National Stroke Association

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Dedicated to reducing the incidence and impact of stroke

374

DRG/GEN

Nefter Hartstein Brooks Fagan Gruber Kelly Hue

June 23, 2005

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

RE: Stroke DRG 14/15

Dear Colleagues,

The National Stroke Association (NSA) wants to thank you and your colleagues at the Centers for Medicare and Medicaid Services (CMS) for being receptive to our support of changes to Medicare hospital inpatient reimbursement for advanced stroke treatment.

Stroke is a devastating disease that affects more than 750,000 people annually in the United States, and as you are aware, costs the U.S. medical system more than $52 billion annually in post-acute care. NSA, as the leading, independent national nonprofit organization devoting 100 percent of its efforts and resources to stroke, firmly believes the administration of reperfusion therapies has been proven to reduce the poor outcomes in stroke patients thus, reducing the burden of post-acute and rehabilitative care.

By changing the current structure of stroke DRGs 14 and 15, CMS can make a significant impact on stroke treatment while also reducing the long-term costs to Medicare. There are two primary ways that the coding could be changed, either by redefining the two current codes to include reperfusion therapies or by creating a new DRG for the administration of reperfusion therapies.

Since CMS' request for additional data last spring, there has been additional review of several sources including the MedPar Database, the Premier Perspective Database and survey results from NSA's Stroke Center Network members. This additional data indicates a higher administration of thrombolytic therapy, as much as two to three times than is reported by the ICD-9 code 99.10.

This is an exciting time for stroke with the development of new programs nationwide for prehospital providers, stroke center development and data review. Changes to the reimbursement for stroke would be timely and ~~historic~~al in the coalition's objective to improve care of stroke patients.

Regards,

Jim Baranski
Chief Executive Officer / Executive Director
National Stroke Association

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General Surgery

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June 21, 2005

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1500-P
Room C5-14-03
7500 Security Blvd.
Baltimore, MD 212244-1850

Subject: [CMS-1500-P] Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2006 Payment Rates (42 Federal Register 405, 412, 413, 415, 419, 422, and 485), May 4, 2005

To Whom It May Concern:

As a member of the resident teaching faculty of St. John Health (SJH), a Southeast Michigan health system with eight hospitals and over 400 interns and residents in allopathic, osteopathic, dental and podiatry training programs, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the 2005 Inpatient Prospective Payment System (PPS), published May 4, 2005 in the Federal Register. The adequacy of Medicare payment to cover the cost of training our future generation of physicians is essential to maintain financially viable teaching hospitals in Michigan and across the United States to ensure the adequacy of future Medicare beneficiary access.

My comment is regarding New Teaching Hospitals in Medicare GME Affiliated Groups (§413.79 (e) (1)) of the proposed rules beginning on page 23440 of the Maay 4, 2005 Federal Register.

CMS proposes to allow new urban hospitals that qualify for an adjustment under (§413.79 (e) (1) may enter into a Medicare GME affiliation agreement only if the resulting adjustment is an increase in the new teaching hospital's DGMME and IME caps as a result of the affiliation agreement.

I fully concur with this proposed policy update. New urban teaching hospitals should be provided with the flexibility to start new teaching programs without jeopardizing their ability to count additional FTE residents training at the hospital under affiliation agreement. This flexibility will occur if new urban teaching hospitals are allowed to

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General Surgery

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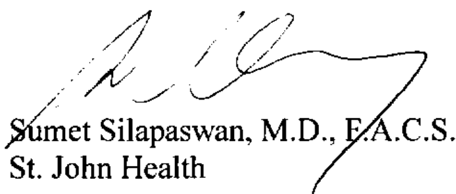
enter into affiliation agreements with other teaching hospitals to increase their DGME and IME FTE caps.

By definition, a new urban teaching hospital would initially have a resident FTE cap of zero, (0). When residents from existing teaching hospitals rotate to the new urban teaching hospital, it is appropriate for the new urban teaching hospital to receive Medicare IME and DGME payments. These additional Medicare payments are necessary for the new teaching hospital to cover the direct and indirect costs the new urban teaching hospital will be incurring to train the "in rotating" residents from other hospital teaching programs.

Thank you for considering my comment regarding your proposed improvement to the Medicare program's existing payment rules for graduate medical education.

Sincerely,



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JUN 24 2005
BY:

Wake Forest University Baptist
MEDICAL CENTER

Len B. Preslar, Jr.
President and Chief Executive Officer
North Carolina Baptist Hospital
Telephone: (336) 716-4750
Fax: (336) 716-2067

June 24, 2005

Transfers

Hefter
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Via Electronic Mail and Fascimile

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: Post Acute Care Transfer

North Carolina Baptist Hospital is a Medicare participating hospital that admits nearly 14,000 Medicare patients each year. We are extremely concerned about the proposed changes to the Post Acute Care transfer policy and the impact to our Medicare reimbursement. We would be willing to discuss this proposed policy further or to offer suggestions which may be helpful in developing post acute payment reform as would be deemed appropriate.

The proposed policy undermines clinical decision-making and penalizes hospitals for ensuring that patients get the most appropriate care in the most appropriate setting. At North Carolina Baptist Hospital we strive to provide excellence in healthcare to all our patients and it is becomes increasingly more difficult with reductions to our reimbursements. We have approximately 450 post acute transfers annually. Under the proposed expansion that number would increase to 815. We estimate the expansion will negatively impact our facility by about $1 million dollars annually.

We believe that ***any*** expansion of the inpatient transfer policy would fundamentally weaken incentives inherent in the inpatient Prospective Payment System and disrupt the continuum of care typical of quality delivery. It penalizes hospitals that try to ensure that Medicare patients receive care in the most appropriate setting.

Please rescind this proposed policy change and allow hospitals to provide quality care to all Medicare recipients.

Sincerely,

Len B. Preslar, Jr.

LBP:KM:kds

THE STROKE CENTER
HARTFORD HOSPITAL

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Co-Medical Director
The Stroke Center
Vascular Neurology

Isaac E. Silverman, MD
Co-Medical Director
The Stroke Center
Vascular Neurology

A. Jon Smally, MD
Co-Medical Director
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Gary Spiegel, MDCM
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Stephen K. Ohki, MD
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Nursing Director, Neurology
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Leslie I. Wolfson, MD
Director, Neurology

Arnold J. Rossi, MD
Director, Neurosurgery

June 22, 2005

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

RE: **CMS-1500-P: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal-Year 2006 Rate**

Dear Sir or Madam:

On behalf of The Stroke Center at Hartford Hospital, we are writing to support the Centers for Medicare & Medicaid Services (CMS's) decision to restructure and improve DRG payments associated with complex acute ischemic stroke cases. Specifically, we support restructuring DRG 14 to include cases involving, "Ischemic Stroke Treatment with a Reperfusion Agent". DRG 15 would then be restructured to include cases with "Hemorrhagic Stroke or Ischemic Stroke without a Reperfusion Agent".

This is an important first step towards addressing the payment inadequacies associated with these resource-intensive cases.

Every year in the United States, about 700,000 individuals suffer a stroke of which 88% are ischemic in nature.[1] Stroke is the third leading cause of death in the U.S. (mortality rate, 7.6% at 30 days) and it is the leading cause of long-term disability. The annual cost is about $51 billion in direct medical costs and indirect costs including losses in productivity. [1]

At The Stroke Center at Hartford Hospital, we treat approximately 500 acute ischemic stroke cases annually. The majority (72%) of these cases involve Medicare beneficiaries. A subset of this population includes resource-intensive cases such as those involving thrombolytic therapy where a reperfusion agent is used (eg, tissue plasminogen activator, tPA). The average costs per case are about $20,400 whereas mean DRG reimbursement is only $9,566. These patients are hospitalized on average 6.7 days, with 86% requiring 3.1 days in intensive care; the remainder (14%) in a step down/intermediate level of care. Despite stroke being an important health policy concern, we suffer economic losses from treating these very sick individuals and find it difficult to continue to care for these patients.

[1] American Heart Association/American Stroke Association, Heart Disease and Stroke Statistics – 2003 Update.

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www.harthosp.org/stroke

The most challenging aspect of acute stroke care are these cases involving acute intracranial arterial or venous occlusions, where we typically use reperfusion agents. For example, 20% of the time, we use thrombolytic therapy (eg, tissue plasminogen activator) or clot retrieval devices with or without stent placement to recannalize an occluded vessel.

The restructuring of DRG 14 is key to enabling hospitals and providers to proactively treat ischemic stroke patients with all the appropriate options available today. More hospitals would likely take advantage of the benefits of tissue plasminogen activator where indicated, if they were properly reimbursed for this expensive, but beneficial therapy. The current payment inadequacies contribute to slowed expansion of stroke center programs and ultimately adversely impact nationwide advances in stroke treatment development. Through the restructuring of DRG 14 with a focus on more intensive therapies (reperfusion), hospitals will be better equipped with the tools to achieve improved patient outcomes and minimize occurrences of permanent neurologic deficits and disabilities for these critically ill patients.

DRG 14 should be restructured to include ischemic stroke treatment with a reperfusion agent. DRG 15 should be then restructured to include hemorrhagic stroke or ischemic stroke without a reperfusion agent.

Thank you again for your time and attention to this important public health policy initiative. If you have any questions, please feel free to contact me at 860-545-3621.

Sincerely,

Dr. Nora Lee
Neurology
Co-Medical Director,
The Stroke Center at Hartford Hospital

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Transfer

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June 13, 2005

Honorable Mark B. McClellan, M.D. PH.D.
Center for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1500-P
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Dr. McClellan:

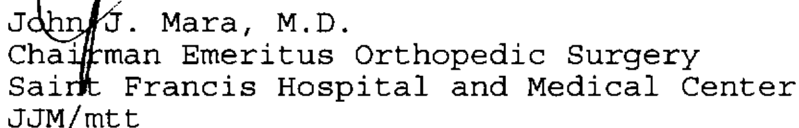
I am writing to you regarding a recent draft ruling by Medicare Hospital Inpatient Prospective Payment System expanding the number of DRG subjects to a post acute transfer policy from 30 to 223. As a practicing physician and a member of the Board of Directors at Saint Francis Hospital I think this proposed change in payment is onerous for the hospital and for the quality of care in general.

The current Medicare transfer payment policy requires cases assigned to one of thirty DRGs be paid as transfers when patients are discharged to psychiatric or rehab facilities. This also includes children's long term care, cancer hospitals and skilled nursing facilities. The payment is made on a per diem basis.

Expanding the transfer policy to encompass additional classes of patient cases would fundamentally weaken the incentives inherent in the inpatient PPS. The new proposal would effectively uproot an incentive basis fueled by per case control to one inordinately focused on per diem cost. I think it is inappropriate and should not be implemented. Such a move would most assuredly not be in the best interest of patients or providers. The proposed policy would undermine clinical decision making and penalize hospitals for providing patients with the most appropriate care in the most appropriate settings.

I very much appreciate your taking the time to read my letter and I hope you will consider my concerns with respect to this change.

Sincerely yours,



John J. Mara, M.D.
Chairman Emeritus Orthopedic Surgery
Saint Francis Hospital and Medical Center
JJM/mtt

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

Reference: CMS-1500-P

To Whom It May Concern:

I am writing on behalf of the Rural Wisconsin Health Cooperative and Hudson Hospital, located in Hudson, Wisconsin, to oppose the proposed construction ban on the vast majority of Critical Access Hospitals in our state and across America.

In particular, I absolutely oppose any and all deadlines for actions related to Critical Access Hospital (CAH) replacement or relocation in the Inpatient Prospective Payment System (IPPS) final rule. The proposed "75% threshold" is appropriate and sufficient to assure that a replacement or relocation CAH facility continues to meet the intent of its original Necessary Provider designation, i.e. that the "CAH serves at least 75 percent of the same service area that it served prior to its relocation, provides at least 75 percent of the same services that it provided prior to the relocation, and is staffed by 75 percent of the same staff (including medical staff, contracted staff, and employees."

Our basis for this position is as follows:

1. The Proposed Regulation transfers to the Centers for Medicare and Medicaid Services (CMS) control over the basic structure of 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 forever 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. Many rural hospitals are in 40-50 year buildings with antiquated floor plans, construction and utilities. Newer facility designs promote patient safety and quality of care that would be, as a

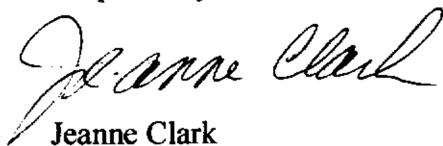
practical matter, prohibited by the proposed rule. Forcing hospitals to continue in outdated facilities is an inappropriate and avoidable risk for rural communities.

6. A ban on major construction projects developed after December 8, 2003 is an over reaction against a potential problem that can be thoroughly 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.

7. 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.

8. A CAH's Necessary Provider designation is associated with its current Medicare provider agreement that remains 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.

Respectfully submitted,



Jeanne Clark

KEN SALAZAR
COLORADO

COMMITTEES:
AGRICULTURE, NUTRITION, AND FORESTRY
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United States Senate

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June 20, 2005

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Hefter Hartstein Collins Pinney Smith

Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATT: CMS – 1500 – P
Post Office Box 8011
Baltimore, MD 21244-1850

Re: CRITICAL ACCESS HOSPITALS-Comment Regarding Proposed Rule RN 0938AN57

Dear Sir/Madam:

We write to provide comments to the Inpatient Prospective Payment System (IPPS) proposed rule regarding critical access hospitals, published in the Federal Register in Vol.70/No.85/Wednesday May 4, 2005/Proposed Rules under the listing of RN 0938 AN57.

As you know, the Critical Access Hospital (CAH) Program was created by Congress to provide cost-based reimbursement to limited service hospitals in rural areas to support the fragile health care delivery systems that exists in many rural communities. In order to qualify for CAH eligibility, a hospital must not be located within 35 miles of another hospital or must be designated by the state as a "necessary provider" of health care to its community, among other requirements.

The Medicare Modernization Act (MMA) prohibits a state from designating a hospital as a "necessary provider" after January 1, 2006. Congress's intent was to limit the states' ability to designate necessary providers because of the proliferation of CAHs that might not fulfill the goals of the program—to support rural hospitals serving a distinct population. The MMA did not intend to impact the existing CAHs that are necessary providers.

The proposed rule addresses whether presently designated CAHs that renovate and/or relocate facilities may retain the "necessary provider" designation. Two provisions of this rule are problematic, and actually work to undermine access to health care in rural communities.

The first provision provides that CAHs that renovate facilities may only be considered a "replacement facility" and retain their necessary provider designation if they renovate their current building or construct a new building within 250 yards of the current building. This proposed rule is unduly restrictive and fails to serve the goals Congress envisioned in designing the Critical Access Hospital program. CAHs exist to provide residents in rural areas access to quality, affordable health care. This rule undermines that goal because it prevents CAHs, many of which are older facilities, from expanding and updating their facilities to provide quality care to their residents. Many of these facilities exist on land that restricts their ability to renovate or expand. In these cases, it

KEN SALAZAR
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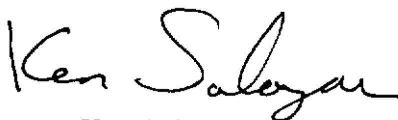
simply is not feasible for CAHs to renovate or expand their facilities on their physical locations. This rule assumes that existing hospitals have geographic land to expand on site. In some instances, the hospitals may have been given donated land on which to expand. Under this rule, hospitals that wish to renovate and relocate to donated land and serve the same community would lose their necessary provider status.

The second provision provides that for a Critical Access Hospital to maintain its "necessary provider" status and to be considered to be "relocating" according to PL 106-173, the facility must demonstrate construction plans were "under development" by December 8, 2003 (RN0938 AN57 – 5(B)(3)(a)). This date limits the plans of CAHs that commenced renovation plans after this date but before this proposed rule was published, and thus were unaware that their necessary provider designation would be in jeopardy when they initiated plans to rebuild their hospitals. In Colorado, two CAHs with necessary provider designations began plans to rebuild and invested substantial resources in the planning stages. This rule will endanger their designation if they proceed with their moves. Conversely, if they chose to remain at their current locations, they will be unable to renovate and modernize their facilities to provide quality care to the rural communities they serve.

Ultimately, this policy could mean less medical care for rural areas. We suggest a more flexible rule that grandfathers all CAHs with "necessary provider" designations provided they continue to meet the same needs of the population they were previously serving with substantially the same staff. We leave CMS to outline these guidelines, with the objective to promote the original intent of the CAH "necessary provider" designation—to promote the health care delivery systems in rural areas to provide quality, affordable health care to their residents. Necessary providers should not be forever foreclosed from modernizing their facility. Health care delivery is dynamic, incorporating technological advances that promise to improve quality and reduce the costs of health care. Necessary providers in Colorado and nationwide should be given flexibility to promote technological advances. Our state's rural areas count on these facilities and we must assist them in meeting the health care challenges of tomorrow.

Thank you for your careful consideration of these comments.



Ken Salazar
United States Senator

Wayne Allard
United States Senator

Marilyn Musgrave
United States Representative

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BY:..................

Congress of the United States
Washington, DC 20510

June 22, 2005

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Hartstein
Kenly
T. Jones
Miller
NAVARRO

Marc Hartstein
Deputy Director
Division of Acute Care
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS - 1428 - P
P.O. Box 8010
Baltimore, Maryland 21244-1850

Dear Mr. Hartstein:

As you draft the final rule for 2006 Medicare inpatient prospective payment, we wish to call to your attention an anomalous situation regarding the geographic wage index for the Beebe Medical Center in Lewes, Delaware. Beebe Medical Center, located in Sussex County, Delaware, has been defined as a Rural Referral Center under CMS guidelines.

It is our understanding that, because of the very small size of Delaware, the particular configuration of its counties, and the specific geographic location of Beebe Medical Center, the labor market from which Beebe Medical Center draws routinely encompasses a number of non-contiguous areas, including particularly the non-adjacent Wilmington, Delaware, metropolitan area. However, the current Medicare rules for geographic classification and reclassification for purposes of assigning the wage index, which generally limit wage index reassignments only to adjacent areas, do not anticipate this particular situation in which Beebe Medical Center finds itself.

Since the purpose of establishing such geographic wage index classifications is, in fact, to ensure accurate reimbursement for medical facilities that takes into account their actual cost of labor, we, the members of the Delaware Congressional delegation, ask that you take into consideration the unique circumstances facing Beebe Medical Center as you complete work on the final rule for the Medicare 2006 inpatient prospective payment system.

Yours truly,

Joseph R. Biden, Jr.
United States Senator

Michael N. Castle
Member of Congress

Thomas R. Carper
United States Senator

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Office of Legislation
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Washington DC 20201
Ph. 202-690-5960
Fax 202-690-8168

Date: 6/24/05

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TO:	FAX#	PHONE#
Marc Hartstein	410-786-0192	

FROM:	FAX#	PHONE#
Beverly Massey		2/690-5443

MESSAGE:

Pls control

Tennessee Hospital Association

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June 24, 2005

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

To Whom It May Concern:

In the recently released inpatient prospective payment system (IPPS) proposed rule (2006), the Centers for Medicare and Medicaid Services (CMS) only provides continued Critical Access Hospital (CAH) status for state-designated necessary providers, which includes all Tennessee CAHs, that are building replacement facilities at another location and can demonstrate their construction plans began before December 8, 2003. The Tennessee Hospital Association believes this arbitrary date restriction is a broad overreach of CMS authority. It puts in jeopardy many relocation projects in Tennessee that were started or planned in the year and a half since the passage of the Medicare Prescription Drug Improvement and Modernization Act (MMA).

As outlined in the proposed rule, CMS seeks to clarify the issue of CAH relocations and offers the stark reality that only a few CAHs will be grandfathered prior to the cut-off date of Jan. 1, 2006, with no other exceptions. To maintain their CAH status, all necessary providers must submit an application to CMS for relocation prior to Jan. 1, 2006, and be able to: 1) demonstrate they will continue to meet the necessary provider criteria that was used to originally receive a state waiver at the new location, serve at least 75 percent of the same service area, offer 75 percent of the same services, utilize 75 percent of the same staff, maintain compliance with all conditions of participation (42 CFR 485); and 2) demonstrate that construction plans were under development prior to the enactment of the MMA. CAHs moving within 250 yards of their current buildings, or to contiguous land that was owned prior to Dec. 3, 2003, will be exempted from the relocation rules.

The Tennessee Hospital Association's (THA) concern is the CMS IPPS proposed rule prohibits any CAH operating with a necessary provider designation from relocating its facility and maintaining its CAH status unless the move is completed by Jan. 1, 2006, or grandfathered. Necessary provider CAHs that had construction plans already under development as of Dec. 3, 2003, must also demonstrate this fact in their application for relocation and submit it to CMS prior to Jan. 1, 2006.

It was clearly not the intent of Congress in the MMA that a CAH designated as a necessary provider be perpetually prohibited from replacing or relocating their facility,

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which are often 40 to 50 years old. 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. 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. 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.

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.

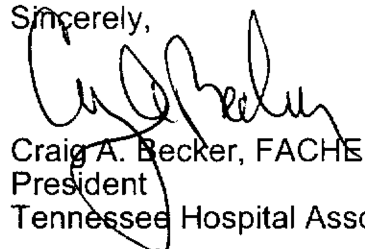
A CAH's necessary provider designation is associated with its current Medicare provider agreement which should remain intact unless the CAH fundamental changes its business (e.g., ceases its current operations) or is terminated by Medicare. It is a longstanding policy that the provider agreement describes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

With the exception of a select group of CAHs that may receive grandfather status under the relocation sunset provision, this proposal makes it virtually impossible for any CAH operating with a necessary provider designation, including approximately 14 hospitals in Tennessee, to ever afford an offsite replacement facility project, as it would immediately become ineligible for cost-based reimbursement.

If the proposal is approved as is, the impact would derail the modernization of a major percentage of America's antiquated CAHs that face limited onsite renovation or replacement options. If enacted, Tennessee's CAHs will be faced with the choice of either undertaking more costly, space-constrained, operationally inefficient onsite construction projects, or relinquishing their cost-based reimbursement, which is the "financial life preserver" necessary to offer quality health care to their communities. This choice would place rural hospitals at a major disadvantage in competing with larger, more financially secure hospitals in attracting physicians and patients in order to preserve market share and remain operationally viable.

The Tennessee Hospital Association is requesting CMS take all steps necessary to eliminate the arbitrary deadline on Critical Access Hospital replacement or relocation in the Inpatient Prospective Payment System (IPPS) final rule.

Sincerely,



Craig A. Becker, FACHE
President
Tennessee Hospital Association

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BY:

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UNIVERSITY OF MINNESOTA

Twin Cities Campus

Department Of Neurology
Medical School

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DRG/Gen

Hefter
Hartstein
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June 22, 2005

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

Re: DRG reimbursement for stroke patients receiving acute reperfusion therapy

To the Center for Medicare Services:

It has come to my attention that the Center for Medicare Services is considering a change in DRG reimbursement for stroke patients receiving acute reperfusion therapy. I believe improved reimbursement would lead to improved stroke care. Let me explain. First of all, I am a senior vascular neurologist, Neurology Department Chair at the Medical School of the University of Minnesota and stroke program director at Hennepin County Medical Center (HCMC). The academic hospitals of our Medical School (University of Minnesota Medical Center, HCMC, Minneapolis Veterans Administration Medical Center, and Regions Medical Center) provide services to hundreds of acute stroke patients each year. At present we are also creating a "hub and spoke" relationship with HCMC as a stroke center for outlying Minnesota hospitals wishing to offer cutting edge reperfusion treatments for their patients with stroke.

Reperfusion therapy for the brain works. It substantially increases the likelihood that a person will be left without disabling deficits of movement, sensation, vision, speech and thinking after a stroke. It is as effective as reperfusion therapy of the heart after a heart attack, and the stakes are as high or higher (at least my older patients tell me that). At present, we are treating about one in 10 patients with stroke with reperfusion therapy at HCMC, and increasing efficiencies as well as public awareness will double that percent, I predict. The number of treated patients in Minnesota will increase as hub and spoke relationships are developed among hospitals. Creating centers and systems for reperfusion therapy, however, requires hospital expenditures to improve processes and availability of key personnel around the clock. Hospitals devote their resources very strategically nowadays to assure their survival in a tough healthcare world. Improved reimbursement for reperfusion-treated stroke patients will enable and stimulate creation of improved models for stroke care in Minnesota.

In summary, I thank you for your work on behalf of Medicare beneficiaries of Minnesota and for your attention to my letter. I urge you to support creation of a new DRG for reperfusion treated stroke patients so that we can actualize advances in stroke treatment for the citizens of Minnesota.

Centers for Medicare and Medicaid Services
Re: DRG reimbursement for stroke patients receiving acute reperfusion therapy
June 22, 2005
Page Two

I am more than happy to respond to questions or comments (612-624-1903, ander012@umn.edu).

Sincerely,

David C. Anderson, M.D.
Professor and Head
Department of Neurology
University of Minnesota Medical School
MMC #295, 420 Delaware Street SE
Minneapolis, MN 55455
Tel: 612-624-1903
Fax: 612-625-4195

Director
Stroke Program
Hennepin County Medical Center
Tel: 612-873-2430

NATIONAL ASSOCIATION OF URBAN HOSPITALS

Private Safety-Net Hospitals Caring for Needy Communities

384

June 23, 2005

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BY: ....

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

TRANSfer

Hefter
Hartstein
WALZ
Hart

Subject: Post-acute-care transfers

To Whom it May Concern:

I am writing on behalf of the National Association of Urban Hospitals to express our opposition to the proposal by the Centers for Medicare & Medicaid Services (CMS) in the FY 2006 Medicare inpatient PPS regulation to extend the Medicare post-acute-care transfer policy from the current 21 Medicare DRGs to 238 Medicare DRGs.

We oppose this proposed change for several reasons.

First, we believe that this policy would unfairly and disproportionately harm urban safety-net hospitals such as those represented by the National Association of Urban Hospitals. Because of the broader mix of services these hospitals provide and their tendency to care for the more severely ill patients covered by this policy, and because they have more post-acute-care options than other hospitals because of the more densely populated regions in which they are located, these hospitals are much more likely to be affected, and much more likely to be hurt, by the extension of the post-acute-care transfer policy to 238 DRGs. CMS has an appropriate goal of reducing average length of stay in hospitals, but the extension of this policy would penalize hospitals for helping the agency meet this worthwhile goal.

Second, we believe that the proposed method of paying for cases involving post-acute transfers undermines the incentives built into the Medicare inpatient prospective payment system – and shortchanges many hospitals in the process. The DRG system is based on averages, and under this proposal, hospitals that transfer patients to post-acute-care settings in a period of time more than one day shorter than the average length of stay receive less than the full DRG payment, which is based on an average case. This has the effect of penalizing hospitals that have managed to treat patients quickly – in effect, penalizing them for their efficiency. Medicare has worked hard to foster this behavior over the years, and now it proposes to punish hospitals for it. While hospitals that care for patients more than a day less than the average length of stay are penalized for such timely transfers, those that must care for patients longer than the average length of stay do not receive additional reimbursement (unless they become outliers). When the averages that constitute DRGs are calculated, they take into account both cases that fall below the average length of stay and those that fall above the average. We do not understand why all cases are not paid the DRG amount as is intended by the DRG system.

Third, the proposed regulation does not address the problem posed by inhomogeneous DRGs, which include more than one distinct type of case and different average lengths of stay within the same DRG. NAUH believes that using a severity-based DRG system would help alleviate this problem, but applying the proposed policy to the current DRGs will exacerbate both the systematic underpayments and

21351 Gentry Drive • Suite 210 • Sterling, VA 20166 • (703) 444-0989 • Fax: (703) 444-3029
www.nauh.org

systematic overpayments of providers in some cases. We do not believe CMS should either underpay or overpay for any care.

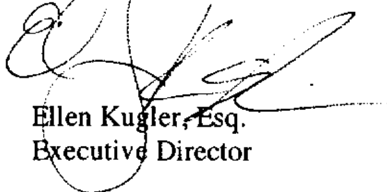
Fourth, we believe that the proposed regulation would expand the post-acute-care regulation to too many DRGs. Originally, the regulation applied to 10 DRGs, and then, it was expanded to the current 21. The original 10 were selected based upon "a high volume of discharges to postacute care and a disproportionate use of postacute services," as were the additional 11 to which the policy was extended. We do not understand how an additional 217 DRGs – roughly 44 percent of all DRGs – can possibly be considered to have "a disproportionate use of postacute services." While the enabling legislation authorized the Department of Health and Human Services to extend the regulation to additional DRGs, we believe that CMS has already extended the policy to DRGs with "a disproportionate use of postacute services" and should extend it no further. As it is, the proposed policy is not budget-neutral and will result in a reduction in federal Medicare expenditures. The National Association of Urban Hospitals believes that CMS should not reduce Medicare hospital expenditures by potentially hundreds of millions of dollars, hurting many hospitals, without specific direction from Congress to do so.

For these reasons, we urge CMS to remove the provision extending the post-acute-care transfer policy to 238 DRGs from the final version of the FY 2006 Medicare inpatient PPS regulation.

About the National Association of Urban Hospitals

The National Association of Urban Hospitals (NAUH) advocates for adequate recognition and financing of private, non-profit, urban safety-net hospitals that serve America's needy urban communities. These private, urban safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are much older and poorer; they are far more reliant on Medicare and Medicaid for revenue; they provide far more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NAUH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive private, urban safety-net hospitals. NAUH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.

Sincerely,



Ellen Kugler, Esq.
Executive Director

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ICD-9-CM
DRG/CEN
NT
Transfers
MedPAC

Heffler
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Brooks
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Treitel
Hart

June 23, 2005

Honorable Mark McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
Room 445-G, HHH Bldg.
200 Independence Ave., SW
Washington, DC 20201

Re: Hospital Inpatient Prospective Payment Systems
Proposed Rule, May 4, 2005 CMS-1500-P
Update for Calendar Year 2006

Dear Dr. McClellan,

Comments Overview

We commend CMS for the efforts in addressing the continuing refinement of the Inpatient Prospective Payment Systems. The following comments are submitted in response to the Proposed Hospital Inpatient Prospective Payment Systems FY2006 Proposed Rule for your serious consideration.

ICD-10 Implementation

The progress of ICD-10-CM and ICD-10-PCS implementation was not addressed in the proposed regulation but we feel it is an important component in responding to MedPAC's "Physician-Owned Specialty Hospitals" number 1 recommendation to better align severity of illness with reimbursement. The ICD-10-CM and ICD-10-PCS code set will provide the specificity necessary to evaluate the impace of patient condition, treatment, complications and comorbidities on facility treatment resources.

We *strongly urge* CMS to issue a notice of proposed rulemaking for ICD-10-CM and ICD-10-PCS implementation as recommended by NCVHS to the Secretary of HHS in 2003. Prior to developing hospital inpatient PPS alternatives, ICD-10-CM and ICD-10-PCS implementation would provide the specificity necessary to analyze the relationship of severity of illness with hospital payment. Also, as recorded in the ICD-9 Committee minutes of March 31, 2005 during the discussion of "Hip replacement bearing surfaces", a commenter stated "that a policy should be created to severely restrict the creation of new codes so that the codes could last longer". ICD-9 does not have sufficient available codes to support the current or future clinical coding complexity. The limitations of ICD-9 were recognized by CMS as published on September 7, 2001 in the Final Rule for Payments of New Medical Services and New Technologies under Acute Care Hospital Inpatient PPS. Although we understand the urgency to respond to MedPAC, any proposed possible alternatives may result in misalignment due to lack of patient condition and treatment coding specificity.

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Section II.B.4.b. "Coronary Artery Stents"

We *support* CMS on creating new ICD-9 codes for identifying *coronary and peripheral* multiple vessel treatment and four new ICD-9 codes for identifying multiple stent placement. This will provide more specific data on multiple vessel procedure and multiple stent placement for cost analysis. The restructuring of DRGs 516 and 526 to four new DRGs reflecting paired DRGs defined as "with CCs" and "without CCs" will better align payment with the complexity of patient conditions.

We *recommend* an initiative, in addition to the ICD-9 Addenda, developed by CMS and Contractors for further provider education on the use of these codes that will encourage accurate reporting for both *coronary and peripheral* vessel procedures. As noted by CMS these new add-on ICD-9 codes may potentially be used as the basis for future DRG restructuring.

Section II.B.11 "(CC) List"

We *agree* with CMS that since the delivery and treatment of inpatient care has changed, it is time for a comprehensive and systematic review of the CC list as assigned to DRGs. However, an insufficient review period may result with misalignment of patient CCs to DRG payment.

We *strongly urge* CMS to establish sufficient time for an analysis and review process of any revisions to the CC List. This process should incorporate; (a) development of clinically cohesive CC classifying alternatives, (b) stakeholder input on alternative methods, (c) posting of data modeling and analysis of alternatives to determine impact to all DRGs and facilities prior to proposed rule, (d) sufficient period for public analysis and comment. This process will provide a deliberate and thoughtful process to ensure that severity of illness is aligned appropriately with reimbursement. This analysis would be more meaningful if conducted after ICD-10-CM and ICD-10-PCS implementation.

Section II.B.4 "FY2006 applicants for New Technology Add-On Payments"

We *commend* CMS for their continuing improvements of the New Technology Add-On Payment applications process. An important intent of the add-on payment, as CMS has stated, is to encourage rapid adoption of new technology. This was supported by Congress in the passage of MMA Public Law 108-173 Section 503(d), which provided new funding and eliminated the Budget Neutrality requirement for New Technology. We urge CMS to include these factors in the evaluation for Add-on payments of the remaining applicants.

Section V.A "Postacute Care Transfers"

We *recommend* the postponement of the proposed Postacute Care Transfer DRG expansion. There have been significant changes in inpatient acute treatments and postacute care payment systems since the initial implementation of this policy. To appropriately analyze patient treatment resources provided prior to postacute care, a more comprehensive review should be conducted.

The existing regulations originally published on July 31, 1998 as found at 42 CFR Ch. IV. €412.4 in the Final IPPS Rule, established the criteria for 10 DRGs subject to the postacute care transfer policy. The basis for these regulations was published in the Proposed IPPS Rule dated May 8, 1998 and stated the law enacting this regulation was accompanied by "The Conference Ageement" in which the Conferees wanted "..strong incentives to treat patients in the most effective and efficient manner,...". In the current proposed rule, CMS considered 2 new criteria options and selected Option 2 to expand the postacute care transfer DRGs from 30 to 231. Either option of expanded Postacute Care DRGs at this time will not provide incentives to treat patients in the most effective and efficient manner

Medical technologies, innovative treatment modalities, and evidence-based physician practice patterns have significantly changed treatment delivery resulting in reduced length of stays. In days one and two of an acute inpatient stay, procedures and most of the intense treatment are delivered. The review of FY 2003 and FY 2004 MedPAR data does not contain any criteria for cost analysis as was included in the original policy formulation.

When the original policy was published in 1998, the postacute care service payments were based on cost-reimbursed systems. At that time, by establishing the postacute care transfer policy it was intended to deter any early patient discharge from a prospective payment setting to a cost based setting for financial incentives. Subsequently, all postacute care settings have transitioned to prospective payment systems; SNF PPS 10/01/1998; HHA PPS 10/01/2000; IFRS 01/01/2002; LTCH 10/01/2002; IPF 01/01/2005. By increasing the number of DRGs subject to the postacute care transfer policy of one PPS system to another PPS system is not creating incentives for effective and efficient treatment. By implementing such a broad range policy without cost analysis will not improve payment accuracy for severity of illness and may encourage delays in transfers to postacute care settings.

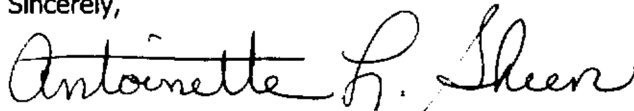
Section IX. "MedPAC Recommendations"

We *support* CMS in their response to the MedPAC Recommendations for developing changes in the DRG methodology to better reflect severity of illness and that the current CMS hospital cost report does not provide sufficient detail for a DRG cost based methodology. We present the following comments for your consideration as the process is developed to design and analyze alternatives.

A. Implement ICD-10-CM and ICD-10-PCS code set to capture more specificity for patient condition, treatment, complications and comorbidities prior to developing alternative DRG payment methods.
B. Establish sufficient time for the careful analysis of claims data generated by the IPPS complex coverage, coding, and billing system
C. Obtain stakeholder input throughout the entire process
D. Publish alternatives and data for public review on the CMS website with sufficient time for comment prior to a proposed rule.

We appreciate the opportunity to submit these comments for your consideration and would be happy to discuss further.

Sincerely,



Antoinette L. Sheen, MBA (Ext. 42420)
Coverage, Coding, & Reimbursement Associate
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Flagstaff, AZ 86003

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Hefter
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Director, Stroke Center

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Interim Chair

John D. Steffens, M.D.
Assistant Professor
Director, Neurosciences Clinic

David Renner, M.D.
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Assistant Professor
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Co-director, Stroke Center

William T. Couldwell, M.D., Ph.D.
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June 23, 2005

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

To Whom It May Concern:

Please allow me to introduce myself. I am a neurologist with sub specialty training in Stroke and Neurocritical Care. Since 2001, I have been the Medical Director of the University of Utah Stroke Center in Salt Lake City, Utah. I am writing this letter to encourage CMS to support changes to the Medicare hospital reimbursement for advance stroke treatment in FY06.

The University of Utah Stroke Center is a comprehensive Stroke Center which sees approximately 350 stroke patients per year. We have a multi-disciplinary response team available 24/7 to emergently evaluate and treat acute stroke. Currently, we are treating over 20% of ischemic stroke patients in our system with thrombolytic therapy. The University of Utah Stroke Center became the first JCAHO certified primary Stroke Center in the intermountain west in October 2004. We are actively working with the community and EMS systems. In addition to educating the county EMS system, we have also trained emergency room staff within the Salt Lake City area and have implemented several Telestroke sites. This system enables rural emergency rooms to deliver state of the art acute stroke care.

Stroke is the leading cause of disability in the United States. If left untreated, stroke leads to loss of independence, loss of income, and a need for long term assistance. Fortunately, there is an effective treatment for acute stroke. In 1996 the FDA approved a tissue plasminogen activator for acute ischemic stroke. This medication must be given within 3 hours of the onset of symptoms in order to be effective. It has clearly been shown that patients qualifying and receiving this reperfusion therapy have better outcomes and less long term disability. This narrow time window to treat necessitates a tremendous commitment on the part of organized stroke centers.

The current level of reimbursement for reperfusion therapy does little to support this extensive infrastructure. In fact, the prospect of poor reimbursement in the face of higher costs deters most hospitals from setting up stroke centers even though the national recommendations state that primary stroke center criteria are the minimum requirement to care for stroke patients.

I strongly support a new DRG for acute stroke patients with reperfusion therapy that would reimburse at a higher rate. This would help financially support increased intensive care, imaging and pharmacy costs that are incurred by this patient group. It would also make the establishment of stroke centers more economically feasible and lead to increased access for stroke patients to acute treatment programs.

Thank you for your work on behalf of Medicare beneficiaries and your attention to the special needs of stroke patients. Please feel free to contact me at any time,

Sincerely,

Elaine Skalabrin, MD
Assistant Professor of Neurology
Director University of Utah Stroke Center

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

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EDUARDO J. SANCHEZ, M.D., M.P.H.
COMMISSIONER

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1100 W. 49th Street • Austin, Texas 78756
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June 21, 2005

DRG/Gen

Hefter, Hartstein, Brooks, Gruber, Fagan, Kelly, Hue

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

Re: Proposed rules, Federal Register May 4, 2005 (Volume 70, Number 85), proposing changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates

Dear Sir or Madam:

The Texas Department of State Health Services (TDSHS) collects hospital inpatient discharge data from most Texas hospitals. The data are collected using the HIPAA and reporting implementation standards, allowing for the collection of the principal diagnosis code, and up to 24 additional diagnosis codes, and the principal procedure code, and up to 24 additional procedure codes. Reports are published using the DRGs assigned to these data. TDSHS submits the following comments on the proposed changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates for your consideration:

B. DRG Reclassifications

The proposed regulations provide for the continued use of the principal and up to eight additional diagnosis codes and the principal and up to five additional procedure codes for the assignment of DRGs. The HIPAA and reporting implementation standards allow for the reporting of the principal diagnosis code, and up to 24 additional diagnosis codes, and the principal procedure code, and up to 24 additional procedure codes. The proposal to continue the use of more limited diagnosis and procedure codes acts as a disincentive for the reporting of additional codes, and will result in less precise assignment of DRGs.

DRGs are used for the reporting of health care quality. Limiting the diagnosis and procedure codes used for the assignment of DRGs and the resulting imprecision will have an adverse effect on healthcare quality reporting efforts. If the additional diagnosis and procedure codes allowed are not used by CMS, they may not be reported. Additional external cause of injury codes that can now be reported may not be reported as well.

Quality initiatives are dependent on more complete diagnosis and procedure coding. The proposed CMS regulations would negatively impact those efforts. TDSHS respectfully requests that all available codes be used in the assignment of DRGs.

Sincerely,

Sylvia Cook

Sylvia Cook
Texas Health Care Information Collection
Center for Health Statistics

WEST VIRGINIA
HOSPITAL ASSOCIATION

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CAH Relocation

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Smith
Morey

June 20, 2005

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

Dear Dr. McClellan:

On behalf of the 74 member hospitals and health systems comprising the West Virginia Hospital Association, I appreciate the opportunity to submit these comments regarding the proposed changes to the Hospital Inpatient Prospective Payment System for Fiscal Year 2006, as originally published in the *Federal Register* dated May 4, 2005. Our primary concerns are with regards to the following areas in the proposed rule:

- Hospital Market Basket Update
- Proposed expansion of the transfer policy
- Proposed increase in the outlier threshold
- Proposed changes to the Critical Access Hospital Program

In FY 2003, fully 56 percent of West Virginia's hospitals had negative Medicare inpatient margins, and 77 percent lost money on Medicare services in total. The proposed rule, if adopted, will further exacerbate this payment inadequacy, and further jeopardize West Virginia's senior citizens' access to vital healthcare services.

Hospital Market Basket Update

CMS is currently reporting that for FY 2005, the actual market basket increase will approach 4.1 percent, compared with the 3.3 percent increase that was used to update the rates for FY 2005. In fact, for seven of the last eight years, the market basket projection used in the update has been less than the actual increase for the year. **We urge CMS to review the methodology that was used to determine the projected inflation for FY 2005, and revise it for FY 2006.** Since in many previous years, the update has actually been a percentage below the market basket, these under-projections have clearly contributed to the inpatient margin shortfalls identified above.

Post-acute care transfers

The Association strongly objects to the proposed major expansion of the post-acute care transfer rule from the current 30 to the proposed 231 DRGs. The expansion of the transfer policy undercuts the basic objectives of the Medicare prospective payment system, which is based on a system of averages. The impact of this proposed expansion will be that hospitals will "lose" if a patient is discharged prior to the mean length of stay, and "lose" if the patients are discharged after the mean length of stay.

When the post-acute care transfer policy was first implemented, Medicare post-acute care reimbursement was on a cost-based approach. Since that time, however, each of these systems has transitioned to its own unique prospective payment system, removing any incentive that may have existed for hospitals to "game" the system. In West Virginia, in fact, the majority of the patients in the proposed DRGs, who use post-acute care, have longer lengths of stay than those who do not use post-acute care. Furthermore, Section 1886(d)(4)(J) of the Social Security Act specifically directs CMS to focus on those DRGs that have a high volume of discharges to post-acute care and a **disproportionate** use of post-discharge services. Given the large number of additional DRGs being added in this proposed rule, it would be inappropriate to say that these criteria are being met in all cases.

The Association strongly objects to the expansion of the post-acute care transfer policy, which penalizes hospitals for providing efficient care and undermines appropriate clinical decision-making. CMS must withdraw this provision in its final rule.

Outlier payments

CMS states in its proposed rule that actual outlier payments for 2005 will be 0.7 percent lower than the 5.1 percent of funds that are withheld from hospitals to fund outlier payments. This is not the first time that CMS has failed to fully pay out the amount that has been set aside to fund the outlier pool. The Association believes that the increase in the proposed outlier threshold to $26,675 for FY 2006 will once again result in a real payment cut to hospitals.

The Association objects to the methodology used to estimate the outlier threshold for FY 2006, and recommends that CMS consider the methodology proposed by the American Hospital Association in its comment letter to you. This would result in a slightly lower threshold of $24,050, and would more likely result in the payment of the full 5.1 percent of funds set aside for outlier payments.

Critical Access Hospitals

One of the primary requirements for designation as a CAH is that the hospitals be located in or reclassified to a rural area. Unfortunately, as a result of the recent labor market changes, some counties that were previously considered rural were redesignated as urban. Included in this redesignation are those counties known as "Lugar counties." Some CAHs are now located in Lugar counties and are unable to meet the rural location requirement, even though they were in full compliance at the time they were designated as CAHs, and even though the majority of patients they serve live in rural census tracts within their county. **The Association recommends that CAHs that were in these formerly rural counties should be grandfathered in and remain in the CAH program.**

The Association also strongly objects to CMS' proposal that would essentially bar CAHs with necessary provider designations from relocating more than 250 yards from their existing sites. As required in the proposed rule, the CAH had to have its relocation application in to the state agency by no later than December 8, 2003, even though the date for governors to newly approve necessary providers does not expire until January 1, 2006. **CMS must remove this arbitrary date restriction for relocations.**

CAHs are often housed in older buildings that are in desperate need of renovations. Prior to converting to CAH status, these facilities may have been unable to gain access to necessary capital due to deteriorating financial conditions under the prospective payment system. By stabilizing their finances through CAH conversion, many of these CAHs are now able to access the necessary financing to rebuild their aging facilities. In many cases, CAHs are relocating to improve site utilities and air handling, modernizing telecommunications to support health information technology, or other essential upgrades. Such improvements will no doubt result in better patient outcomes and more efficient service. **Facilities that must relocate to make critical safety improvements should not be penalized and barred from moving. The Association recommends that CMS should automatically consider any CAH that moves within five miles from its current location to be rebuilding and not relocating, and thus remains the same provider with the same necessary provider designation it currently carries.**

For a CAH that moves further than five miles from its current location, the Association would recommend that an approach similar to the 75 percent test used in the proposed rule be applied, but that **some flexibility in the measures is needed to allow for natural changes in demographics that may have occurred since the time the CAH was first designated. The Association would recommend that perhaps CMS should consider that such a relocation require three out of its five criteria be satisfied in order for the CAH to maintain its current designation.**

CAHs are the sole providers of inpatient acute-care services in their communities, and often the sole provider of outpatient and long-term care services. Facilities that converted to this status did so because of their deteriorating financial conditions under the prospective payment system. It is therefore highly unlikely that they would be able to successfully covert back to the inpatient PPS program, if denied CAH status due to their relocation efforts. **The Association urges CMS to rescind its overly restrictive proposed policy and allow necessary provider critical access hospitals to relocate as needed to improve care and meet the needs of their communities.**

Finally, the Association is concerned about CAHs that may be converting under the necessary provider program, but may not receive their formal designation and receive their new provider number by the January 1, 2006 deadline. **The Association recommends that hospitals that have requested a CAH survey in advance of the January 1 deadline, but are unable to get the state agency to complete the survey process by that deadline, be considered as having demonstrated a good faith effort, and as having met the January 1 deadline.**

I appreciate the opportunity to comment on the proposed Inpatient PPS rule for FY 2006. If you have any questions, please don't hesitate to contact me at (304) 344-9744.

Sincerely,

Michael B. Robbins
VP/Financial Policy

MBR/ch

30 South Wacker Drive
Suite 2302
Chicago, Illinois 60606

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312 474 1950 Fax

389

June 21, 2005

RECEIVED
JUN 24 2005
BY:

SpH

Hefter, Hartstein, Romano, Treitel

Mark McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
PO Box 8011
Baltimore, Maryland 21244-1850

Re: File Code CMS-1500-P: Medicare Program- Clarification of the Definition of "Hospital" in Connection With Specialty Hospitals

Dear Dr. McClellan:

National Surgical Hospitals ("NSH") welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' ("CMS") proposed clarification of the definition of "hospital" in connection with specialty hospitals, as published in the May 4, 2005 *Federal Register*. NSH, the nation's leading developer and manager of specialty surgical hospitals, is pleased to provide information relevant to CMS'examination of the definition of "hospital" as applied to healthcare facilities in the country. NSH is a partner in 15 surgical facilities specializing in orthopedics, neurosurgery, and more complex general surgery cases.

Section 1861(e) of the Act provides a definition for a "hospital" for purposes of participating in the Medicare program. In order to be a Medicare-participating hospital, an institution must, among other things, be primarily engaged in furnishing services to inpatients. This requirement is incorporated in CMS regulations as a condition of participation for hospitals at 42 CFR 482.1. CMS has advised that any "institution that applies for a Medicare provider agreement as a hospital but is unable to meet this requirement will have its application denied in accordance with our authority at 42 CFR 489.12." We note that CMS has extended this caution to all "institutions that have a Medicare hospital provider agreement but are no longer primarily engaging in furnishing services to inpatients". These existing institutions are subject to having their provider agreements terminated pursuant to 42 CFR 489.53.

CMS has expressed concern that some institutions that describe themselves as surgical or orthopedic specialty hospitals may be primarily engaged in furnishing services to outpatients, and thus might not meet the definition of a hospital as contained in section 1861(e). Therefore, CMS has initiated a review of its procedures for hospital certification to, "determine whether additional or different standards should apply to specialty hospitals in light of the focused nature of their services". (See *Medicare Fact Sheet*, June 9, 2005)

While NSH recognizes the concerns expressed by CMS we feel the agency is misguided in attempting to redefine hospital for purposes of Medicare certification. CMS seems to have undertaken this initiative in a rushed and haphazard fashion without a compelling reason to disturb the established certification process. As discussed below, the proposed "clarification" is unneeded at this time as CMS has better alternatives to pursue in correcting the payment system rather than corrupting long-standing definitions.

First, NSH believes CMS should clarify what it is actually proposing under its May 4, 2005 proposed rule as published in the *Federal Register*, p. 23447. The proposed rule refers to possible changes intended as "clarification of the definition of a hospital as it relates to 'specialty hospitals'". However, the text of the proposed rule suggests no changes in the law. Instead, it discusses the possible selective and amplified application of one of the existing elements of the definition of hospital, as applied to specialty hospitals. This is not a change in law but rather a change in interpretation and enforcement. CMS added more confusion in publishing a *Medicare Fact Sheet* on June 9, 2005 informing the public that, "CMS will review its current standards for approval for participation and payment, to determine whether additional or different standards should apply to specialty hospitals in light of the focused nature of their services." We are left to wonder what CMS intends with its proposed rule. Is CMS seeking to redefine hospital or recalibrate its enforcement? Does the agency intend to add new and different criteria to the definition of hospital or re-interpret existing law? This lack of clarity in the CMS proposed rule hinders our ability to provide useful comments.

Second, NSH is concerned that CMS has decided to undertake this clarification of the definition of a hospital only as to specialty hospitals. This narrow focus would be highly discriminatory and lacking both legal and logical justification. While specialty hospitals are of interest to CMS, partly because of section 507 of Pub. L. 108-173, the statutory definition of hospital and the Medicare hospital certification requirements do not provide for a separate set of rules for different types of hospitals. In particular, we believe that CMS is misguided in considering a plan to selectively enforce one particular element of the hospital definition against specialty hospitals. Singling out specialty hospitals for more stringent measurement against the "primarily engaged in furnishing services to inpatients" standard of the Act presents substantial equal protection concerns. A valid statute may be rendered invalid as violative of equal protection if its provisions are selectively enforced.

CMS has very seldom relied upon the primarily engaged standard in declining to certify a hospital applicant or in revoking the certification of an existing hospital. The "primarily engaged" standard is not statutorily defined nor is there a body of case law or administrative interpretations adequately defining what it means for a hospital to be primarily engaged in furnishing services to inpatients. Should CMS choose to heighten its scrutiny of compliance with the "primarily engaged" standard it must do so even-handedly and in a non-discriminatory manner. All hospitals, large and small, general and specialized, urban and rural, must comply. The law makes no allowance for CMS to consciously and deliberately enforce certain requirements against some hospitals, while premeditatedly abstaining from enforcement of the same requirements against others.

We anticipate that CMS will act in compliance with the law and consistent with their representations in the May 4, 2005 proposed rule. CMS stated that "institutions that have a Medicare hospital provider agreement but are no longer primarily engaging in furnishing services to inpatients are subject to having their provider agreements terminated pursuant to 42 CFR 489.53." CMS should note that an unbiased application of this standard might well result in the termination of Medicare provider agreements for **over 620 hospitals**. This is based upon analysis of 2003 Medicare admissions data for all hospitals. Lacking a clear definition of the meaning of primarily engaging in furnishing services to inpatients, we have assumed that primarily engaged means performing more inpatient cases than outpatient cases.

The preceding analysis highlights several other problems with the proposed rule. The first of these is the definition of "primarily engaged in furnishing services to inpatients". Does this mean a bear majority of cases performed at the hospital must be inpatient cases? How are these cases counted, i.e. what type of cases are included in the inpatient count? Should the measurement of primarily engaged be based upon revenues rather then case numbers? It is interesting to note that CMS itself in a recent specialty hospital related publication has used a 45 percent standard in trying to define primarily engaged.[1] These and other questions leave hospitals to guess as to their status under the law.

Previous attempts by CMS to define "primarily engaged" have been less than illuminating. In an October 25, 2002 Program Memorandum addressing the definition of hospice, CMS explained, "Although the law does not explicitly define its expectations for 'primarily engaged', CMS has interpreted it to mean exactly what it says, that a hospice provider must be primarily engaged in providing hospice care and services." It is hoped that if CMS chooses to terminate Medicare hospital provider agreements based on a determination that a facility is no longer primarily engaging in furnishing services to inpatients, the agency will have a more precise and intelligible standard of measure than the tautology stated above.

Finally, NSH sees significant practical difficulty for CMS in carrying out its intention to deny the application of any institution that applies for a Medicare provider agreement as a hospital but is unable to meet the primarily engaged requirement. How will CMS decide whether a new facility, which is not yet open for business, is primarily engaged in inpatient care? How will such a facility be identified as a specialty hospital if the definition of specialty hospital requires the examination of cases performed? As a practical matter, a new hospital is not able to predict, with a high degree of certainty, what type of cases and the case mix that will come to the facility. This will leave both CMS and hospital administrators to question whether and how a modified definition of hospital applies to a specific facility.

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[1] See CMS letter dated June 9, 2005 to State Survey Agency Directors – "Hospitals – Suspension of Processing New Provider Enrollment Applications for Specialty Hospitals". The letter states: "For purposes of this suspension, specialty hospitals are identified as those hospitals that have attested to the FI that: 1) they are primarily engaged in cardiac, orthopedic, or surgical care; or 2) project they will have a least 45 percent of inpatient cases in cardiac, orthopedic, or surgical care."

NSH recommends that CMS be very circumspect in attempting to redefine hospital for purposes of Medicare certification. As yet, there has been no compelling reason presented which should cause CMS to create additional or different standards of certification for any type of hospital. If, as CMS conjectures, there are incentives for some surgical cases to be brought to specialty hospitals rather than other sites, this issue should not be addressed through definitional changes. Rather, CMS and healthcare in general, will be better served by changing the DRG system and ASC reimbursement schedule to eliminate the site of service differential. This levels the reimbursement playing field without creating artificial and unnecessary distinctions between specialty and other hospitals. NSH commends CMS for its insights into the reimbursement problems, as set forth in the May 2005 specialty hospital study presented to Congress.

NSH asks that CMS resist suggestions that a discriminatory enforcement policy be adopted to punitively terminate Medicare provider agreements for hospitals which perform a substantial number of outpatient cases. The trend in healthcare is decidedly towards outpatient care and it would be a poor healthcare policy decision to remove from the Medicare provider rolls those facilities which provide both inpatient and outpatient services, but have special capacity to provide outpatient care. If any change is to be made in the definition of hospital it should be to temper the primarily engaged standard to better reflect current healthcare policies and practices.

Sincerely

Scott B. Clark
Vice President and General Counsel

SBC:sm

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

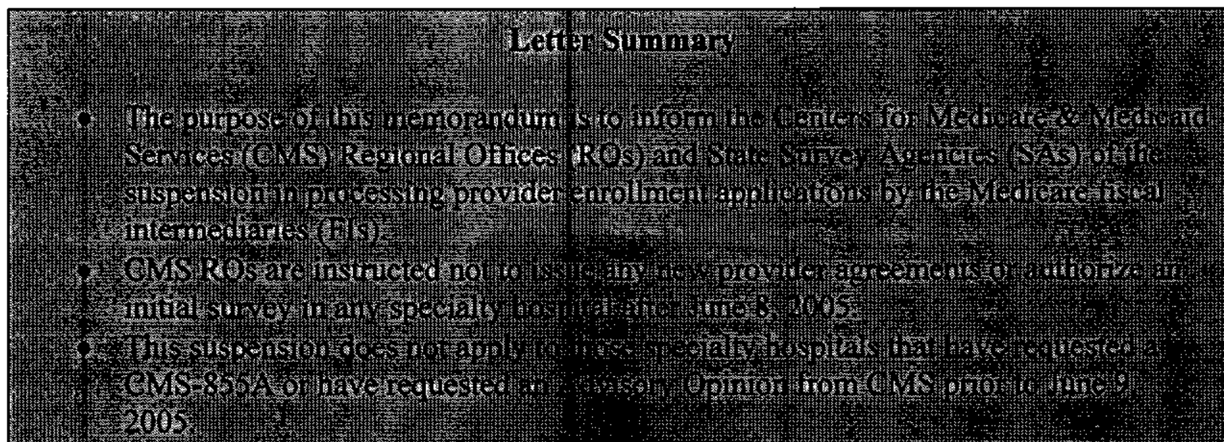
Ref: S&C-05-35

DATE: **June 9, 2005**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: **Hospitals -** Suspension of Processing New Provider Enrollment Applications (CMS-855A) for Specialty Hospitals



Letter Summary

- The purpose of this memorandum is to inform the Centers for Medicare & Medicaid Services (CMS) Regional Offices (ROs) and State Survey Agencies (SAs) of the suspension in processing provider enrollment applications by the Medicare fiscal intermediaries (FIs).
- CMS ROs are instructed not to issue any new provider agreements or authorize an initial survey in any specialty hospital after June 8, 2005.
- This suspension does not apply to those specialty hospitals that have requested a CMS-855A or have requested an Advisory Opinion from CMS prior to June 9, 2005.

Effective June 9, 2005, the Medicare fiscal intermediaries (FIs) have been instructed not to process any new Medicare provider enrollment applications (CMS-855A forms) for specialty hospitals, and not to forward recommendations for approval of CMS-855As for these hospitals to the CMS ROs or SAs.

ROs should not issue any new provider agreements or authorize an initial survey in any specialty hospital that has submitted a provider enrollment application (CMS-855A) on or after June 9, 2005. Additionally, SAs should not perform any initial Medicare surveys unless they first verify that the CMS-855A has been approved by the FI. In addition, if a new applicant specialty hospital receives accreditation as a hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association, they may not receive approval to participate in Medicare until a recommendation for approval of the CMS-855A is received in the RO.

This suspension does not apply to those specialty hospitals that have submitted a provider enrollment application or requested an Advisory Opinion from CMS prior to June 9, 2005. In order to determine whether a specialty hospital has requested an advisory opinion prior to June 9, 2005, please contact Jacqueline Proctor at (410) 786-8852 or email her at jproctor2@cms.hhs.gov.

Background

Sections 507(b)(2) and (b)(3) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires that both the Department of Health and Human Services and the Medicare Payment Advisory Commission (MedPAC) conduct a study of a set of important quality and cost issues related to certain physician-owned specialty hospitals. Section 507 of the MMA defines a "specialty hospital" as a hospital that is primarily or exclusively engaged in the care and treatment of patients with a cardiac condition, orthopedic condition, or receiving a surgical procedure.

In the Administrator's May 12, 2005 testimony to Congress concerning specialty hospitals, Dr. McClellan expressed his concern that some entities that describe themselves as specialty hospitals may not meet the definition of a hospital. CMS also wants to be assured that, given their limited focus, specialty hospitals meet such core requirements that we determine are necessary for the health and safety of our beneficiaries. In addition, we wish to consider how EMTALA should apply to specialty hospitals, in particular with reference to potential transfer cases arising in the emergency departments of other hospitals.

Therefore, CMS is temporarily suspending the processing of new provider applications for specialty hospitals while we comprehensively review the procedures used to qualify these hospitals for participation in the Medicare program. This suspension does not apply to specialty hospitals that currently have provider agreements or those specialty hospitals that have requested an Advisory Opinion from CMS prior to June 8, 2005. For the purposes of this suspension, specialty hospitals are identified as those hospitals that have attested to the FI that: 1) they are primarily engaged in cardiac, orthopedic, or surgical care; or 2) project they will have at least 45 percent of inpatient cases in cardiac, orthopedic, or surgical care.

ROs and SAs that have questions concerning this memo should contact Frank Sokolik at (410) 786-7089 or e-mail at frank.sokolik@cms.hhs.gov.

Effective Date: Immediately. The SA should disseminate this information within 30 days of the date of this memorandum.

Training: The information contained in this announcement should be shared with all survey and certification staff, their managers, and the state/RO training coordinators.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 303-D
200 Independence Avenue, SW
Washington, DC 20201

Office of External Affairs

MEDICARE FACT SHEET

FOR IMMEDIATE RELEASE
June 9, 2005

Contact: CMS Office of External Affairs
(202) 690-6145

CMS OUTLINES NEXT STEPS AS MORATORIUM ON NEW SPECIALTY HOSPITALS EXPIRES

Overview: The Centers for Medicare & Medicaid Services will undertake over the next six months a review of its procedures for enrolling specialty hospitals in the Medicare program. In addition, CMS will undertake a series of steps to reform Medicare payments that may provide specialty hospitals with an unfair advantage over other types of providers, such as community hospitals and ambulatory surgical centers. Specialty hospitals are those with limited focus that generally treat only cardiac, orthopedic or surgical cases. Physicians who refer patients to these specialty hospitals often have a limited ownership interest in them.

The steps CMS is announcing today are designed to promote true and fair competition in hospital services, while improving quality and avoiding unnecessary costs for patients and for the Medicare program.

Background: In the Medicare Modernization Act of 2003, Congress instructed CMS to prohibit physician-investor referrals to specialty hospitals for a period of 18 months, ending June 8, 2005, unless the hospitals were already under development as of November 18, 2003. Congress mandated that during the moratorium, the Medicare Payment Advisory Commission (MedPAC) and the Department of Health and Human Services (HHS) conduct separate studies, with MedPAC focusing on payment issues raised by specialty hospitals, and HHS focusing on such issues as referral patterns, quality of care, and impact on the provision of uncompensated care. MedPAC submitted its report and recommendations on March 8, and HHS submitted its report and recommendations on May 12.

CMS is now beginning to implement the recommended changes.

Key Steps: In its May 12 Report to Congress, CMS outlines four recommendations concerning specialty hospitals.

Reform payment rates for inpatient hospital services through changes to the DRG system.

CMS will evaluate potential changes to the inpatient prospective payment system (IPPS). The changes will be implemented to more accurately reflect the severity of a patient's illness in setting the

-more-

payment level. CMS will also review specific DRGs such as cardiac, orthopedic, and surgical DRGs that are alleged to be overpaid and that may therefore create incentives for physicians to create specialty hospitals. CMS expects to implement most of these IPPS changes by fiscal year 2007.

Reform payment rates for ambulatory surgical centers (ASCs).

The CMS study of specialty hospitals found that orthopedic and surgical specialty hospitals tend to have few inpatient beds and raised the question of whether these entities concentrate primarily on outpatient care. Physician-owners may seek the specialty hospital designation because payment rates for hospital outpatient services under the outpatient prospective payment system are often higher than those for the same procedures when performed in ASCs. CMS is already planning to reform the ASC payment system to diminish these differences. CMS will implement the ASC payment reforms by January 2008.

Review procedures for approving hospitals for participation in Medicare and closely scrutinize processes for approving and starting to pay new specialty hospitals.

Under Medicare, a hospital must primarily furnish care to inpatients. CMS has expressed concern that some specialty hospitals may concentrate primarily on outpatients and may therefore fail to meet the Medicare definition. Accordingly, the May 4, 2005 proposed rule updating the Hospital Inpatient Prospective Payment System for Fiscal Year 2006 indicated that, if specialty hospitals are not primarily engaged in inpatient care, new applications for hospital provider agreements will be denied and existing provider agreements may be terminated.

CMS will review its current standards for approval for participation and payment, to determine whether additional or different standards should apply to specialty hospitals in light of the focused nature of their services. Specifically, CMS intends to continue meeting this summer with State survey agencies, JCAHO, and AOA, the organizations that accredit hospitals, to discuss standards for determining whether a specialty hospital meets statutory requirements to be a hospital under Medicare.

CMS also plans to seek public comment on the appropriate standards for specialty hospitals. Specifically, CMS will:

- Seek advice from the EMTALA Technical Advisory Group (TAG) - CMS has added several items related to specialty hospitals to the agenda for the TAG's meeting on June 15-17, 2005. Among other items, CMS plans to discuss transfer requirements between community hospitals and specialty hospitals, and the participation of specialty hospitals with emergency departments in local community emergency services protocols.

- Solicit public input on certification issues related to specialty hospitals - To obtain as much information and as many views as possible, CMS will seek input from the public in an Open Door Forum in September 2005. Open Door Forums provide an opportunity for live dialogue between CMS and the provider community at large, in order to understand and then help find

-more-

solutions to contemporary program issues. The date and time of the Open Door Forum will be announced later on the Open Door website at: *www.cms.hhs.gov/opendoor*.

In the context of this review, CMS will also seek public input on how it can best support all types of hospitals in achieving further quality improvements and efficiency gains.

During this review, CMS is instructing its regional offices not to issue new specialty hospital provider agreements or authorize an initial survey by the state survey agency for new specialty hospitals. Medicare fiscal intermediaries have been instructed not to process new provider enrollment applications for specialty hospitals until further notice. The suspension does not apply to those specialty hospitals that have prior to June 9, 2005, submitted an enrollment application or have requested an advisory opinion from CMS concerning whether they were subject to the moratorium under section 507 of the MMA. CMS plans to complete its review process by January 2006.

# # #

RECEIVED
JUN 24 2005
BY:..................

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16001 West Nine Mile Road
Southfield, MI 48075

GME/Aff
IME

Hefter
Hartstein
Lefkowitz
Ruiz
Truong

June 21, 2005

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1500-P
Room C5-14-03
7500 Security Blvd.
Baltimore, MD 21244-1850

RE: [CMS-1500-P] Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2006 Payment Rates (42 *Federal Register 405, 412, 413, 415, 419, 422, and 485*), May 4, 2005

To whom it may concern:

As a member of the resident teaching faculty of St. John Health (SJH), a Southeast Michigan health system with eight hospitals and over 400 interns and residents in allopathic, osteopathic, dental, and podiatry training programs, I appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the 2005 Inpatient Prospective Payment System (PPS), published May 4, 2005 in the *Federal Register*. The adequacy of Medicare payments to cover the cost of training our future generation of physicians is essential to maintain financially viable teaching hospitals in Michigan and across the United States to ensure the adequacy of future Medicare beneficiary access.

My comment is regarding New Teaching Hospitals in Medicare GME Affiliated Groups (§413.79 (e) (1)) of the proposed rules beginning on page 23440 of the May 4, 2005 Federal Register.

CMS proposes to allow new urban hospitals that qualify for an adjustment under §413.79 (e) (1) may enter into a Medicare GME affiliation agreement only if the resulting adjustment is an increase in the new teaching hospital's DGME and IME caps as a result of the affiliation agreement.

I fully concur with this proposed policy update. New urban teaching hospitals should be provided with the flexibility to start new teaching programs without jeopardizing their ability to count additional FTE residents training at the hospital under an affiliation agreement. This flexibility will occur if new urban teaching hospitals are allowed to enter into affiliation agreements with other teaching hospitals to increase their DGME and IME FTE caps.

By definition, a new urban teaching hospital would initially have a resident FTE cap of zero, (0). When residents from existing teaching hospitals rotate to the new urban teaching hospital, it is appropriate for the new urban teaching hospital to receive a positive, increased, adjustment to their FTE cap allowing the new urban teaching hospital to receive Medicare IME and DGME payments. These additional Medicare payments are necessary for the new teaching hospital to cover the direct and indirect costs the new urban teaching hospital will be incurring to train the "in rotating" residents from other hospital teaching programs.

Thank you for considering my comment regarding your proposed improvement to the Medicare program's existing payment rules for graduate medical education.

Sincerely,

John Frownfelter, MD
Staff Physician
Providence Hospital
St. John Health

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RECEIVED
JUN 24 2005
BY:

Labor/S

Queen of the Valley Hospital
ST. JOSEPH HEALTH SYSTEM

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Napa, CA 94558

707.252.4411 Tel
707.226.2901 TDD
707.265.8222 Emergency Room TDD

Hefter
Hartstein
Seifert
Knight
Treitel

June 21, 2005

Marc Hartstein, Deputy Director
Division of Acute Care
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS - 1428-P
P.O. Box 8010
Baltimore, Maryland 21244-1850

Re: Proposed Rule Comments
Labor Share

Dear Mr. Hartstein:

We write on behalf of Queen of the Valley Hospital to provide comments on the Centers for Medicare and Medicaid Service proposed rule for inpatient prospective payment for FY 2006 regarding the change in "Labor Share" proportion.

As a by-product of CMS proposal to change the Market Basket components it is also proposing a change in the labor share proportion of the payment. Such a change would move from the present labor share proportion of 71.066% to 69.731%. CMS acknowledges that the present labor share comes from prior labor share proportion. However, the labor share that should theoretically be used at present is actually 72.495 %, which is the proportion from 1997. The labor share is important because it impacts the portion of the payment that is adjusted by the area wage index.

CMS made an evaluation in 2002 and proposed a 72.495% labor share which it subsequently backed away from. Then Congress required that any hospital with an area wage index of less than 1.0 receive a labor share of 62.0%, if that was more beneficial. Decreasing the labor share proportion is predisposed to positively impact rural hospitals.

In CMS analysis it related and compared the 1992 based labor share weights (71.066%) to the 2002 based labor share weights (69.731%). CMS does not draw any conclusions regarding the related shifts by line item. What CMS should be evaluating is why the proportions changed from 1997 data, which the agency decided not to use. This represents the true question. The real issue to be questioned is why the labor share went from 71.066% (1992) to 72.495% (1997) to 69.7315% (2002). These changes raise questions about 1) the veracity of the data, 2) the change in base cost data, 3) the effect of proxy changes on the trending, 4) consistency of CMS methodology, and 5) other factors. CMS did not seem to analyze these issues or seems to have

ignored them. CMS needs to address why it believes that the labor share proportion is fluctuating (regardless of whether the agency used the 1997 based labor share proportion). The agency needs to concern itself with why this fluctuation occurred and whether it was caused by any methodological or data change and whether such a change was appropriate. This type of analysis has not been performed - rather the agency has chosen to compare the 1992 weights to the 2002 weights which show the least amount of variation.

If CMS were to have compared the 2002 weighted labor share with the 1997 labor share it would have seen a greater variation among the elements. Some variations would have been 100% greater, which would have raised the question of why such variation occurred. CMS discussion in the rule did not focus on the 1997 to 2002 variation. In fact, CMS was almost dismissive of the fact that the 1997 proportions existed.

The fact is that the 1997 data increased labor share proportions and in turn the impact of the AWI. This would have adversely impacted the rural providers. At that time CMS knew of the Senate's interest in protecting rural providers from this effect. Coincidentally, CMS pulled back from implementing this change. Then the Senate pushed to put in place the 62 % labor share for providers with AWIs less than 1.0. Thus, rural hospitals are now protected.

The current labor share proposal would provide a reduction to urban hospitals and would not fundamentally benefit the rurals because they are already protected by the 62% labor share requirement. Thus, CMS should not implement the revised labor share proportions.

In reading the rule , it is not clear that the budget neutrality adjustment incorporates CMS revision to the labor share proportion. The budget neutrality adjustment for the area wage index and recalibration is a slightly positive number (greater than 1.0) while all of the other budget neutrality factors are negative. If the labor share adjustment as proposed were implemented, payments would decrease as a result because the higher AWI areas would receive lower payments. Because the majority of discharges and payments are paid at AWIs above 1.0 one would expect that a shift to paying these discharges at 1.0 would reduce total payments. Due to these lower payments the system would lose aggregate dollars it there is no budget neutrality adjustment for this purpose. Thus a relative high budget neutrality factor (higher than presented in the rule) would apply.

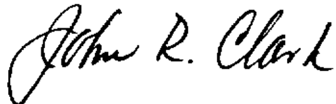
It appears that CMS used the same base rates from FY 2005 then changed the labor non-labor share proportion. If there was no explicit adjustment to account for the fact that the labor share reduction reduced Medicare expenditures, because the AWI is applied to a lower portion, then there is a savings to the trust fund in the absence of a budget neutrality adjustment.

CMS should include an appropriate budget neutrality factor or at a minimum acknowledge that it has not accounted for this change in the standardized amounts. In the absence of increasing rates for this anticipated decrease in payments, there is support for not implementing the new labor share proportions to the standardized amounts.

CMS needs to consider the impact of the proposed change in the labor share proportion (given

the protections provided to rural hospitals through the 62.0% requirement) on urban providers. This is actually hidden somewhat in the rules impact analysis. Essentially, urban hospitals lose about 1.0 percentage point as a result of CMS proposed changes. While CMS acknowledges this it does not discuss nor analyze whether this is tolerable by urban providers and what effects may be caused by its implementation. These are all reasons why CMS should not implement the proposed labor share change.

Regards,



John R. Clark
Vice President, Finance, CFO

Comparison of Labor Share
Proportions
1992-1997-2002

	FY 1992	FY 1997	92 v. 97	FY 2002	97 v. 02	92 v. 02
Wages and Salaries	50.244	50.686	% .442	48.171	& 2.515	& 2.073
Fringe Benefits	11.146	10.970	& .176	11.822	% .852	% 0.676
Non Medicaid Professional	2.127	5.401	% .3.274	5.510	% .109	% 3.383
Postal Service	0.272	---	& .272	---	---	& .272
Other Labor Intensive	7.277	5.438	& 1.839	4.228	& 1.21	& 3.049
Total Labor	71.066	72.495	% 1.429	69.731	& 2.764	& 1.335
Non-labor	28.934	27.505	& 1.429	30.269	% 2.764	% 1.335
Total	100.000	100.000	-0-	100.000	-0-	-0-

Member Baptist Healthcare System

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MEDICAL CENTER

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MILLER
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HARTSTEIN

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BY:

Trillium Way
Corbin, KY 40701

606-528-1212

June 22, 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 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 hospitals' 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.

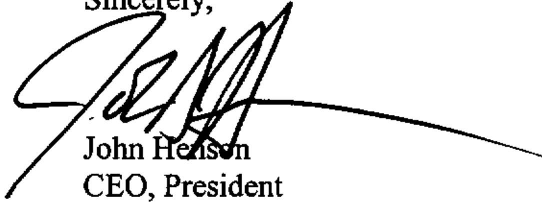
The hospitals received a letter dated October 15, 2004 from James Hart, Deputy Director of the Division of Acute Care for CMS, stating that CMS had reviewed this wage data matter and that it agreed that it was necessary to correct the hospitals' wage data. The letter also states,"[t]he corrected wage 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 criterion proposed by CMS at page 23384. As a practical matter, we believe that CMS had determined prior to October 1, 2004 that the wage data for provider nos. 18-0010 and 18-0043 should be corrected, but did not issue its letter stating so until October 15, 2004. Note that prior to October 1, 2004 there were numerous conversations between CMS, PricewaterhouseCoopers (which was acting as the representative for the St. Joseph Hospitals on this matter) and the St. Joseph Hospitals. In these conversations, CMS verbally agreed that the fiscal intermediary had incorrectly tabulated the wage index data for the St. Joseph Hospitals' wage index data and the correction should be effective October 1, 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,



John Henson
CEO, President

cc: Scott Raab, Office of Senator Mitch McConnell

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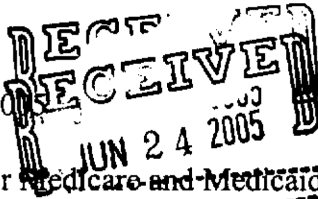

June 22, 2005

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:

This is to follow up on our previous comments regarding wage data corrections and the proposed policy to allow retroactive changes to the fiscal year 2005 wage index. Those comments requested that the Centers for Medicare and Medicaid Services ("CMS") amend the proposed policy to delete the requirement that CMS must have agreed before October 1, 2004 that it made an error in tabulating the data for the fiscal year 2005 wage index. We noted in our letter that CMS had issued a letter dated October 15, 2004 to St. Joseph Hospital (provider no. 18-0010) and St. Joseph Hospital East (provider no. 18-0143) acknowledging an error in tabulating the hospitals' fiscal year 2005 wage data, but that, as a practical matter, we believe that CMS had determined prior to October 1, 2004 that the wage data for the hospitals should be corrected.

We would like to add to our comments the fact that, prior to October 1, 2004, there were numerous conversations between CMS, Pricewaterhouse Coopers (which was acting as the representative for the St. Joseph Hospitals on this matter) and the St. Joseph Hospitals. In these conversations, CMS verbally agreed that the fiscal intermediary had incorrectly tabulated the wage index data for the St. Joseph Hospitals and that the correction should be effective October 1, 2004.

Sincerely,

John Henson
CEO, President

Cc: Scott Raab, Office of Senator Mitch McConnell.

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June 21, 2005

TRANSFERS

The Honorable Mark B. 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

Re: Post-acute Care Transfers; Proposed Changes to the Hospital Inpatient Prospective Payment System and FY'06 Rates; Proposed Rule

Dear Administrator McClellan:

I appreciate this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) draft rule on the Medicare Hospital Inpatient Prospective Payment System, as published in the May 4, 2005 *Federal Register*. We are particularly concerned about CMS' reported request to expand the number of DRGs subject to the post-acute transfer policy from the current 30 to 223.

The current Medicare transfer payment policy requires that cases assigned to one of 30 DRGs be paid as *transfers* when patients are discharged to psychiatric or rehabilitation hospitals or units, children's, long-term care, or cancer hospitals, and skilled nursing facilities or home health agencies. Under this policy, payment is *per diem.*

I strongly oppose expanding the transfer policy to encompass additional classes of patient cases. We believe this would fundamentally weaken the incentives inherent in the inpatient PPS. A new transfer policy covering 223 DRGs would effectively uproot an incentive-based system fueled by per-case control, to one inordinately focused on per diem costs.

Again, we are opposed to any expansion of the inpatient transfer policy, and believe that such a move would most assuredly not be in the best interests of patients or providers. The proposed policy would undermine clinical decision-making and penalize hospitals for providing patients with the most appropriate care in the most appropriate settings.

Thank you for this opportunity to comment on the proposed inpatient PPS rule.

Sincerely,

Thomas J. Barry

The Reverend Thomas J. Barry

BARNES & THORNBURG

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June 24, 2005

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

RE: Geographic Reclassification (CMS-1500-P)

Dear Sir or Madam:

These comments address the May 4, 2005 proposed rule regarding "Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates." 70 Fed. Reg. 23306 ("Proposed Rule"). These comments are submitted on behalf of Ball Memorial Hospital of Muncie, Indiana (Delaware County, IN 15-0089).

With respect to Geographic Reclassification, in Section III.H of the Proposed Rule, CMS did not specifically invite comments about the "special circumstances of hospitals in single-hospital MSAs and whether their special circumstances should be addressed by revisions to the regulations governing reclassification, or other measures" as it did in last year's proposed rule. 69 Fed. Reg. at 28290-28291. However, during a meeting between my partner, Robert T. Grand, and CMS Administrator McClellan on this subject in early May 2005 to discuss the single-hospital MSA issue on behalf of Ball Memorial, Dr. McClellan suggested that we submit comments on this issue in response to the Proposed Rule.

Ball Memorial Hospital is the only hospital in the Muncie, IN MSA. CMS believes that a single-hospital MSA ("S-H MSA") is problematic because it "reduces the averaging effect of the wage index, lessening some of the efficiency incentive inherent in a system based on the average hourly wages for a large number of hospitals. In labor market areas with a single hospital, high wage costs are passed directly into the wage index with no counterbalancing averaging with lower wages paid at nearby competing hospitals. . . . it creates an arguably inequitable system when so many hospitals have wage indexes based solely on their own wages, while other hospitals' wage indexes are based on an average hourly wage across many hospitals." *Id.*

CMS acknowledges that, due to the 108% test, the only way that hospitals in S-H MSAs can currently qualify for reclassification, even if they meet the relevant distance criteria, is to obtain exemption from the wage threshold requirements based on rural referral center status. 69 Fed. Reg. at 28290. However, the only S-H MSAs that have been able to qualify for reclassification to other urban areas under this exemption are those composed of urban counties that were formerly classified as part of rural areas. Most of the current S-H MSAs (and likely most of the newly proposed S-H MSAs) are composed of counties that have not ever been classified as rural. Ball Memorial Hospital has never been classified as rural.

CMS further acknowledges that S-H MSAs are disadvantaged financially in raising wages to levels of nearby MSAs due to the three year lag in the data used to compute the wage index. *Id.* CMS states that this disadvantage "may only be temporary" because, if hospitals in S-H MSAs were to raise their average hourly wage ("AHW") to the same AHW as the urban MSAs with which they compete, the S-H MSAs could increase their wage indexes to the same level as the wage index of competing MSAs in three years time. *Id.* Even if the delay is characterized as "temporary" - it is nevertheless very significant. Because labor supply shortages tend to fuel wage inflation, the AHWs of competing MSAs have historically also increased from year to year and will likely continue to do so for the foreseeable future. Unless the labor shortage becomes a surplus or the AHW of a competing MSA providentially remains frozen during at least one three year period in the future, this "temporary" disadvantage will continue to be perpetuated permanently.

CMS' observations in the preamble to the FY 2005 IPPS proposed rule are helpful in that they suggest ways to address the S-H MSA issue. It is clear that CMS believes that S-H MSAs are inconsistent with the use of average wages in all other labor areas to determine wage indexes. Therefore, CMS could exercise its discretion to merge every S-H MSA into the closest MSA for wage index purposes to eliminate the problem entirely. This straightforward approach is consistent with CMS policy that the wage index is intended to act as an efficiency incentive but can only do so where a counterbalancing occurs based on the AHW of more than one hospital. This policy would also eliminate the inequity that CMS perceives currently exists regarding S-H MSA wage indexes. CMS is not bound by OMB's new MSA designations where they are not appropriate for funding purposes as CMS acknowledges by deciding not to use Micropolitan areas when determining wage indexes. 69 Fed. Reg. at 28249-51.

Second, based on the foregoing rationale, CMS could merge into the closest MSA only S-H MSAs whose hospitals satisfy the 84% test. This would reduce but not entirely eliminate S-H MSAs.

Third, CMS could exercise its discretion to allow hospitals in S-H MSAs to reclassify to the closest MSA if they satisfy all the rural referral center criteria except the rural location requirement. This would also reduce but not entirely eliminate S-H MSAs. For purposes of applying the current criteria for reclassification to another urban area, this solution would also create parity between S-H MSAs composed of counties that have not ever been classified as rural and S-H MSAs composed of counties that have been reclassified by OMB from rural to urban areas. Parity for all hospitals in S-H MSAs that are in effect "urban rural referral centers" is

consistent with CMS' proposal to use the same AHW threshold for all rural referral centers on the grounds that all rural referral centers play a significant role in treating Medicare beneficiaries from rural areas regardless whether they are located in urban or rural areas and should be treated the same. 69 Fed. Reg. at 28289.

Fourth, CMS could combine the second and third options with other options designed to result in the elimination of all or as many S-H MSAs as possible for the same policy reasons discussed above.

Ball Memorial has an additional issue that makes it different from hospitals in most, if not all, other S-H MSAs. The FY 2005 Inpatient PPS Final Rule adopted the use of Core Based Statistical Areas ("CBSAs") based on the 2000 Census for purposes of determining the wage index. The 1990 Census Metropolitan Statistical Areas ("MSAs") had previously been used to determine the wage index. A county was previously included in an MSA if 15 percent of its residents commuted to the central county of the MSA. However, a county is not included in a CBSA unless 25 percent of its residents commute to the central county of the CBSA. 69 Fed. Reg. at 28249.

This change caused a new Anderson, IN MSA to be spun off from the former Indianapolis, IN MSA into its own MSA (even though it is also in the new Indianapolis CSA). As a result, the Muncie, IN MSA is no longer adjacent to the Indianapolis, IN MSA for purposes of wage index reclassification. Segregation of Anderson, Indiana into its own MSA makes little sense given that the population of Madison County, Indiana, whose principal city is Anderson, increased by only 2,789 residents between the 1990 Census (130,699) and the 2000 Census (133,358).

Although the Anderson, IN MSA has been carved out from the 1990 Census Indianapolis, IN MSA, it is part of the 2000 Census Indianapolis-Anderson-Columbus, IN CSA. CMS has discretion to utilize this CSA in order to determine wage indexes and to apply geographic reclassification criteria. OMB Bulletin No. 04-03 indicates that OMB itself believes the CSA is more appropriate to use than the newly created MSAs:

> "Users making comparisons with areas defined under the 1990 standards should note that when the 2000 standards were applied, the result, in some cases, was to create several areas from an existing Metropolitan Statistical Area. The resulting reconfigured areas may also qualify under the 2000 standards to form a complementary Combined Statistical Area, while retaining their separate designations as Metropolitan or Micropolitan Statistical Areas. In these situations, *the Combined Statistical area may be the approximate geographic equivalent of the previous Metropolitan Statistical Area, and thus may be the more appropriate geographic unit for analytic and program purposes.*"

(emphasis added).

OMB cautions that the new 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.* These areas are not intended to serve as a general-purpose geographic framework for nonstatistical activities, and they may or may not be suitable for use in program funding formulas." (emphasis added). OMB Bulletin 04-03. CMS is not bound by OMB's new CBSA designations where they are not appropriate for funding purposes as CMS has already acknowledged when it decided not to use Micropolitan areas to determine wage indexes. 69 Fed. Reg. at 28249-51.

OMB's standards for the 1990 Census generally reflected continuity with those adopted for the 1980 Census, and they maintained the basic concepts originally developed in the 1950 Census. However, the increase in the commuting standard from 15% to 25% in the 2000 Census represents a significant modification of the standards employed during the 1990 Census that causes dramatic changes in wage indexes by creating new MSAs between currently contiguous MSAs.

CMS should do as OMB suggests and utilize the Indianapolis-Anderson-Columbus, IN CSA for wage index purposes. CMS can accomplish this either by utilizing CSAs in every case or by utilizing CSAs only in cases where new MSAs have been created that are part of a CSA. Another option would be to "grandfather" any urban county previously designated a part of a 1990 Census MSA into the corresponding 2000 Census CBSA if the urban county is part of the same CSA.

Another measure that would address the problem created by the Anderson, IN MSA, would be to allow reclassification of S-H MSAs to nearby but not contiguous MSAs based on a showing of unique ties to that MSA. The ties between the Muncie, IN MSA and the Indianapolis, IN MSA are unique.

Since 1974, the Indiana University School of Medicine in Indianapolis and Ball State University in Muncie have jointly operated the Muncie Regional Campus of the School of Medicine located at Ball Memorial Hospital which offers first and second year undergraduate medical education programs. Medical students from Muncie thereafter complete their third and fourth years of medical school at the Indianapolis campus. The Muncie Regional Campus also offers a third year rotation in Ambulatory Care, a fourth year sub-internship in Internal Medicine, several fourth year electives for medical students, and 4 residency programs.

Attracting physicians to practice in rural areas is difficult particularly since most medical schools and residency programs are located exclusively in large urban areas. Physicians trained in rural areas are more likely to practice in rural areas. 75% of Ball Memorial Hospital's primary care physicians are graduates of its undergraduate and residency programs. Many other physicians who began their education at the Muncie Regional Campus or who participated in a residency or fellowship program at Ball Memorial Hospital are practicing in other rural areas both in Indiana and elsewhere.