Baltimore, MD 21244-1850

To Whom It May Concern:

Re: Rechargeable Medtronic Neurostimulators

It is very important for hospitals to continue to provide the best care for our patients utilizing the latest technology. Unfortunately this technology comes at a cost that is typically higher than the previous technology but provides a substantial clinical advantage and improvement.

Rechargeable neurostimulators and Radio Frequency (RF) neurostimulators are distinctly different technologies:

- Radio Frequency – external power source; it is not rechargeable and the therapy ends immediately when the transmitter is removed from the implant site. Further there tends to be less patient compliance (i.e. skin break-down)
- Rechargeable – as it implies it is a rechargeable internal power source that requires a charge for a short period of time about every three to six weeks. Therapy and relief can be provided to the patient endlessly.

Rechargeable neurostimulators represent a significant clinical improvement over the existing technology:

- Rechargeable technology provides more treatment options for those patients requiring high energy stimulation. Prior to the introduction of the rechargeable neurostimulator a patients options were limited to:
  - Frequent neurostimulator replacement
  - Battery conservation which limited the full benefit of the neurostimulation
- Reduction in surgeries related to neurostimulator replacement due to battery depletion.

While I understand the desire to control costs to CMS in this era of an aging population, the technologies (such as the rechargeable neurostimulator) that are coming out may have a higher up-front expense but the end result will be less surgical and physician encounters, thus providing a savings throughout the entire treatment cycle and saving CMS hundreds of thousands of dollars.

I appreciate your consideration of this DRG add-on payment and APC pass-through for this new technology.

Sincerely,

Chris Shoup
CEO
The Spine Hospital of South Texas
18600 N. Hardy Oak Blvd
San Antonio, Texas 78258
(210) 404-0800

#47

Submitter : Mr. Michael White **Date:** 05/27/2005

Organization : Mercy Medical Center - North Iowa

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

The formula for the calculation of the wage index has changed, but no reason or impact was given.

CMS-1500-P-111-Attach-1.DOC

47

RECEIVED
WI/DX JUN 02 2005
BY:.....

Hefter
Hartstein
Miller

Mercy
MEDICAL CENTER
NORTH IOWA

A member of Mercy Health Network

Attachment #111
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P.P.O. Box 8011
Baltimore, MD 21244-1850

Re: Wage Index

To whom it may concern:

A change was made to the calculation of the overhead allocation of wage related costs to excluded areas. In the final rule published in the August 11, 2004, Federal Register, the ratio of overhead hours to revised hours was calculated as follows: Overhead hours (Worksheet S-3, Part III, Line 13) divided by (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, and 7)

In the proposed FY 2006 inpatient PPS rule as published in the May 4, 2005, Federal Register, the same ratio was calculated by taking the Overhead hours (Worksheet S-3, Part III, Line 13) divided by (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, **AND** 8 and 8.01). Including lines 8 and 8.01 in the calculation decreased our wage index by .3% which negatively impacts our reimbursement by over $100,000.

The reason for this change and the overall impact of the change was not described in the Proposed Rule. What is the justification of this change?

Sincerely

Michael White
Reimbursement Accountant

Attachment 116

NT 48

NYUHJD
NYU-Hospital for Joint Diseases
Department of Orthopaedic Surgery
William L. Jaffe, M.D.
Clinical Professor and Vice Chairman

School of Medicine
New York University

Heffler Hartsfield Truett WA12

May 24, 2005

Mark McClellan M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Dr. McClellan:

I would like to commend CMS for approving a new ICD-9 Code for improved bearing surfaces for hip arthroplasty that will allow orthopedic surgeons to track and confirm the superior performance of these devices. It is our hope and expectation that this will eventually lead to a higher reimbursement DRG that will allow hospitals to make these components available to Medicare and Medicaid patients affording them longer survivorship for their implants. This will not only avoid the danger, pain, and suffering associated with premature revision of standard components, but would also avoid the enormous expense of readmission and revision surgery.

Ceramic-ceramic bearings appear to meet your criteria for new technology as outlined in Section 412.87(b)(1) of your current regulations in that they represent an advance in technology that substantially improves performance of a hip arthroplasty using standard bearing materials. The virtual elimination of particulate debris, the benign nature of the minimal debris created, and the absence of wear and osteolysis is in stark contrast to previous experiences with hip arthroplasty. Current and continuing peer-review data confirm and extend our enthusiasm for these devices.

I respectfully request CMS to approve as new technology add on payment ceramic-ceramic bearings to make these devices available to appropriate patients with confidence that it would be both a medically and fiscally responsible decision.

Sincerely yours,

William L. Jaffe, M.D.
Clinical Professor and Vice-Chairman
New York University School of Medicine

WLJ/mg

Hospital for Joint Diseases 301 East 17th Street, New York, NY 10003 Phone 212.598.6796 Fax 212.598.6581

Mount Sinai-NYU
Medical Center and Health System

49

CAH/RELOC

PHILLIPS COUNTY COMMISSIONERS

221 S. INTEROCEAN
HOLYOKE, COLORADO 80734

JERRY BEAVERS
QUENTIN "BUD" BIESEMEIER
SUSAN E. ROLL

970-854-2454
FAX 970-854-3811

May 16, 2005

RECEIVED
JUN 09 2005
BY:.....

Centers for Medicare & Medicaid Services
Department of Health and Human Services,
Attention: CMS-1500-P
P O Box 8011
Baltimore, MD 21244-1850

Hefte
Hartstein
Collins
Neve
Smith

RE: Rules for in patient Prospective Payment System for CMS

Dear Sir or Madam:

"In its recently released inpatient Prospective Payment System (IPPS) proposed rule the Centers for Medicare and Medicaid Services (CMS) only provides continued Critical Access Hospital (CAH) status for necessary providers that are building replacement facilities at another location and can demonstrate their construction plans began before December 8, 2003. This arbitrary date restriction is a broad overreach of CMS authority. It puts in jeopardy many relocation projects that were started in the year and a half since the passage of the MMA. **It leaves no flexibility to relocate facilities in the future...**"

Our local hospitals would be greatly limited by the adoption of the construction deadline.

We are opposed to the Medicare Ban on Critical Access Hospitals because of the following reasons.

1. The Proposed Regulation transfers to the Centers for Medicare and Medicaid Services (CMS) control over the basic structure of local rural health care, a loss of local control never before seen, and if allowed to stand, a precedent that threatens all hospitals and all communities.
2. It was clearly not the intent of Congress in the Medicare Modernization Act that a Critical Access Hospital (CAH) designated as a Necessary Provider be perpetually prohibited from replacing or relocating their facility, facilities that are often 40 to 50 years old.
3. Many rural hospitals are located on a small campus in the middle of residential neighborhoods with relocation being the most appropriate, and sometimes only alternative.

4. Ironically, the CMS proposal to ban a local community's ability to rebuild on an adjacent or nearby location will cost Medicare over time, more, not less-the higher labor costs of operating in a retrofitted building more than offset the slightly higher cost of rebuilding.

5. A ban on major construction projects developed after December 8, 2003 is an over reaction against a potential problem that can be appropriately managed by the portion of CMS's proposed rule that would require assurance that, after the construction, "the CAH will be servicing the same community and will be operating essentially the same services with essentially the same staff."

6. The CMS ban is based on the misguided belief, not tested in law and a break with CMS's past policy, that the relocation of a CAH can be treated differently than for any other hospital. There is no basis in law that the relocation within a community of a CAH with Necessary Provider status constitutes a cessation of business and loss of its provider agreement and number.

7. A CAH's Necessary Provider designation is associated with its current Medicare provider agreement which should remain intact unless the CAH fundamental changes its business (e.g., ceases its current operations) or is terminated by Medicare. It is a longstanding policy that the provider agreement describes the legal entity and services provided—not the physical structure or location.

We would ask that you delete the arbitrary deadline on Critical Access replacement or relocation in the IPPS. This is a very critical issue for rural hospitals.

Sincerely,

Susan Roll, Chairman

Jerry Beavers

Quentin Biesemeier
Phillips County Commissioners