476

Submitter : Mr. Craig Lewis **Date:** 06/24/2005

Organization : Valley Health System/Winchester Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-756-Attach-1.DOC

Transfers
Impact

Hefter
Wartstein
Walz
Hart
Kraemer

Attachment to #756

June 23, 2005

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

RE: Post-acute Care Transfers: Proposed Changes to the hospital inpatient prospective payment systems and FY'06 rates: proposed rule

Dear Administrator McClellan:

On behalf of Valley Health System/ Winchester Medical Center, I would like to comment on the CMS proposed rule for the Medicare Inpatient Prospective Payment System, as published in the May 4, 2005 *Federal Register*. Our hospital and health system are particularly concerned about CMS' reported proposal to expand the number of DRG's subject to the post-acute transfer policy from the current 29 to 230 DRG's.

Since its inception, the transfer rule was founded on a poor premise – that less care takes place for the individual patient when a discharge occurs to rehab, home health, skilled nursing facilities or psych units. **The reality is that acute care hospitals provide all the care that the patient needs in the acute care environment and then appropriately transfers them to the next setting (rehab, home health, skilled nursing) when the patient no longer requires acute care.** Acute care hospitals do not stop providing needed services because a patient is discharged to one of these settings, therefore there is NO significant decrease in costs to the acute care hospital because a patient goes to home health, skilled nursing or rehabilitation.

The current transfer rule affects 29 DRG's and results in a loss of $164,000 reimbursement each year for our hospital. The idea that this loss of reimbursement will be expanded to additional 230 DRG's is not acceptable. The impact of expanding the transfer rule to 230 DRG's would be significant for our hospital. In fiscal year 2004, we had over 25,000 patient discharges, of these 10,800 were Medicare beneficiaries. In reviewing the 230 DRG's that would be included in this proposed rule, over 7000 Medicare patients were discharged to a skilled facility, home health, or rehabilitation setting. Based on these numbers we calculate an expansion of the transfer policy will result is a loss of over $2,000,000 for our hospital alone per year.

Attachment to #756

Winchester Medical Center/ Valley Health System strongly oppose any expansion of the inpatient transfer policy. Isn't the PPS system designed to incentivize providers to move patients to a lower cost of care? It would seem that the expansion of the transfer rule will negate the incentive based system based on per case cost control (DRG Case) and move us to a per-diem method of payment for most Medicare beneficiaries. This proposed rule will undermine any incentives that have been established on the per-case method.

Any expansion of the transfer policy will NOT be in the best interests of patients or providers. The reality is that acute care hospitals provide all the care the patient needs prior to discharge from the acute setting. For many patients, providing additional care in the home, skilled nursing facility or rehab setting is much more cost effective for Medicare, so why do you want to penalize hospitals for moving patients to the most appropriate level of care?

I hope you will reconsider this proposed expansion of the transfer rule. It is in the best interest of patients and providers to keep our incentives on a per case basis and support acute care hospitals moving patients to the most appropriate care setting, instead of penalizing them for doing so. Our hospital cannot afford to sustain another $2,000,000 reduction in reimbursement from Medicare each year, when our hospital continues to provide care to the many uninsured Americans needing acute hospital care.

We are opposed to any expansion of the inpatient transfer policy. Thank you for the opportunity to comment on the proposed PPS rule.

Sincerely,

Craig Lewis
Senior Vice President & CFO

CL/bb

477
Hefter
Hartstein
Brooks
Fagan
Gruber
Kelly
Hue
Walz
Hart
Lefkowitz
Ruiz
Truong

DRG/GEN
Transfers
GME/AFF
GME/RH
IME

Submitter : Mr. Steven Hand **Date:** 06/24/2005

Organization : Memorial Hermann Healthcare System

Category : Hospital

Issue Areas/Comments

Issues

Issues

The Memorial Hermann Healthcare System (MHHS) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services? (CMS or the Agency) proposed rule entitled ?Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates.? 69 Fed. Reg. 28196 (May 18, 2004). Since MHHS founding in 1907, MHHS has grown to become the largest not-for-profit healthcare system in Texas and Houston?s fourth largest non-governmental employer. Our 16,000 employees, volunteers, and medical staff partners share a commitment to deliver the best possible Memorial Hermann experience to every patient, visitor and customer. Through an integrated system of acute, long term, behavioral health, and wellness facilities, Memorial Hermann offers the convenience of health care in suburban neighborhoods as well as easy access to the resources and technology of our university-affiliated teaching hospital in the Texas Medical Center.

Our letters comments on the proposed changes to the regulations for (1) proposed changes to the DRG transfer rule (2) Medicare direct graduate medical education (DGME), (3) indirect medical education (IME) payments for formerly exempt Hospital and Units, and (4) DRG reclassification for cases involving ECMO. .

DRG Reclassifications

(4) DRG CLASSIFICAITON FOR CASES INVOLVING EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)

We agree with this CMS analysis of the average charge associated with cases that involve Extracorporeal Membrane Oxygenation (ECMO) and support the proposal to assign the cases DRG 541. It is used for severely ill patients; often these patient children. We appreciate CMS? recognition that often other insurers use Medicare DRG classifications and payment rates. Consequently, its efforts to ensure accurate DRG classifications for all cases, even those that are predominantly non-Medicare, help to ensure that hospitals are paid appropriately.

CMS-1500-P-757-Attach-1.DOC

Attachment to #757

June 24, 2005

VIA Electronic Submission
HTTP://www.cms.hhs.gov/regulations/ecomments

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 443-G
200 Independence Avenue, SW
Washington, DC 20201

Attention: CMS-1500-P

The Memorial Hermann Healthcare System (MHHS) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates." 69 Fed. Reg. 28196 (May 18, 2004). Since MHHS founding in 1907, MHHS has grown to become the largest not-for-profit healthcare system in Texas and Houston's fourth largest non-governmental employer. Our 16,000 employees, volunteers, and medical staff partners share a commitment to deliver the best possible Memorial Hermann experience to every patient, visitor and customer. Through an integrated system of acute, long term, behavioral health, and wellness facilities, Memorial Hermann offers the convenience of health care in suburban neighborhoods as well as easy access to the resources and technology of our university-affiliated teaching hospital in the Texas Medical Center.

Our letters comments on the proposed changes to the regulations for (1) proposed changes to the DRG transfer rule (2) Medicare direct graduate medical education (DGME), (3) indirect medical education (IME) payments for formerly exempt Hospital and Units, and (4) DRG reclassification for cases involving ECMO. .

Attachment to #757

(1) POST-ACUTE CARE TRANSFER PAYMENT POLICY

Medical patients who are sent from one acute care hospital to another are viewed as "transfers." The transferring hospital is paid a per diem rate based on the DRG payment and the number of days spent at the transferring hospital; the receiving hospital receives the full DRG payment.

In FFY 1999, in accordance with the BBA, CMS expanded its transfer policy such that hospitals that discharge patients associated with one of 10 specified DRGS to a post-acute care (PAC) facility – such as rehabilitation hospitals and units, psychiatric hospitals and units, cancer, long-term care and children's hospitals, skilled nursing facilities, or are discharged home and receive home health services within three days after the date of discharge – would receive payments under the "post-acute care (PAC) transfer" policy. In subsequent years, CMS further expanded the post-acute care transfer policy, and as a result, a total of 30 Dregs were subject to the PAC transfer policy in FFY 2005.

CMS is proposing to expand again—again—the post acute care transfer policy, from 30 to 223 Dregs. Dregs that meet the following criteria would be subject to the PAC policy:

- The DRG has at least 2,000 discharges to post-acute care;
- It has at least 20 percent of cases in the DRG were discharged to post-acute care;
- Out of the cases, discharged to post-acute care, at least 10% percent occur before the geometric mean length of stay for the DRG;
- The DRG has a geometric mean length of stay of at least 3 days; and
- If the DRG is one of a paired set of Dregs based on the presence or absence of a comorbidity or complication, both paired DRGs are included if either one meets the first three criteria above.

Accordingly to CMS, this proposed expansion would result in $880 million less in Medicare program payments to hospitals, the equivalent of a 1.1 percent decrease in payments, although our analyses show a reduction of $894 million when the effects of IME, disproportionate share, capital and outlier payments are considered.

Simply put, CMS should not implement an expansion of the post-acute care transfer policy. Such a policy penalizes hospitals that ensure that Medicare patients receive care in the most appropriate setting. Moreover, it undercuts the fundamental principle of the PPS, which is that some cases will cost more than the DRG payment, while others will +cost less, but on average, the overall payments should be adequate. It also is important to recognize that to the extent there still are cost reductions associated with discharging patients to post-acute care facilities (a debatable presumption given the current low average lengths of stay), such reductions will be reflected in lower DRG case weights during the DRG recalibration process.

We also agree with comments by the American Hospital Association that this proposal does not comport with the statutory directive that CMS focus on those DRGs that have a high volume of discharges to post-acute care and a disproportionate use of post-discharge

services (emphasis added). (SSA section 1886(d) (40(J)(ii). Moreover, contrary to CMS's assertion that the PAC transfer policy levels the playing field for rural hospitals that do not have access to post acute care that is comparable to urban hospitals, AHA analyses show that rural patients have essentially the same access. Consequently, the proposed rule would harm all hospitals. We urge the Agency to rescind this proposal.

(2) DGME AS IT RELATE TO NEW AND EXPANDING PROGRAMS

Under the current regulations, existing teaching hospitals that meet specified criteria may enter into Medicare GME affiliation agreements by which they combine their respective resident caps and then redistribute them according to their agreement – with the provision that the sum of the new caps cannot exceed the aggregate combined cap. Currently, 42 C.F. R. section 413.79 (e) (10 (iv) specifies that new teaching hospitals that are located in urban areas cannot be part of Medicare GME affiliation groups. New Rural teaching hospitals may enter into these agreements but only if the rural hospital provides training for at least one-third of the FTE residents in all of the joint programs of the affiliated hospitals.

CMS states that it rationale for the new teaching hospital provision is to prevent "gaming" by current teaching hospitals that might encourage nonteaching hospitals to become teaching hospitals, receive a resident cap, and then enter into a GME affiliation agreement in which they would transfer many of their cap slots to the existing teaching hospital. A more flexible standard is provided for new rural teaching hospitals because rural hospitals may not have sufficient patient volumes to support residency training programs.

The proposed rule would allow new urban teaching hospitals to enter into GME affiliation groups but only if there is a "positive adjustment" to the direct GME and or IMP cap: that is, the new teaching hospital's revised cap pursuant to the affiliated agreement must be higher that its base year cap.

While we favor this proposal, we continue to believe the overall policy is unnecessary. Hospitals do not decide to become teaching institutions and go through the rigorous process of accreditation with the thought of "gaming" the system. CMS has provided no evidence of that this type of gaming has ever occurred.

(3) IME RESIDENT CAPS FOR FORMERLY INPATIENT PPS-EXCLUDED HOSPTIALS AND UNITS

PPS-excluded rehabilitation and psychiatric hospital and PPS-excluded distinct-part units of acute care hospitals do not receive IME payments under the current inpatient acute system of payments. Consequently, they do not have an IME resident cap. However,

these hospitals and units receive Direct Graduate Medical Education (DGME) payments and thus have a DGME resident cap.

We acknowledge CMS' position that PPS-excluded teaching hospitals that become subject to the acute inpatient PPS must also be subject to an IME resident cap, like other inpatient PPS teaching hospitals.

CMS proposes that for PPS-excluded hospitals that subsequently become subject to the inpatient PPS, the IME cap that will be established for theme will equal the resident count that was used to establish their DGME cap. If CMS ultimately chooses this option, we believe it also should be the method for determining the IME cap for units.

(4) DRG CLASSIFICAITON FOR CASES INVOLVING EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)

We agree with this CMS analysis of the average charge associated with cases that involve Extracorporeal Membrane Oxygenation (ECMO) and support the proposal to assign the cases DRG 541. It is used for severely ill patients; often these patient children. We appreciate CMS' recognition that often other insurers use Medicare DRG classifications and payment rates. Consequently, its efforts to ensure accurate DRG classifications for all cases, even those that are predominantly non-Medicare, help to ensure that hospitals are paid appropriately.

CONCLUSION

Thank you for this opportunity to present our views. If you have questions concerning these comments, I have included my contact information below.

Sincerely,

Steven W. Hand
AVP of Government Reporting-Operations
Memorial Hermann Healthcare System
9401 Southwest Freeway, Suite 337, 77074
Phone (713) 448-4191
Fax (713) 448-4158
Email steven_hand@mhhs.org

478

Submitter : Mr. Paul Rowland

Organization : Nassau Suffolk Hospital Council

Category : Health Care Provider/Association

Date: 06/24/2005

Issue Areas/Comments

GENERAL

GENERAL

Please see the attached Nassau Suffolk Hospital Council comments.

CMS-1500-P-758-Attach-1.DOC

MB|H
TRANSfers
Geo Reclas

Hefter
Hartstein
Seifert
Knight
Treitel
Walz
Hart
Kenly
Jones

Attachment to #758

Nassau – Suffolk Hospital Council

Representing the not-for-profit and public hospitals serving the residents of Long Island
1383 Veterans Memorial Highway, Ste. 26, Hauppauge, NY 11788
Phone (631) 435-3000 • Fax (631) 435-2343 • Fax (631) 435-3540

June 24, 2005

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1500-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-1500-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Proposed Rule.

Dear Dr. McClellan:

The Nassau Suffolk Hospital Council (NSHC), on behalf its 23 hospitals, nursing homes, and home health agencies welcomes the opportunity to comment on the proposed rule related to the Medicare Prospective Payment System (PPS) for inpatient admissions.

HOSPITAL MARKET BASKET

The hospital update is based on a "market basket" factor that is intended to reflect the average change in the price of goods and services hospitals purchase to furnish inpatient care. These price changes must be projected forward to estimate increases for the subsequent year so that an appropriate market basket update can be determined in advance of payment. The payment system is prospective, and the update is not retroactively reconciled to reflect actual price increases for the year. Therefore, a reliable projection methodology is vital to ensure equitable payments.

In recent years the projection has consistently been lower than the actual increase. The actual increase in FY 2003 was 3.9% while the projected increase was 3.5%. In FY 2004 the actual was 3.8% compared to a 3.4% projection. CMS reports that, based on the most recent data, the FY 2005 market basket increase is now estimated to be 4.1% compared to the projected 3.3% increase that was used to determine the update factor. We are concerned that the methods used to project the market basket increase are flawed and fail to provide a reliable estimate of hospital cost increases. Given a 4.1% cost increase for FY 2005, a projected FY 2006 increase of 3.2% does not seem reasonable. We request that CMS review the methodology that was used to determine the projected FY 2005 market basket and make details of the calculation available to the public.

LABOR-RELATED SHARE

CMS proposes a revised calculation of the labor-related share of the PPS rate. This would result in a decrease in the labor-related share from 71.066% to 69.731%. NSHC opposes the proposed revision.

In the inpatient PPS rule for FFY 2003, CMS examined the methodology used to determine the labor-related share. The CMS calculation of the labor-related share for FFY 2003 resulted in an increase from 71.066% to 72.495%. However, CMS did not implement the increase pending further research to determine whether a different methodology for determining the labor-related share should be adopted. In the FFY 2006 proposed rule, CMS discusses continuing research on alternative methodologies for calculating the labor-related share. However, CMS states that the analysis has not yet produced sound enough evidence to propose a change and that they will continue to study the issue. We believe that it is inequitable to decline to implement a labor-share increase in FFY 2003 pending an analysis of the methodology and then propose a labor-share decrease in FFY 2006 while that analysis is still incomplete.

In addition to updating the data, CMS proposes to eliminate postage costs from the labor-related share because they no longer believe that these costs meet the definition of labor-related. CMS does not provide any evidence or analysis to support this belief. NSHC opposes the elimination of postage from the labor-related costs. CMS should not select a single cost category and make a decision in isolation. Instead, any proposed revision should be based on a comprehensive analysis of all cost categories to determine those costs that vary with local market conditions. The analysis should not focus only on the costs that are currently considered to be labor-related. It should also look at costs that are not currently included in the labor-related share to determine if any of these are influenced by the local market area. For example, professional liability insurance is not currently included as a labor-related cost. However, there is evidence that these costs are wage-related and locally determined.

CMS should maintain the related share at 71.066% pending completion of a comprehensive analysis of the calculation.

POST-ACUTE CARE TRANSFERS

CMS proposes to expand the post-acute care transfer policy from 30 DRGs to 231 DRGs. NSHC opposes this proposal.

The law gives CMS authority to expand the number of DRGs for FFY 2001 and subsequent years. However, the law specifies that DRGs be selected based upon a high volume of discharges to post-acute care and a disproportionate use of post discharge services. The proposed criteria fail to carry out this requirement. The proposed expansion of the policy to cover 231 DRGs goes far beyond those DRGs with a disproportionate use of post-discharge services.

In the proposed rule, CMS says "[The purpose of the IPPS transfer payment policy is to avoid providing an incentive for a hospital to transfer patients to another hospital early in the patients' stay in order to minimize costs while still receiving the full DRG payment." The

proposal results in expansion of the policy to many DRGs where there is no evidence that hospitals are changing behavior to take advantage of the payment system.

In this proposal, CMS makes substantial revisions to the DRG selection criteria with little justification or evidence. The revised criteria do not address specific changes in hospital behavior that might indicate an attempt to take advantage of the payment system. Moreover, they would not result in more equitable payments. For all practical purposes, such an extensive expansion of the post-acute transfer policy acts as an across-the-board reduction in Medicare payments. As a result, hospitals would be penalized for providing efficient care in the setting that is most appropriate for the patient.

NSHC opposes the expansion of the post-acute care transfer policy, which is not in the best interests of patients or caregivers. It undercuts the basic principles and objectives of the Medicare PPS and undermines clinical decision-making and penalizes hospitals for providing efficient care, at the most appropriate time and in the most appropriate setting.

GEOGRAPHIC RECLASSIFICATIONS – GROUP APPEALS

NSHC, along with AHA and HANYS, is recommending a change in policy regarding group reclassifications that are affected by the timing of Section 508 of the MMA. In several instances, hospital groups will be prevented from reclassifying for 2007 because there is a Section 508 hospital in the county that cannot join the group without foregoing its more beneficial Section 508 reclassification. We do not believe that Congress intended for the Section 508 hospitals to prevent group reclassifications. We urge CMS to allow Section 508 hospitals to commit to a group reclassification and be considered as a member of the group for the determination of the reclassification request, but allow them to retain their Section 508 reclassification and accept the group reclassification after the Section 508 funding expires.

Please contact me at (631) 435-3000 or prowland@nshc.org if you have any questions.

Sincerely,

Paul J. Rowland
VP/COO

479

Submitter : Dr. Nelson Oyesiku

Date: 06/24/2005

Organization : Congress of Neurological Surgeons

Category : Health Care Professional or Association

DRG / GEN

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-759-Attach-1.DOC

Heffer
Hartstein
Brooks
Fagan
Gruber
Kelly
Hue

Congress of Neurological Surgeons

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Attachment to #759

June 24, 2005

Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8011
Baltimore, MD 21244-1850

Attention: CMS-1500-P

Dear Dr. McClellan:

On behalf of the Congress of Neurological Surgeons, representing over 3,000 neurosurgeons in the United States, I am writing to add formal support to the Brain Attack Coalition's request that CMS consider changes to the Medicare hospital in-patient reimbursement for the advanced treatment of stroke in Fiscal Year 2006. The mission of the Congress of Neurological Surgeons (CNS) is to serve and educate our colleagues and advocate for issues important not only to neurosurgeons, but also to our patients and the population at large. One healthcare issue in which the CNS is involved is stroke. Neurosurgeons are intimately involved in the care of patients who suffer both hemorrhagic and ischemic stroke. In fact, more and more neurosurgeons are participating on the front line of thrombolytic therapy as endovascular technologies are embraced by our specialty

As a member of the Brain Attack Coalition, the CNS has also been very instrumental in some of the recent guidelines published for both primary and, soon, comprehensive stroke centers. These initiatives will help to address the very serious problem that stroke poses to the community at large.

As is well known to the CMS, stroke represents a serious public health issue today. The amount of productivity lost in addition to lives lost is staggering. Several studies have indicated however that with the identification of stroke symptomatology early, thrombolytic therapy along with other acute stroke interventions can often result in a significantly improved outcome. This improved outcome pays dividends not only to the individual patient but to the health care system at large as lost productivity, long term rehabilitation, and hospice care may be avoided.

Unfortunately, the reimbursement schedule for the treatment of stroke with aggressive thrombolytic therapies has lagged behind the actual cost of these treatments. Paradoxically, this has resulted in a disincentive for the utilization for these potentially life-saving resources. In fact, currently, hospitals that administer

proven reperfusion therapies incur higher cost than those who do not provide such therapies, while reimbursement remains the same

In conclusion, the Congress of Neurological Surgeon's strongly recommends that the CMS considers changes in the reimbursement schedule for acute stroke therapy. Specifically, we support the creation of a new DRG for acute stroke patients treated with reperfusion therapy as outlined by the Brain Attack Coalition's recommendations.

We thank the CMS for their work on behalf of Medicare beneficiaries and also for the special attention that they have given to the needs of all stroke patients.

Please do not hesitate to contact us if we can be of any further assistance.

Sincerely,

Nelson M. Oyesiku, MD
President

Washington Office Contact:
Katie O. Orrico, Director
CNS Washington Office
725 15th Street, NW
Suite 800
Washington, DC 20005
Office: 202-628-2072
Fax: 202-628-5264
Email: korrico@neurosurgery.org

480 BODDEN HAMMEL HEFTER HARTSTEIN

Submitter : Ms. Bonnie Jones **Date:** 06/24/2005

Organization : Saint Vincent Health Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Q DATA

CMS-1500-P-779-Attach-1.DOC

Attachment to #779

Saint Vincent Health Center
232 West 25th St
Erie, Pa 16544

June 22, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500p

RE: Comments on FY'06 Medicare Inpatient Prospective Payment System (PPS) Proposed Rule Section V. B. Reporting of Hospital Quality Data for Annual Hospital Payment Update

Saint Vincent Health Center appreciates the opportunity to submit comments concerning the reporting of hospital quality data for the annual hospital payment update. Although the reporting of hospital quality data may be important, the process of maintaining specification and validation revisions is challenging. It is understandable that deadlines must be set, reporting rules must be made, and adjustments are sometimes needed but if the data being submitted isn't accurate it has little value. The data submission process leaves many opportunities for error and unless more provisions are made to allow for data submission and process imperfections the results are data inaccuracies and hospital misrepresentations. Ultimately, the goal is to see quality of care or improvement in quality of care. Although reasonable data submission quality should be expected, imperfections in data submission and the process shouldn't always be penalized. The proposed rule should clearly address the following items:

- QNET should have the ability for vendors to "test" data submission changes
- hospitals shouldn't be penalized for submission delays caused by their vendor or the QIO
- hospitals shouldn't be penalized for submission errors caused by their vendor
- hospitals should have the ability to appeal any submission errors caused by vendor submission errors or caused by incomplete/inaccurate specifications
- only those variables related to the 10 quality measures should be used in the CDAC re-abstraction quality audit
- hospitals should have the ability to appeal any audit issues, regardless of reliability rate
- hospitals should have at least 30 days to appeal submission errors discovered by the CDAC re-abstraction
- hospitals should have the option of not publishing, without penalty, results that they feel is a misrepresentation of their data.

In addition to the suggestions above, also consider the suggestions on the following pages that were made by our data submission vender.

Thank You,

Bonnie Jones
Database Analyst
Saint Vincent Health Center

Attachment to #779

PREMIER

Comments on data provisions of FY'06 Medicare Inpatient Prospective Payment System (PPS) Proposed Rule

The ability of hospitals and their vendors to comply with the requirements for timely and accurate data submission has been challenged by miscommunication over data edits, technical ambiguities, and other issues. Therefore, Premier believes that the final rule governing the FY'06 Inpatient PPS should establish a clear documentation and communications process for this purpose. Additionally, Premier believes that hospitals should not be penalized when technical issues specific to the Centers for Medicare and Medicaid Services (CMS) or Quality Improvement Organizations (QIOs) hinder their ability to meet specific data requirements.

Data Submission

- The parameters of the data submission process should be stated explicitly and documented. This includes exact specifications, all edits or audits to be applied, and other related information. Hospitals and their submission agents (vendors) must be privy to such parameters to ensure timely data submission. In addition, CMS should communicate any changes to submission file requirements no less than 120 days prior to the effective/implementation date. No changes should be permitted once a submission quarter has begun, as this puts the integrity of the process at risk.

- For greater reporting accuracy, Premier believes that a test process for validating data file submissions and measuring calculations should be established. Hospitals and submission agents should be provided with a test file in the appropriate file specification format for internal verification *prior* to testing a submission. The process should permit submission of test file(s) to verify file formats, accuracy of data calculations, and other audit criteria related to data submission. An appropriate test process should be permitted each time changes in data submission or measure specifications are prescribed.

- In the proposed rule, there is no mention of a minimum sample size for hospitals that elect to sample. Alternately, if hospitals that do *not* sample elect to submit all of their qualifying cases for a given study (i.e., 425 pneumonia cases for a given quarter) and three get "rejected," will they still meet the data requirements—or, must such hospitals correct the case errors so that *every* one gets into the warehouse? Under our reading of the proposed rule, it appears that they do not—so long as such hospitals have met the minimum number of cases required by the "aligned" JCAHO/CMS sampling requirements, however they are established.

Data Validation

- The parameters of the validation process should be stated explicitly and documented. This includes clear definitions, all applicable skip logic, all edits or audits to be applied, and other related information. Hospitals must know exactly *what* is being validated so they may adhere to the specifications during the data collection process. Under the current process, by the time hospitals receive feedback on one quarter's validation, they have already moved onto the next quarter's data collection and can not make changes quickly enough to impact the next quarter. If the validation specs and requirements were clear and well- documented, hospitals could be proactive. Any changes must be communicated clearly and within a timeframe sufficient for hospitals to react and changes their attendant processes. Premier proposes that any modifications to the technical processes be published 120 days prior to the effective/implementation date.

- Premier believes that the validation process should incorporate *only* data associated with the ten specified measures. Under the current system, a hospital that submits multiple data sets may earn an *overall* quality score of 80 percent; however, if errors occur more frequently in the subset required for the annual payment update, the quality of such data may be considerably *lower*. In this way, payments risk being based on inconsistent calculations and inaccurate data.

- Further, Premier believes that hospitals should be notified of any validation rule changes at least 120 days prior to the hospital data abstraction period. The validation rules applied by CMS as of June 6, 2005 are, in fact, retroactive to the July—September 2004 data. CMS validated the three test LDL measures for the AMI clinical focus group. Consequently, hospitals are receiving mismatches for not collecting this optional data. The validation documentation for the July 1, 2004 discharges is dated April 29, 2005. Since the data was submitted at the end of January, hospitals have not had sufficient time to make the appropriate change.

- Under the proposed rule, CMS only allows ten days for a hospital to appeal its validation; however, the agency fails to specify whether the reference is to "business" or "calendar" days. Premier believes that *neither* case offers sufficient time for hospitals to respond. Therefore, we propose allowing hospitals 30 calendar days to appeal their validation findings.

- Many Premier hospitals report having received inconsistent communications relating to the "data reporting for annual updates" provision of the Medicare drug law (MMA). Premier believes that all communications and directives regarding this initiative should be centralized and disseminated to all stakeholders (hospitals, vendors, and QIOs) simultaneously. Such a strategy would simplify and standardize message generation. It would also eliminate the confusing and often contradictory communications typical of the current process, which requires state QIOs to interpret a given communication before forwarding it to hospitals.

481 WALZ HART HEFTER HARTSTEIN

Submitter : Mr. Craig Lewis **Date:** 06/24/2005

Organization : Winchester Medical Center/ Valley Health System

Category : Hospital

Issue Areas/Comments

TRANSFERS

GENERAL

GENERAL

The attached letter documents our opposition to CMS-1500-P with expansion of the transfer rule to 230 DRG's. See attachment

CMS-1500-P-775-Attach-1.DOC

CMS-1500-P-775-Attach-2.DOC

Attachment 1 to #775

June 23, 2005

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

RE: Post-acute Care Transfers: Proposed Changes to the hospital inpatient prospective payment systems and FY'06 rates: proposed rule.

Dear Administrator McClellan:

On behalf of Valley Health System/ Winchester Medical Center, I would like to comment on the CMS proposed rule for the Medicare Inpatient Prospective Payment System, as published in the May 4, 2005 *Federal Register.* Our hospital and health system are particularly concerned about CMS' reported proposal to expand the number of DRG's subject to the post-acute transfer policy from the current 29 to 230 DRG's.

Since its inception, the transfer rule was founded on a poor premise – that less care takes place for the individual patient when a discharge occurs to rehab, home health, skilled nursing facilities or psych units. **The reality is that acute care hospitals provide all the care that the patient needs in the acute care environment and then appropriately transfers them to the next setting (rehab, home health, skilled nursing) when the patient no longer requires acute care.** Acute care hospitals do not stop providing needed services because a patient is discharged to one of these settings, therefore there is NO significant decrease in costs to the acute care hospital because a patient goes to home health, skilled nursing or rehabilitation.

The current transfer rule affects 29 DRG's and results in a loss of $164,000 reimbursement each year for our hospital. The idea that this loss of reimbursement will be expanded to additional 230 DRG's is not acceptable. The impact of expanding the transfer rule to 230 DRG's would be significant for our hospital. In fiscal year 2004, we had over 25,000 patient discharges, of these 10,800 were Medicare beneficiaries. In reviewing the 230 DRG"s that would be included in this proposed rule, over 7000 Medicare patients were discharged to a skilled facility, home health, or rehabilitation setting. Based on these numbers we calculate an expansion of the transfer policy will result is a loss of over $2,000,000 for our hospital alone per year.

Attachment 1 to #775

Winchester Medical Center/ Valley Health System strongly oppose any expansion of the inpatient transfer policy. Isn't the PPS system designed to incentivize providers to move patients to a lower cost of care? It would seem that the expansion of the transfer rule will negate the incentive based system based on per case cost control (DRG Case) and move us to a per-diem method of payment for most Medicare beneficiaries. This proposed rule will undermine any incentives that have been established on the per-case method.

Any expansion of the transfer policy will NOT be in the best interests of patients or providers. The reality is that acute care hospitals provide all the care the patient needs prior to discharge from the acute setting. For many patients, providing additional care in the home, skilled nursing facility or rehab setting is much more cost effective for Medicare, so why do you want to penalize hospitals for moving patients to the most appropriate level of care?

I hope you will reconsider this proposed expansion of the transfer rule. It is in the best interest of patients and providers to keep our incentives on a per case basis and support acute care hospitals moving patients to the most appropriate care setting, instead of penalizing them for doing so. Our hospital can not afford to sustain another $2,000,000 reduction in reimbursement from Medicare each year, when our hospital continues to provide care to the many uninsured Americans needing acute hospital care.

We are opposed to any expansion of the inpatient transfer policy. Thank you for the opportunity to comment on the proposed PPS rule.

Sincerely,

J. Craig Lewis
Chief Financial Officer

Attachment 2 to #775

June 23, 2005

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

RE: Post-acute Care Transfers: Proposed Changes to the hospital inpatient prospective payment systems and FY'06 rates: proposed rule.

Dear Administrator McClellan:

On behalf of Valley Health System/ Winchester Medical Center, I would like to comment on the CMS proposed rule for the Medicare Inpatient Prospective Payment System, as published in the May 4, 2005 *Federal Register.* Our hospital and health system are particularly concerned about CMS' reported proposal to expand the number of DRG's subject to the post-acute transfer policy from the current 29 to 230 DRG's.

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Attachment 2 to #775

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Any expansion of the transfer policy will NOT be in the best interests of patients or providers. The reality is that acute care hospitals provide all the care the patient needs prior to discharge from the acute setting. For many patients, providing additional care in the home, skilled nursing facility or rehab setting is much more cost effective for Medicare, so why do you want to penalize hospitals for moving patients to the most appropriate level of care?

I hope you will reconsider this proposed expansion of the transfer rule. It is in the best interest of patients and providers to keep our incentives on a per case basis and support acute care hospitals moving patients to the most appropriate care setting, instead of penalizing them for doing so. Our hospital can not afford to sustain another $2,000,000 reduction in reimbursement from Medicare each year, when our hospital continues to provide care to the many uninsured Americans needing acute hospital care.

We are opposed to any expansion of the inpatient transfer policy. Thank you for the opportunity to comment on the proposed PPS rule.

Sincerely,

J. Craig Lewis
Chief Financial Officer

Log as Both
CMS-1500-P-770
and
CMS-1500-P 777

482 MILLER
HAMMEL
BODDEN
KENLY
KNIGHT
SEIFERT
TREITEL
HEFTER
HARTSTEIN

Submitter : Mr. Michael Racioppo **Date:** 06/24/2005
Organization : North General Hospital
Category : Hospital
Issue Areas/Comments

GENERAL

GENERAL
See Attachment

WI/Bd
Q DATA
CBSAs
WI/OM
MB/H
P/MT RTs/OUTLIER

Submitter : Mr. Michael Racioppo **Date:** 06/24/2005

Organization : North General Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-777-Attach-1.DOC

Attachment to #777

NORTH GENERAL HOSPITAL
Growing With Our Community, Caring For Your Health

June 24, 2005

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

Subject: Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Proposed Rule, *Federal Register* 70, no. 85 (May 4, 2005): 23306–23673. [CMS-1500-P]

Dear Dr. McClellan:

On behalf of North General Hospital, I appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule for the Federal fiscal year (FY) 2006 inpatient prospective payment system (PPS). North General Hospital ("NGH"), located in the Harlem area of New York City, is dependent on government program funding for eighty-five percent of its revenues. Thirty percent of its patients are beneficiaries of the Medicare program.

NGH is located in a medically underserved area, and it is the only community-based hospital serving this area. All other hospital facilities in the immediate area are government owned. Without the funding sources available to government owned hospitals, NGH, which is designated as a Financially Distressed hospital by the New York State Department of Health, has taken on the economic challenges facing a hospital in this community. The large majority of its patients are indigent. In 2004, NGH provided approximately $6.7 million in charity care.

Our principal recommendations this year are:

1. Wage index. We oppose CMS's decision to discontinue the blend of the MSA and CBSA wage indices for hospitals that were disadvantaged by the change to CBSAs, and recommend that the MGCRB designate the old New York City MSA as a core urban area within the new CBSA and reimburse providers in or reclassifying to the core urban area based on a wage index derived solely from the hospitals located in the old MSA

   We also urge CMS to implement 100% of the occupational mix adjustment.

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www.northgeneral.org

Affiliated with the Mount Sinai School of Medicine of the City University of New York

2. Labor share. We believe that CMS should not update the cost category weights in the hospital market basket unless it also designates professional liability insurance as a labor-related cost. Postal delivery should also be considered as a labor-related cost.

3. Outliers. We are very disturbed that CMS has not been able to estimate the cost outlier threshold to a reasonable degree of accuracy, noting that the Agency estimates it did not spend 31% of the outlier pool in FY 2004.

4. Hospital quality data. We believe that the current flaws in the data validation process are so fundamental that CMS should not tie the full payment update to that process in FY 2006.

More detailed comments about these issues are provided below.

Hospital Wage Index: Core-Based Statistical Areas

After the 2000 census, the Census Bureau and the Office of Management and Budget (OMB) changed the definition of many of the nation's metropolitan statistical areas (MSAs) and renamed them "core-based statistical areas" (CBSAs). Most MSA boundaries were not affected; however, some were tightened and others were expanded. CMS proposed to use the new CBSAs in place of the old MSAs as wage index labor markets starting in FY 2005, which would have generated gains for some hospitals and huge losses for other hospitals, including hospitals located in the old New York City MSA. We, along with many other disadvantaged facilities, opposed this proposal on policy and fiscal impact grounds and, in response, CMS agreed to compute area wage indices based upon a blend of the old and new labor market definitions for disadvantaged hospitals during FY 2005.

Since then, CMS has proposed to implement the new boundaries for its other prospective payment systems without a transition, and has proposed to end the blend in the inpatient PPS in FY 2006. This action would unjustly harm the minority of providers located in areas whose statistical boundaries were expanded. The U.S. Government Accountability Office and MedPAC have both criticized the indiscriminate use of MSAs (and CBSAs) as hospital labor markets because some are obviously too large to effectively discriminate between separate hospital labor markets.

Therefore, just as CMS has used the Medicare Geographic Classification Review Board (MGCRB) in the past to correct flaws in the hospital labor markets as defined by MSAs, we now urge CMS to 1) use the MGCRB to designate the old New York City MSA as a core urban area within the New York City CBSA, 2) base the wage index of the core urban area solely on the wage index data of hospitals located in that area, and 3) apply that wage index to all providers located in or reclassifying to the core urban area.

Hospital Wage Index: Occupational Mix Adjustment

CMS conducted its first occupational mix survey in a highly compressed time frame in early 2004 and did not have confidence in the validity of the results. For that reason, the agency implemented a 90%-10% blend of the unadjusted area wage index and the occupational mix-adjusted area wage index, respectively, in FY 2005. For the past year, hospitals have had the opportunity to correct any mistakes they may have made in their original submissions, so CMS should have greater confidence in the validity of the current occupational mix adjustments. Nonetheless, CMS has proposed to continue the blend in FY 2006 in the same proportion as the blend used in FY 2005. We do not believe that continuing the blend is appropriate and urge CMS to fully implement the occupational mix adjustments in FY 2006.

Hospital Market Basket

The sum of the labor-related hospital market basket cost category weights represents the portion of the standardized amount that is wage-adjusted. The current labor share is 71.1% and it is based on FY 1992 data. CMS would have updated the weights in FY 2003 based on FY 1997 data, but declined to do so because the update would have increased the labor share to 72.5%, which would have hurt rural and other low-wage hospitals. Now CMS is proposing to update the weights based on FY 2002 data, which would reduce the labor share to 69.7% and hurt high-wage urban hospitals. This change would not materially help rural and other low-wage hospitals because their labor share was fixed at 62% in the Medicare Modernization Act of 2003.

We can make a good case on behalf of relatively high-wage hospitals that CMS should not update the cost component weights in FY 2006 to make up for not updating the weights in FY 2003. However, we would support CMS updating the weights in FY 2006 *if* the Agency also designated professional liability insurance as a labor-related cost. These costs are clearly wage-related—indeed, they are reported in the wage index—and are clearly locally determined. We believe that the failure to include professional liability insurance in the wage-adjusted portion of the standardized amount in the past was a grave oversight. Including this important cost component in the labor share would bring it up to 71.3%, which is virtually the same as the current labor share of 71.1%.

We also believe that postal delivery costs should be considered in the labor share component given that there are regional adjustments to the base pay rates of U.S. Postal workers.

Outliers

CMS estimates that outlier payments in FY 2004 made up only 3.5% of total inpatient PPS payments, which is 31% less than the amount of funding that the hospitals contributed to the pool. We are compelled to express, once again, our concern about the Agency's inability to estimate the outlier threshold to a reasonable degree of accuracy.

Hospital Quality Data

The health care industry is in the very early stages of implementing electronic health records and the national health information infrastructure. Moving forward is analogous to a baby learning to walk because the systems—and financing—are very weak and the path is strewn with obstacles. Therefore, we agree with Congress and CMS that the appropriate way to implement "pay-for-performance" at this stage is to pay for data submission.

For FY 2006, however, CMS has proposed to make full payment of the annual Medicare inpatient PPS update also contingent on hospitals passing a data validity test. We believe that data validity is very important and appreciate the opportunity to work with IPRO (our quality improvement organization) and CMS on the data validation process. However, we believe that the current data validation process is, itself, not yet sufficiently valid to be tied to the payment. The problems are so fundamental that we believe they must be resolved before CMS penalizes hospitals financially. Therefore, we recommend that CMS not yet tie the full payment update to data validity.

The Greater New York Hospital Association has thoroughly catalogued the flaws in the data validation process and we fully support the Association's series of recommendations to correct these flaws.

Thank you for considering these comments.

Sincerely,

Samuel J. Daniels, M.D.
President and C.E.O.

483 HUDSON HEFTER HARTSTEIN

Submitter : Mr. Frank Battafarano
Organization : Kindred Healthcare
Category : Long-term Care

Date: 06/24/2005

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment

CMS-1500-P-773-Attach-1.DOC

LTC/DRG

484 COLLINS MOREY SMITH HEFFER HARTSTEIN

CMS-1500-P-772

Submitter :

Date: 06/24/2005

Organization : **Natl. Org. of State Offices of Rural Health**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CAH/RELOC

CMS-1500-P-772-Attach-1.DOC

CMS-1500-P-772-Attach-2.DOC

current operations, or is terminated by Medicare. Historically, the provider agreement describes the legal entity and services provided. It does define the physical structure or location.

Attachment 2 to #772

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

Reference: Medicare Program Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates.

CMS-1500-P

Subject: Proposed Policy Change Related to Designation of CAHs as Necessary Providers

Comments Submitted by the National Organization of State Offices of Rural Health

The National Organizations of State Offices of Rural Health opposes the Medicare Construction Ban on Critical Access Hospitals for the following reasons:

The Proposed Regulation effectively allows for the transfer of local rural health care to the Centers for Medicare and Medicaid Services (CMS). This loss of local control of health planning and care is threatens all hospitals and all communities.

Congress did not intend for the Medicare Modernization Act to prevent Critical Access Hospitals (CAHs) designated as a Necessary Provider from replacing or relocating their facility. In many cases, CAHs have physical plants that are 40 to 50 years old and in need of repair that is not cost effective.

The CMS proposal to ban a local community's ability to rebuild their Critical Access Hospital on an adjacent or nearby location is not cost effective as the labor costs of operating in a retrofitted building are much higher than operating in a new facility and more than offset the slightly higher cost of rebuilding.

A ban on major construction projects developed after December 8, 2003 is an over reaction to a potential problem that can be appropriately managed by the portion of CMS's proposed rule requiring 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 relocation of a CAH that has been designated a Necessary Provider within the same community that it currently serves does not constitute a cessation of business, of providing health care to the residents of the community, or a loss of provider number.

A CAH's Necessary Provider designation is associated with its current Medicare provider agreement. This should remain intact unless the CAH changes its business, ceases its

current operations, or is terminated by Medicare. Historically, the provider agreement describes the legal entity and services provided. It does define the physical structure or location.

485

HUDSON
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ELLINGTON
KNIGHT
WALZ
HART
HEFTER
HARTSTEIN

Submitter : Mr. William Walters

Date: 06/24/2005

Organization : Acute Long Term Hospital Association (ALTHA)

Category : Long-term Care

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-1500-P-771-Attach-1.DOC

LTC/DRG

MB/EX. HOSPS

TRANSFER

Attachment to #771

ALTHA
Acute Long Term Hospital Association

Acute Long-Term Hospital Association
625 Slaters Lane · Suite 302
Alexandria, VA 22314
703-473-6112
703-518-9900

June 24, 2005

Hon. Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
Room 443-G Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: 42 CFR Parts 405, 412, 413, 415, 419, 422, and 485
Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates

Dear Dr. McClellan:

This letter presents the **Acute Long Term Hospital Association's (ALTHA's)** comments and recommendations on the proposed policy changes contained in the FY 2006 inpatient hospital PPS update that will affect long-term care hospitals (LTCHs). In particular, we are commenting on the proposed update to LTC-DRG relative weights described under Section II.D.

ALTHA represents over 300 LTCHs across the United States, constituting over two-thirds of this provider community nationwide. ALTHA's member hospitals provide care to severely ill, medically complex patients with multiple co-morbidities. Patients require hospitalization averaging at least 25 days in both freestanding and HIH facilities. Many LTCH patients—including Medicare beneficiaries—are admitted directly from short-stay hospital intensive care units with respiratory/ventilator-dependent conditions and/or other complex medical conditions. At LTCHs, these patients receive a specialized treatment program with aggressive clinical and therapeutic intervention. LTCHs are a critical provider in the continuum of post-acute care. They provide a specialized level of care to medically complex patients that could not be provided elsewhere.

ALTHA appreciates the consideration CMS puts into developing the proposed LTC-DRG weights and proposed policy changes. As always, we look forward to working with CMS to develop a final rule that is reasonable and fair.

Attachment to #771

1. Proposed Changes to LTC-DRG Relative Weights
[LTC-DRGs]

General Description. CMS uses a hospital-specific relative value (HSRV) methodology to update the LTC-DRG relative value weights. Since the inception of the LTCH PPS, CMS has used the HSRV method to calculate LTC-DRG relative weights because it removes the hospital-specific bias in measuring LTCH average charges and reduces the impact of the variation in charges (high or low) across different providers. In using the HSRV method, each LTCH's relative charge value is adjusted by its case-mix to an average reflecting the complexity of cases the LTCH treats relative to the complexity of cases treated by all other LTCHs.

The changes CMS is proposing to the LTC-DRG relative weights for FY 2006 were calculated using the December update of the 2004 MedPAR file and the proposed version 23 of the GROUPER. CMS estimates that the proposed change in the GROUPER from version 22 to version 23 will decrease aggregate LTCH payments 4.7 percent. CMS attributes the overall reduction in payments to improvements in coding practices and an increase in the number of relatively lower charge cases in certain LTC-DRGs. An increase in the number of relatively lower charge cases in LTC-DRGs with relatively higher weights in the prior year can reduce the LTC-DRG relative weight in the following year. Overall, more than 70 percent of LTC-DRG relative weights decreased from FY2005 to proposed FY2006.

Assessment. Our own evaluation of the change in the LTC-DRG relative weights shows that certain LTC-DRGs weights have significant proposed reductions of more than 10 percent from 2005. The proposed FY2006 relative weights are reduced for the majority of the most common LTC-DRGs seen in LTCHs. There are few concomitant relative weight increases for the most common LTC-DRGs. Table 1 shows some of the most frequent LTC-DRGs and the reduction in their relative weights from FY2005 to proposed FY2006.

Table 1: Examples of LTC-DRG Relative Weight Reductions

LTC-DRG	Description	2005 Relative Weight	2006 Proposed Relative Weight	Percent Reduction
79	Respiratory Infections & Inflammation Age> 17 w/CC	0.9350	0.8252	12%
87	Pulmonary Edema & Respiratory Failure	1.6797	1.0797	36%
89	Simple Pneumonia & Pleurisy Age > 17 w/CC	0.7762	0.7027	9%
271	Skin Ulcers	0.9572	0.8707	9%
430	Psychoses	0.4746	0.4350	8%
462	Rehabilitation	0.6569	0.5815	11%

The proposed reductions in LTC-DRG relative weights have a significant impact on overall LTCH payments and individual LTCH facilities. Any significant fluctuation in payments, downward or upward, can be destabilizing for Medicare providers, particularly as they transition to a new payment system. Significant year-to-year changes in payments, whether the result of weight adjustments or federal base rate changes, can

make it difficult for Medicare providers to plan for the future. In this uncertain environment, it can be challenging for providers to effectively operate their facility and maintain the highest quality of care for their patients.

LTCH providers specialize to provide care for a small population of patients who are medically complex and generally have respiratory or other severe problems. As a unique provider type, LTCHs do not see a broad spectrum of patients in their facilities with many different diagnoses. There are 550 LTC-DRGs which are based on a large set of DRGs used in the IPPS. Of these LTC-DRGs, 172 are categorized as low-volume for LTCHs and have less than 25 cases annually. Consequently, a much narrower group of only 378 LTC-DRGs and relative weights are employed on a regular basis compared to the IPPS. This pool is further restricted for many LTCHs that sub-specialize in respiratory or wound care. With this narrower set of LTC-DRGs, a majority of discharges can be concentrated in only those groups with declining weights. If the LTCHs do not have offsetting discharges in other LTC-DRGs with proposed weight increases, they will have difficulty balancing their current ability to specialize in certain unique care areas with future Medicare payment incentives.

Since the inception of the LTCH PPS, CMS has implemented Congress' intent to maintain a smooth transition from the previous cost-based payment system. The August 2002 final regulation implementing the LTCH PPS established a five-year transition period and a wage-index adjustment phase-in (42CFR §412.533(a) and Federal Register Vol. 67, No. 169, p. 56018). In addition, CMS has employed the Congressional mandate that the LTCH PPS "maintain budget neutrality" to the transitional phase-in of the payment system (Federal Register Vol. 69, No. 154, pp. 48999-49000). CMS has also reserved the discretion to make a one-time prospective adjustment before October 1, 2006 in an effort to adjust for errors built into the first year of the LTCH PPS (42CFR §412.523(d)(3)).

The LTCH PPS, in its third year of implementation, is still in transition; the initial five-year phase-in will end in September 2006. During this time of transition, LTCH coding and data are still undergoing improvement. In fact, the December update of the 2004 MedPAR file used to establish the proposed weights only reflects the claims from the second year of the LTCH PPS. While coding practices are improving, we are concerned that the proposed LTC-DRG relative weights do not yet fully reflect the nature and type of services, staff, and other resources we provide for our patients. However, ALTHA believes the dramatic reduction in over 70 percent of the LTC-DRG relative weights is reflective of transitional concerns and not a trend in LTCH patient case-mix.

CMS has put significant efforts into smoothing the transition to the LTCH PPS, and the reductions in the LTC-DRG relative weights disrupt this transition. ALTHA believes the currently proposed decrease in LTC-DRG relative weights is inconsistent with the statutory mandate that LTCH PPS be maintained in a budget neutral manner. The statutory LTCH PPS budget neutrality language should apply, not only to the aggregate payments during the phase-in, but to changes in LTC-DRG relative weights.

The LTC-DRG relative weight revisions in this proposed rule fail to take into account the same budget neutrality factors that are annually taken into account for the underlying

IPPS DRGs on which the LTCH LTC-DRGs are based and inextricably linked. IPPS DRGs are "normalized" to ensure annual recalibrations do not increase or decrease total IPPS payments. Given the common statutory language and ancestry of the LTCH PPS and IPPS, and the lack of any distinguishing language in the legislative histories of the two payment systems, ALTHA believes CMS is required to follow the same principles of budget neutrality when updating the LTC-DRG relative weights as when CMS is updating the IPPS DRGs.

Recommendations. ALTHA recommends CMS apply a budget neutrality adjustment to LTC-DRG relative weights. Absent such an adjustment for the LTC-DRG relative weight changes, our member hospitals may find the changes in LTC-DRG relative weights difficult to absorb in the context of their transition to LTCH PPS. We believe the Congressional mandate that the LTCH PPS "maintain budget neutrality" applies not only to aggregate payments during the transition, but to LTC-DRG relative weight changes. The LTC-DRG relative weights are linked to the IPPS DRGs and CMS has for many years applied a budget neutral "normalization" adjustment factor on an annual basis to ensure the proposed IPPS DRG updates do not increase or decrease total IPPS payments.

ALTHA also recommends an additional transitional adjustment to mitigate the impact of the reductions in LTC-DRG relative weights. The reduction in over 70 percent of LTC-DRG relative weights from FY2005 to proposed FY2006 has a substantial impact on ALTHA's member hospitals. We encourage the Secretary to exercise his discretion to maintain a smooth transition to the LTCH PPS and establish a dampening policy for LTC-DRG relative weights similar to that employed with Ambulatory Payment Classifications (APCs) in the Outpatient Prospective Payment System (OPPS) (Federal Register Vol. 67, No. 212, pp. 66749-66750). We believe this adjustment to the relative weights would follow CMS' and Congress' intentions to smooth the transition to the LTCH PPS from cost-based reimbursement. This policy should be implemented with or without a budget neutrality adjustment to the LTC-DRG relative weights.

Under the dampening policy, all proposed FY2006 LTC-DRG relative weights with decreases or increases of 10 percent or more would be adjusted. The dampening policy would reduce the proposed change for those FY2006 LTC-DRG relative weights meeting this 10 percent threshold by one half of the difference between the FY2005 LTC-DRG relative weight and the FY2006 LTC-DRG relative weight. This would reduce wide swings in LTC-DRG relative weight value from year-to-year while LTCHs are implementing changes in response to the new payment system.

CMS established a similar policy for the OPPS during the first years of hospitals' transition to this prospective payment system. The dampening policy was created due to concerns during the early years of the OPPS about changes in pass-through payments for drugs and devices, miscoding, restructuring of APCs, and use of data from a period following implementation of the OPPS. We believe this last point is particularly germane to the LTCH PPS. As we stated previously, the December update of the 2004 MedPAR file represents only the second year of the LTCH PPS. For many LTCHs, many cost report years begin in September, consequently the 2004 MedPAR represents the first full year of data. As the transition unfolds, more data is available, and coding continues to improve, we do not believe a dampening policy will be necessary.

A dampening policy would reduce the de-stabilizing effect of LTC-DRG relative weight changes of 10 percent of more for LTCHs. The policy would ensure that CMS' and Congress' previous commitments to a smooth LTCH PPS transition continue and LTCHs have the ability to maintain their current levels of high quality care to medically complex beneficiaries.

2. **Separate Market Basket for Hospitals and Hospital Units Excluded from the IPPS**
   [Excluded Hospital Market Basket]

General Description. In this proposed rule, CMS states it is considering a separate market basket for LTCHs, IRFs, and IPFs. The market baskets would include operating and capital costs and be specific to each hospital. Any proposal to revise/create a separate market basket for each of these hospital-types would be done through the rule-making process.

Assessment. In the 2006 LTCH rate year update, CMS discussed consideration of an "RPL market basket." This market basket would replace the excluded hospital with capital market basket with a market basket based on the capital and operating costs of IRFs, LTCHs, and IPFs. As with the current IPPS proposed rule discussion, they defer presentation of a proposed new market basket until the 2007 LTCH rate year update.

Recommendations. ALTHA supports CMS' evaluation of a potential new market basket for LTCHs and other post-acute care providers. Market baskets should be reflective of the industry upon which they are applied and employ the most recent available data about capital and operating costs. ALTHA will begin looking at this issue in the fall 2005. We encourage CMS to work closely with LTCHs to develop market basket frameworks that reflect the most recent research, data, and operational expertise. We caution CMS, however, to look at the distinct attributes and price inputs of various providers in evaluating this issue. As licensed acute care providers furnishing care to a medically complex population, the price inputs for LTCHs are linked more closely to those of acute care hospitals than others types of providers.

3. **Proposed Rebasing and Revision of the Excluded Hospital Market Basket**
   [Excluded Hospital Market Basket]

General Description. CMS is proposing to shift the base year cost structure used in calculating the excluded hospital market basket from FY 1997 to FY 2002. This market basket is used to update the TEFRA portion of LTCH payments (for those hospitals that still are transitioning to the full LTCH PPS). CMS states that the major source of Medicare expenditure data for calculating the proposed rebasing of the hospital market basket is the FY 2002 Medicare cost reports. CMS chose the FY 2002 Medicare cost report data because it is the most recent year with relatively complete data.

In addition to the FY 2002 Medicare cost report data, other data sources include the Benchmark Input-Output tables (derived from the 1997 Economic Census) which are updated every 5 years. CMS states that because the FY 2002 Benchmark Input-Output

tables are not yet available, they are proposing to use the FY 1997 Benchmark Input-Output tables that have been aged forward to FY 2002. The Benchmark Input-Output data were aged from FY 1997 to FY 2002 using a methodology that applies the annual price changes from price proxies to the appropriate cost categories.

Assessment. ALTHA commends CMS for updating the excluded hospital market basket data year baseline from FY 1997 to FY 2002. Using the most recent cost report data available will allow for calculation of a more accurate hospital market basket update. ALTHA strongly believes that reflecting true hospital operating costs within the market basket update is essential for hospitals to maintain access to an appropriate level of high quality care.

Recommendations. ALTHA supports CMS' updating of the base year cost structure for calculating the excluded hospital market basket. In the absence of a new LTCH-specific or RPL market basket, ALTHA recommends CMS use the updated FY 2002 hospital index data when calculating the excluded hospital with capital market basket in the 2007 LTCH rate year payment update.

4. Post-Acute Care Transfer Policy
[Postacute Care Transfers]

We support the post-acute care transfer policy comments of the Federation of American Hospitals in Part V (A) of their comment letter. We believe decisions to transfer patients from acute care hospitals to other settings should be based on medical necessity and the clinical judgment of physicians.

Thank you for your review of ALTHA's comments. We appreciate your attention to the issues we have raised and look forward to working with you in the future.

Sincerely,

William Walters
Chief Executive Officer
Acute Long Term Hospital Association

486 TREITEL WALZ BROOKS FAGAN GRUBER KELLY HUE HEFTER HARTSTEIN

Submitter : Mr. Jim Greenwood **Date:** 06/24/2005

Organization : Biotechnology Industry Organization

Category : Health Care Professional or Association

Issue Areas/Comments

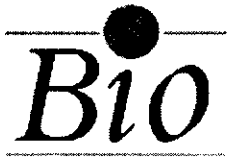
GENERAL

GENERAL

Please see attached.

CMS-1500-P-767-Attach-1.DOC

NT DRG/GEN



BIOTECHNOLOGY
INDUSTRY
ORGANIZATION

Attachment to #767

June 24, 2005

BY ELECTRONIC DELIVERY

Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS-1500-P – Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates

Dear Administrator McClellan:

The Biotechnology Industry Organization (BIO) appreciates this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule regarding the hospital inpatient prospective payment systems (PPS) for operating and capital-related costs and fiscal year 2006 rates, published in the Federal Register on May 4, 2005 (the Proposed Rule).1 BIO is the largest trade organization to serve and represent the biotechnology industry in the United States and around the globe. BIO represents more than 1,000 biotechnology companies, academic institutions, state biotechnology centers, and related organizations in the

1 70 Fed. Reg. 23306 (May 4, 2005).

United States. BIO members are involved in the research and development of health-care, agricultural, industrial and environmental biotechnology products.

Representing an industry that is devoted to discovering new cures and ensuring patient access to them, BIO remains very concerned about CMS' approach to incorporating new technologies and services into the inpatient PPS. Despite Congress' mandate to provide timely access to new technologies, CMS continues to interpret the new technology add-on payment requirements extremely narrowly, preventing many technologies from receiving this status and cutting short the time that hospitals receive add-on payments for therapies that do meet the stringent eligibility requirements. We ask CMS to better carry out the intent of the Medicare statute's protections for new technologies and ensure beneficiary access to innovative therapies in the final rule. The Proposed Rule also fails to reclassify the stroke diagnosis-related groups (DRGs) to better recognize the costs of using reperfusion agents for treatment of severe ischemic stroke. We urge CMS to modify the DRGs for stroke in the final rule to better recognize the costs of these advanced therapies.

I. CMS continues to flout the Medicare statute and its own regulations in its decisions regarding new technology add-on payments (New Technology Applications)

In our comments on the proposed inpatient PPS rule for 2005, BIO urged CMS to correct its exceedingly narrow interpretation of the new technology add-on provisions. We are disturbed to see the agency continuing to make the same errors, denying new technologies the protection Congress intended, and harming beneficiary access to them. Specifically, we urge CMS to withdraw its statements suggesting that the 2-3 year period for new technologies to receive add-on payments begins on the date the technology is approved by the Food and Drug Administration (FDA).

Contrary to both the statute and CMS' own regulations, the agency once again asserts that the "2-year to 3-year period in which a technology or medical service can be considered new would ordinarily begin with FDA approval, unless there is some documented delay in bringing the product onto the market."[2] In contrast, the statute clearly requires data collection and add-on

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2 70 Fed. Reg. at 23354.

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I. CMS continues to flout the Medicare statute and its own regulations in its decisions regarding new technology add-on payments (New Technology Applications)

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2 70 Fed. Reg. at 23354.

payments beginning on the "date on which an *inpatient hospital code* is issued with respect to the service or technology."3 The regulation implementing this section acknowledges that an "inpatient hospital code" is an ICD-9-CM code and requires a medical service or technology to be considered new within 2 or 3 years after the "point at which data begin to become available reflecting the ICD-9-CM code assigned to the new service or technology (depending on when a new code is assigned and data on the new service or technology become available for DRG recalibration)."4 Neither the statute nor the regulation refers to the date of FDA approval in determining whether a technology is "new." Instead, recognizing that CMS is supposed to study the costs of a new technology during the 2-3 year period,5 the statute and regulation begin this special status on the date an ICD-9-CM code is assigned that will allow CMS to collect detailed data on the therapy. We urge CMS to acknowledge what the statute and its regulation make clear – the 2-3 year period begins with the issuance of an ICD-9-CM code. Accordingly, CMS must use the issuance date of a new code, not the date of FDA approval, as the starting date for new technology status.

II. CMS should modify the DRGs for stroke to improve access to advanced therapies for severe ischemic stroke (DRG Reclassifications)

In addition to new technology add-on payments, CMS can use the DRG reassignment process to protect beneficiary access to advanced therapies. We urge CMS to modify the DRGs for stroke to protect beneficiary access to reperfusion agents to treat ischemic stroke, and other acute pharmacological interventions now in advanced clinical development to treat both ischemic and hemorrhagic strokes. In the Proposed Rule, CMS discusses a proposal it received from representatives of hospital stroke centers to modify the existing stroke DRGs 14 (Intracranial Hemorrhage or Cerebral Infarction) and 15 (Nonspecific CVA and Precerebral Occlusion without Infarction).6 These stakeholders recommended that CMS modify these DRGs or create a new DRG to recognize the difference in cost of treating severe ischemic stroke with

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3 Social Security Act § 1886(d)(5)(K)(ii)(II) and (III) (emphasis added).
4 42 C.F.R. § 412.87(b)(2).
5 SSA § 1886(d)(5)(K)(ii)(II); 42 C.F.R. § 412.87
6 70 Fed. Reg. at 23315.

reperfusion agents, such as tissue plasminogen activator (tPA). CMS' review of the data found that the average standardized charges for cases treated with a reperfusion agent are more than $16,000 higher than all other cases in DRG 14 and more than $10,000 higher than all other cases in DRG 15. CMS concluded that the number of cases in which ICD-9-CM code 99.10 (injection or infusion of a thrombolytic agent) was too small to support changing the DRGs. CMS correctly recognized, however, that the use of reperfusion agents might be underreported due to the code's lack of effect on DRG assignment.

We agree that the use of these brain-saving agents is underreported, and we urge CMS to use alternate sources of data to determine the number of stroke cases in which they are used. We recommend that CMS use pharmacy records to obtain a more accurate assessment of the volume of use of reperfusion agents in stroke cases. We are aware of a study of over 500 hospitals in the Premier Perspective Hospital database which found that code 99.10 was used only half of the time for patients receiving reperfusion agents in DRGs 14 and 15. This study suggests that at least twice the number of Medicare discharges coded with 99.10 in the MedPAR database receive these agents.

We recommend that CMS work with the representatives of stroke centers to determine which proposed modification is most appropriate to protect beneficiary access to reperfusion agents for treatment of ischemic stroke. Moreover, we recommend that CMS broaden the title of the proposed reperfusion DRG to facilitate the assignment of other acute pharmacological interventions in the future. We suggest the DRG title "Ischemic or Hemorrhagic Stroke with Acute Pharmacologic Intervention." We note that several other pharmacological agents targeted at acute stroke intervention are far along in clinical trials, with positive results to date. If these other agents are shown to be safe and efficacious in the future, they too should be assigned to the same DRG as 99.10 to ensure that this DRG remains clinically coherent and reflects an acceptable range of resource consumption.[7] This will help ensure Medicare beneficiaries have access to advanced therapies in the treatment of severe ischemic stroke.

III. Conclusion

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[7] See 42 C.F.R. § 412.10(b)(1)-(2).

BIO appreciates this opportunity to comment on our concerns about the Proposed Rule, and we look forward to working with CMS to protect Medicare beneficiaries' access to new and advanced therapies. We urge CMS to implement the new technology add-on consistent with the statute and regulatory language and intent to expand access to breakthrough therapies. We also recommend that CMS modify the DRGs for stroke to better recognize the costs of providing advanced care for this life-threatening condition.

We hope our suggestions will help CMS address these important issues in the final rule. Please contact Jayson Slotnik at 202-312-9273 if you have any questions regarding our comments. Thank you for your attention to this very important matter.

Respectfully submitted,

/s/

Jim Greenwood
President and CEO
Biotechnology Industry Organization

487 WALZ
HART
HEFTER
HARTSTEIN
Kraemer

CMS-1500-P-766

Submitter : Mr. Peter Fine
Organization : Banner Health
Category : Health Care Provider/Association
Date: 06/24/2005

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1500-P-766-Attach-1.DOC

TRANSFERS
IMPACT

488 WALZ HART HEFTER HARTSTEIN TREITEL

CMS-1500-P-762

Submitter : Mr. Bruce McClymonds **Date:** 06/24/2005

Organization : West Virginia University Hospitals

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-762-Attach-1.DOC

TRANSFER PYMT RTS/OUTLIER

Attachment to #762

June 24, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Room 443-G
Attention: *CMS-1243-P; P.O. Box 8010*
Baltimore, MD 21244-8010

Re: CMS-1500-P – Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates. *(70 Federal Register 23305 May 4, 2005).*

Dear Administrator McClellan:

We appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule regarding changes to the Hospital Inpatient Prospective Payment Systems, published on May 4, 2005 in the *Federal Register*. I am the President of West Virginia University Hospitals, a 522 bed teaching hospital located in Morgantown, West Virginia.

While we agree with many components of the proposed rule, we are concerned by some aspects, which potentially have a negative impact on the entire hospital community. In particular, we urge the CMS not to expand the post-acute care transfer policy and to reduce the proposed outlier threshold.

Post-Acute Care Transfer Payment Policy

In FFY 1999, in accordance with the BBA, CMS expanded its transfer policy so that hospitals that discharge patients from 10 specified DRGs to a post-acute setting such as rehabilitation hospitals, psychiatric hospitals, skilled nursing facilities or home health would receive reduced payments under the "post-acute care (PAC) transfer" policy. In subsequent years, CMS further expanded the post-acute transfer policy and as a result, 30 DRGs are now subject to the PAC transfer policy in FFY 2005.

CMS is proposing to expand this again from 30 to 223 DRGs that meet specific criteria. According to CMS, the proposed expansion would result in $880 million less in Medicare program payments to hospitals, the equivalent of a 1.1 percent decrease in payments. It is our belief that CMS should not implement an expansion of the post-acute transfer policy. This has the result of penalizing hospitals that are ensuring the Medicare patients are receiving care in the most appropriate setting. In addition, it reduces payment to hospitals for short lengths of stay without increasing payment for those exceeding the geometric mean length of stay, thereby undercutting the fundamental principal of a PPS system, whereby some cases will cost more than the DRG payment while others will cost less, but on average payments should be adequate. **We strongly urge CMS not to implement this change.**

Attachment to #762

Outlier Payment Threshold

Outlier payments were created by Congress to limit a hospitals financial risk in caring for serious illnesses in addition to ensuring that elderly patients receive appropriate care. They are a critical and necessary component of the prospective payment system (PPS) based on averages. The outlier payment formula is very complex and the threshold is set at a level that is intended to result in outlier payments that are between five and six percent. Outlier payments are intended to be budget neutral.

The proposed rule would increase the fixed-loss cost threshold for outlier payments from $25,800 to $26,675, an increase of 3.5%. CMS proposes an increase to the threshold even though CMS estimates that outlier payments for FFY 2005 will represent only 4.4 percent of actual total DRG payments. CMS also estimates that outlier payments represented only 3.5 percent of total DRG payments in FFY 2004. Because outlier payments were less than 5.1 percent, which was the reduction to the standardized amount to allow for outlier payments, the result is less total Medicare payments to hospitals in both of these years, contrary to the intent of the outlier payment policy. **We believe that the outlier threshold should not be increased and should actually be reduced based on the actual expected outlier payments in FFY 2005 and FFY 2004.**

Thank you for your review and consideration of these comments. If you have any questions, please feel free to contact me.

Sincerely,

Bruce McClymonds
President
West Virginia University Hospitals

489 WALZ HART HEFTER HARTSTEIN

CMS-1500-P-761

Date: 06/24/2005

Submitter : Mr. Eric Kemper
Organization : The Ohio State University Medical Center
Category : Hospital
Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1500-P-761-Attach-1.DOC

TRANSFER

THE OHIO STATE UNIVERSITY
UNIVERSITY MEDICAL CENTER

Attachment to #761

June 24, 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

Reference: CMS-1500-P

On behalf of the The Ohio State Medical Center, we are submitting the following comment on the Medicare Program; Proposed Changes to the Hospital Prospective Payment Systems and Fiscal Year 2006 Rates

Re: Post-Acute Transfers

The Ohio State University Medical Center System continues to strongly oppose the existence and expansion of the IPPS Post-acute Care Transfer Payment Policy from 30 to 223 DRGs. The transfer policy undermines basic objectives and reimbursement methodologies of the IPPS by cutting payments for a set of diagnosis-related groups (DRGs) with discharges that lie under the mean length-of-stay-specifically chosen to reduce Medicare payments. Our estimated impact of this rule change is a reduction of $1,700,000 to the Ohio State University Medical Center System.

This policy continues to penalize hospitals for delivering the most appropriate care to specific beneficiaries; it adds incentives to keep inpatients longer than necessary, which adds to the administrative burden of the Medicare claims process.

If CMS has any questions please feel free to contact me at (614) 293-2074.

Sincerely,

Eric A. Kemper
Director of Reimbursement

490

Submitter : Dr. Gary Duckwiler

Date: 06/24/2005

Organization : ASITN

Category : Health Care Professional or Association

DRG/GEN

Hefter
Hartstein
Brooks
Fasan
Gruber
Kelly
Hue

Issue Areas/Comments

GENERAL

GENERAL

See Attachments - same letter - one in PDF, one in Word

CMS-1500-P-791-Attach-1.PDF

CMS-1500-P-791-Attach-2.DOC

ATTACHMENT 1 to #791

ASITN
American Society of
Interventional & Therapeutic
Neuroradiology

Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
PO Box 8011
Baltimore, MD 21244

Attn: CMS-1500-P
DRG Reclassification: Stroke

Dear Dr. McClellan:

The American Society of Interventional and Therapeutic Neuroradiology (ASITN) recommends that CMS take this proposed first step in recognizing the increased hospital costs associated with acute stroke stays by creating a new medical DRG for ischemic stroke patients treated with revascularization therapies, reflecting the real costs of treating these patients. At the same time, the ASITN recommends that CMS should also commit to creating a separate and distinct DRG for ischemic stroke patients who are treated with endovascular surgical-based interventions, such as mechanical embolectomy and intraarterial thrombolytic therapy.

As an Interventional Neuroradiologist, member and president of the ASITN and a Professor at UCLA Medical Center, I appreciate the opportunity to comment on the Proposed Rule for the Hospital Inpatient Prospective Payment Systems and Fiscal-Year 2006 Rates (CMS-1500-P). With nearly 500 members, the ASITN is the leading medical society working on issues related to neurointerventional surgery procedures and practice. ASITN members are directly involved in the interventional treatment of stroke and routinely see the devastating effects of stroke when patients arrive too late for treatment. Many of our members practice at an active stroke center, treating patients by all means, including intravenous (IV) thrombolysis, direct intra-arterial (IA) thrombolysis and endovascular mechanical embolectomy. Many practice at certified stroke centers with an emergency team that responds immediately to the paramedic calls. These teams typically include: neurologists, neuroradiologists, interventional neuroradiologists, neurosurgeons, radiological technologists and nurses. These considerable resources are necessary to adequately treat patients and should be reimbursed accordingly.

RE: DRG Reclassification: Stroke

At my institution, UCLA Medical Center, a typical certified stroke center in regard to patient mix and characteristics, approximately 48 percent of the acute ischemic stroke cases we treat are Medicare beneficiaries that are treated by all available methods. Typically, the average adjusted total cost per case to treat an ischemic stroke patient with IV thrombolysis is $25,030 whereas the average DRG reimbursement is only $17,294 per case. For IA thrombolysis, the average adjusted cost per case is $34,486 whereas the average DRG reimbursement is only $19,263. For mechanical embolectomy, an endovascular surgical procedure, the average adjusted total cost per

case is $36,711 whereas the average DRG reimbursement is only $22,138. Under the present reimbursement system, this cost burden to hospitals provides a disincentive to care for Medicare beneficiaries who so desperately need this treatment.

Therefore, the ASITN has reviewed with great interest the Center for Medicare and Medicaid Services' (CMS) analysis of the proposed DRG changes, and we commend CMS for addressing the inadequacy of current reimbursement rates to hospitals for the care they provide to ischemic stroke patients. Inadequate reimbursement rates are causing fewer of the hospitals to be in a position to take advantage of the benefits of reperfusion therapy and of endovascular surgical interventions, such as mechanical embolectomy and intra-arterial thrombolysis. Advancing the standard of care for ischemic stroke patients from a "wait and see" approach to an aggressive approach improves patient outcomes. These improved outcomes are well documented and are the basis for the JCAHO standards for Stroke Centers.

As you are aware, an application will be submitted for consideration at the September 29-30, 2005 meeting of the ICD-9-CM Coordination and Maintenance Committee containing several options for the committee to consider regarding ICD-9-CM procedure coding for the surgical intervention of a mechanical embolectomy performed to remove the blood clot that is causing a stroke. Updating the ICD-9-CM procedure coding would enable CMS to track appropriate cost and create ICD-9-CM procedure code(s) that reimburses the hospital at an appropriate level. As evidenced from the data from UCLA, the lack of systematic procedure coding that affects DRG assignment, for both medical and surgical interventions, is impacting reimbursement rates to hospitals for stroke cases and is also hindering CMS in its ability to identify these cases in its MedPAR data for appropriate payment.

About 700,000 individuals suffer a stroke of which 88 percent are ischemic in nature. We believe that the incidence within the Medicare population of those treated with a medical or surgical intervention is much greater than the 2,448 cases that CMS identified in the MedPAR database using ICD-9-CM procedure code 99.10 as the search criteria.

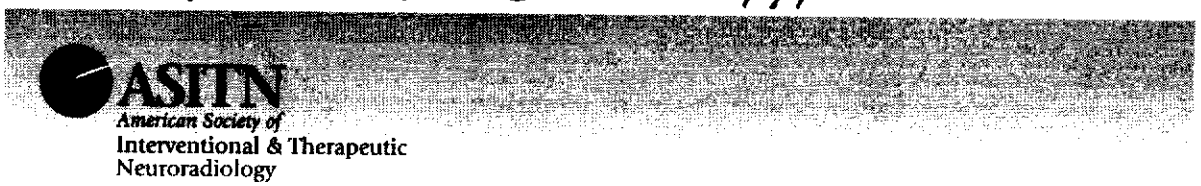
The ASITN would be happy to meet with CMS regarding the ICD-9-CM coding and how CMS could expand its data collection efforts to identify a greater percentage of the ischemic stroke patients in its MedPAR data prior to the publication of the Final IPPS rule for 2006. Also at this meeting, we could discuss the recommendations we have presented above regarding the new DRGs for stroke cases. We look forward to hearing from you regarding the scheduling of this meeting.

Thank you for your attention to this matter of great importance to Medicare beneficiaries, and for your continuing work.

Sincerely,

Gary Duckwiler, MD
President
gduckwiler@mednet.ucla.edu
UCLA School of Medicine

ATTACHMENT 2 TO #791



Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
PO Box 8011
Baltimore, MD 21244

Attn: CMS-1500-P
DRG Reclassification: Stroke

Dear Dr. McClellan:

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Thank you for your attention to this matter of great importance to Medicare beneficiaries, and for your continuing work.

Sincerely,

Gary Duckwiler, MD
President
gduckwiler@mednet.ucla.edu
UCLA School of Medicine

491

Submitter : Ms. Shelly Carling

Date: 06/24/2005

Organization : Northwestern Memorial Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment on Post acute Transfer & Outlier Threshold

CMS-1500-P-792-Attach-1.DOC

Transfer
Pymt Rf/Outlier

Hefter
Hartstein
Walz
Hart

Attachment to #792

Northwestern Memorial Hospital

251 East Huron
Chicago, IL 60611
312/926-2000

June 24, 2005

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

RE: Post-acute Care Transfer & Outlier Threshold

Dear CMS Administrator:

Northwestern Memorial Hospital ("NMH") is a 730 bed academic medical center in Chicago, Illinois. Our organization has two concerns with the 2006 proposed PPS rules as presented in the May 4, 2005 Federal Register. The first is to expand the post-acute care transfer policy to 223 DRGs. We believe this has as a punitive impact on providers that transfer Medicare patients to the most appropriate care setting at the most appropriate time during their course of care.

The transfer reimbursement policy is counter to the PPS principle that some inpatient cases will have higher costs than the DRG payment and some will have lower costs but that overall the payments should be adequate. Inherent in this principle is that the provider receives the full DRG reimbursement. It is accepted that the first days of hospitalization incur the heaviest costs for a provider. By not just expanding the number of DRGs payable under the transfer payment policy but by also including the DRG's with at least a geometric length of stay of 3 days CMS will disproportionately shift the overall cost burden onto the transferring hospital, thus disproportionately increasing the percentage of cases for which the per diem payment does not cover costs.

The decision to increase the number of DRGs subject to the transfer payment policy also has a ripple effect on future calculations for DRG reimbursement. For those situations in which there are still cost reductions achieved by discharging patients to a post-acute care facility the reductions will result in lower DRG case weights used in the DRG recalibration process.

NMH requests that CMS not expand the post-acute care transfer policy.

Our second concern is in regards to the increase in the outlier threshold. Setting the target at 5.1% has not proven to be an accurate level to ensure the proper outlier reimbursement as witnessed by the last few years. Given that there is no retrospective recourse for providers to appeal under-reimbursement we believe the threshold needs to be placed at a level that will assure the intent of the original PPS Legislation.

Sincerely,

Shelly Carling
Manager, Reimbursement & Cost

492

Submitter : Mrs. Donna Littlepage

Date: 06/24/2005

Organization : Carilion Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-793-Attach-1.DOC

TRANSFER IMPACT

Hefter
Hartstein
Walz
Hart
Kraemer

Attachment to #793

CARILION
Health System

June 24, 2005

Mark McClellan, M.D., Ph.D.
Centers for Medicare and Medicaid Services
Department of Health and Human Services

RE: CMS-1500-P Postacute Care Transfers, from *2006 Proposed Changes to the Hospital Inpatient Prospective Payment Systems*

Dear Dr. McClellan:

This letter is in response to the proposed rule for Postacute Care Transfer Payment Policy. I am the Chief Financial Officer for Carilion Medical Center. It is an 825-bed hospital in Roanoke, Virginia providing the only level-one trauma services in Southwest Virginia. It is also a teaching hospital with six residencies. We serve a significant Medicare and Medicaid population in Southwest Virginia. We are very concerned about the addition of almost 200 DRG's to the post-acute care transfer policy. For the past several years, a limited number of DRG's have fallen into this category for special treatment. Although this has been of concern to us, the reasoning behind the DRG's selected, significant discharges with increasing post-acute care and decreasing lengths of stay, seemed somewhat understandable. However, that does not appear to be true for the proposed changes and the impact to our Center will be significant.

Our concern is that this plan will further penalize us for the patients who are transferred prior to the geometric mean length of stay, even if these patients are simply sent home using home health services. In general, our facility has lengths of stay that exceed the national mean within a DRG. This would indicate that we do not normally transfer our patients or discharge them to a SNF or home health agency early. Under this proposal, for the times when we do discharge early, we will now receive a reduced payment, although we receive no additional payment from Medicare when a patient exceeds the geometric mean length of stay unless their bill exceeds approximately $100,000 in charges. These additional payments or outlier payments in conjunction with the DRG payments generally are far from sufficient to cover the cost to care for the particular longer stay Medicare patient.

In determining what DRG's would qualify, a DRG only had to have 10% of the discharges occur prior to the geometric mean length of stay. This means that 90% of the patients were discharged at lengths of stay equal to or greater than the mean. This could easily indicate that a significant number of patients are well over this mean and are costing more than the payment the Center would receive from Medicare. The few patients discharged early helped to offset that effect, a reasonable offset that Medicare is now taking away.

There is also a concern with the argument that DRG's should not be selected based upon rising post-acute care utilization and declining lengths of stay. A rising length of stay means facilities

are having to expend greater dollars to care for the Medicare patients in these DRG's despite utilizing post-acute care where appropriate. Medicare payment increases have likely not covered this increase in cost, yet Medicare is now planning to penalize a facility for the minority of patients that are able to leave the hospital earlier in their stay. Requiring a declining length of stay and rising post-acute care utilization would seem most appropriate to determine DRG's where the overall payment may have become inappropriate. The proposed criteria, regardless of Option 1 or 2, would include virtually all DRG's whose payment would be reduced by being part of this policy. Is this simply a payment reduction methodology with no concerns whether it is appropriate in relation to the cost incurred by the facilities? The DRG's that are proposed for inclusion also do not seem to fall within the confines of Section 1886(d)(5)(J)(iv) in that 223 DRG's (40% of all DRG's) likely do not all have a "high volume of discharges to postacute care facilities and a disproportionate use of postacute care services".

Carilion Medical Center already has a negative margin in caring for the Medicare patients of our region. This change will increase that negative margin by 10%, which is over $1,000,000. It is difficult for a center such as ours to see the equity in Medicare further reducing payments to us when our cost to care for Medicare beneficiaries is not covered already. If the Medicare program is going to follow the theory that the length of stay should effect the payment received, then it also needs to increase payments as soon as the patient passes the geometric mean length of stay. Although the funding issues faced by Medicare are obvious, the changes chosen to address them must also consider the effect they will have on hospitals that offer specialized services to Medicare beneficiaries. Your consideration of these comments is greatly appreciated.

Sincerely,

Donna M. Littlepage
Chief Financial Officer
Carilion Medical Center
P.O. Box 40032
Roanoke, VA 24022-0032

CMS-1500-P-794

493

Submitter : Ms. Erin Mass

Date: 06/24/2005

Organization : The Nebraska Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-794-Attach-1.DOC

DRG/Gen
Transfer
DSH
GME/IRP

Hafter
Hartstein
Brooks
Fagan
Gruber
Kelly
Hue
Walz
Hart
Smith
Lefkowitz
Ruiz
Truong

Attachment to #794

SENT ELECTRONICALLY ON JUNE 24, 2005

June 24, 2005

The Honorable Mark B. McClellan
Administrator
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: CMS-1500-P, Medicare Program; Proposed Changes to Hospital Inpatient Prospective Payment System and Fiscal Year 2006 Rates

Dear Dr. McClellan:

The Nebraska Medical Center appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule establishing new policies and payment rates for hospital inpatient services for fiscal year (FY) 2006.

The Nebraska Medical Center is a 687-licensed medical/surgical bed acute care hospital located in Omaha, Nebraska. As a provider of Medicare services, we are always concerned about any significant revisions to the Hospital Inpatient Prospective Payment System and Payment Rates.

DRG Reclassifications

In FY 2005 the Centers for Medicare and Medicaid Services (CMS) reassigned intestinal transplant cases designated with ICD-9-CM procedure code 46.97 (Transplant of Intestine) out of DRG's 148 and 149 (Major Small and Large Bowel Procedures with and without CC) and into DRG 480 (Liver Transplant). Additionally the descriptor for DRG 480 was changed to "Liver Transplant and/or Intestinal Transplant". Analysis at that time demonstrated the average charges for intestinal transplant cases were much higher than those of other cases in DRG's 148 and 148; however there was not enough data to support creating a separate, stand-alone DRG for intestinal transplants. Continued evaluation for the FY 2006 proposed rule supported the decision to move these cases into DRG 480.

As one of a few transplant centers in the nation certified to perform intestinal transplants, we agree with CMS' decision to reclassify these cases to DRG 480; however urge CMS to continue to evaluate the need for a separate DRG for such procedures. Although only a handful of intestinal transplants were performed during our fiscal year ended June 30, 2004, the average charges on these procedures were $421,713 which was 53% higher than the average charge on liver transplants. This is has become even more important as our center is beginning to encounter cases covered by a payer who model their payments off of the Medicare DRG's. The current payment for intestinal transplants as paid under DRG 480 is better than in the past, but still inadequate. Because of the scarcity of centers qualified to perform these transplants we are concerned that the absence of a separate DRG and therefore insufficient reimbursement could ultimately hinder beneficiary access to care.

We commend CMS for its progress on this issue; however believe our evidence shows a clear need for a distinct intestinal transplant DRG.

Attachment to #794

Postacute Care Transfers

CMS is proposing to expand the post acute care transfer DRG's to 223 from 30 DRG's that are currently covered.

While we understand CMS' reasoning for paying these DRG's as transfers if they meet certain criteria, we do not agree with CMS' reasoning for including certain DRG's.

Our first concern is the administrative burden that this will put on providers who model their payments to better determine the correct payments from payers and for budgeting purposes. This will require an enormous amount of manpower to apply the special payment methodologies to all 223 DRG's. In order to determine the net effect of this proposed rule for our hospital, it took approximately 10 hours. This was done via an Access Database and Excel Spreadsheet. You can be certain that it will take 3 times that to model the special payments within our system.

During CMS' review, 220 DRG's have Geometric Mean Lengths of Stay (GMLOS) that are less than 3 days. CMS' justification for not applying the transfer payment policy to these DRG's was that the policy provides 2 times the per diem rate for the first day of care (due to the large proportion of charges incurred on the first day of a patient's treatment). Including these DRG's in the transfer policy would be relatively meaningless as they would all receive a full DRG payment.

Of the 223 proposed DRG's to be paid as transfer DRG's, 56 have a GMLOS less than 3. Based on CMS' theories on GMLOS less than 3, these should not be included in the DRG's considered for post acute transfer payment. Additionally, it appears that several of these DRG's are part of a paired set that CMS is proposing should be included if one of the paired sets meets the criteria. We disagree with this methodology. Each DRG should be reviewed and the criteria be applied uniformly. By including the paired sets within the post acute care transfer DRG's, CMS believes incentives for hospitals to code cases in ways designed to avoid triggering the application of the policy will be precluded. We understand CMS' concern, but propose that CMS remove those DRG's that have a GMLOS is less than 3. After data has been gathered, CMS can determine if the cases in those DRG's have increased since the passage of the expanded post acute care transfer policy.

DSH Adjustment Data

CMS is proposing to furnish Med PAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request regardless of whether there is a properly pending appeal relating to DSH payments. In addition, CMS is proposing to make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the months included in the two Federal fiscal years that encompass the hospital's cost reporting period.

We would like to applaud CMS for their efforts on streamlining the data collection to determine the best outcomes for the Medicare fractions. This will relieve providers of the burden to submit appeals before obtaining the data for review. The process to obtain this data has been long, and in some instances, data still has not been received for outstanding appeals.

We would like to caution CMS that if the process is not streamlined, and the turnaround time is as long as it is currently, CMS could still see the number of appeals for DSH issued at the same level. We would hope that the number of appeals would decrease if the providers could get the information sooner.

In addition to the Medicare Fraction, CMS is also proposing to not change legislation that would require State Plans to verify Medicaid eligibility for providers. While we understand CMS' position, we would like to see a consistent process between all State Plans. Our hospital is a nationally renowned Transplant Center and as such, we deal with many different State Plans. It would decrease administrative work if each State was required to supply Medicaid Eligibility and that eligibility is done the same way by every State Plan.

Attachment to #794

Graduate Medical Education

The Nebraska Medical Center supports the use of the "Simultaneous Match" to determine the "Initial Residency Period" (IRP) for residents training in programs requiring a "clinical base year" of training (effective 10/01/04). However there are instances in which a resident may not simultaneously match to a clinical base year when they match for an advanced program to begin in their second year of training. We believe that the "IRP" should be based on the specialty the resident enters in the second year of training regardless of when a resident matches to the advanced specialty program. We would like to commend CMS for recognizing that these types of situation exist and express our support for the proposal to use the "IRP" for the advanced program, as long as it can be supported. This is a promising step in ensuring that residents are assigned the appropriate "IRP".

I would like to take this opportunity to thank CMS for allowing The Nebraska Medical Center to comment on these very important issues. If you should have any additional questions or need additional information, please feel free to contact me at (402) 559-5289 or EMass@nebraskamed.com.

Sincerely,

Erin Mass
Reimbursement Manager
The Nebraska Medical Center

CMS-1500-P-789

494

WALZ
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Treitel

Submitter : Ms. Shelly Carling **Date:** 06/24/2005

Organization : Northwestern Memorial Hospital

Category : Hospital

Issue Areas/Comments

Issues

Issues

Post-acute Transfer & Outlier Threshold

CMS-1500-P-789-Attach-1.DOC

TRANSFERS
PYMT RTS/OUTLIER

Attachment to #789

Northwestern Memorial Hospital

251 East Huron
Chicago, IL 60611
312/926-2000

June 24, 2005

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

RE: Post-acute Care Transfer & Outlier Threshold

Dear CMS Administrator:

Northwestern Memorial Hospital ("NMH") is a 730 bed academic medical center in Chicago, Illinois. Our organization has two concerns with the 2006 proposed PPS rules as presented in the May 4, 2005 Federal Register. The first is to expand the post-acute care transfer policy to 223 DRGs. We believe this has as a punitive impact on providers that transfer Medicare patients to the most appropriate care setting at the most appropriate time during their course of care.

The transfer reimbursement policy is counter to the PPS principle that some inpatient cases will have higher costs than the DRG payment and some will have lower costs but that overall the payments should be adequate. Inherent in this principle is that the provider receives the full DRG reimbursement. It is accepted that the first days of hospitalization incur the heaviest costs for a provider. By not just expanding the number of DRGs payable under the transfer payment policy but by also including the DRG's with at least a geometric length of stay of 3 days CMS will disproportionately shift the overall cost burden onto the transferring hospital, thus disproportionately increasing the percentage of cases for which the per diem payment does not cover costs.

The decision to increase the number of DRGs subject to the transfer payment policy also has a ripple effect on future calculations for DRG reimbursement. For those situations in which there are still cost reductions achieved by discharging patients to a post-acute care facility the reductions will result in lower DRG case weights used in the DRG recalibration process.

NMH requests that CMS not expand the post-acute care transfer policy.

Our second concern is in regards to the increase in the outlier threshold. Setting the target at 5.1% has not proven to be an accurate level to ensure the proper outlier reimbursement as witnessed by the last few years. Given that there is no retrospective recourse for providers to appeal under-reimbursement we believe the threshold needs to be placed at a level that will assure the intent of the original PPS Legislation.

Sincerely,

Shelly Carling
Manager, Reimbursement & Cost

CMS-1500-P-788

495 BROOKS FAGAN GRUBER KELLY HUE HEFTER HARTSTEIN

Submitter : Mr. John Shaw **Date:** 06/24/2005

Organization : Next Wave

Category : Health Care Professional or Association

Issue Areas/Comments

Issues

DRG Reclassifications

Split Revisions for Hip and Knee Joint Replacement
DRG for Artificial Disc

See attached for Details

New Technology Applications

Treatment of Artificial Discs

See Attached for details

CMS-1500-P-788-Attach-1.DOC

DRG/GEN

NEXT WAVE

"We Understand Health Care"

Attachment to #788

June 24, 2005

Mr. Marc Harstein
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850 http://www.cms.hhs.gov/regulations/ecomments

Re: File Code CMS-1500-P – DRGs for Hip/Knee Joint Revisions, Artificial Disk

Dear Mr. Harstein:

We are a health services research and consulting firm which specializes in using data to classify patients into categories for policy, management, financing, and quality improvement. We have worked on projects over the years for federal and state governments, provider groups, insurers, and individual institutions. Our emphasis is on policy design and provider implementation:

- Data - ICD-9-CM/CPT code refinement and administrative/assessment/clinical data sets,
- Payment systems (DRG for Hospitals, RUGs for nursing homes, etc.),
- Quality and patient safety measurement and improvement, and
- Risk adjustment.

Our comments on these issues represent work with Orthopedic referral hospitals and their patient populations.

DRGs for Hip/Knee Joint Revisions

We are writing to support the proposed creation of DRGs to split Hip and Knee Arthroplasty (joint replacement) patients into those receiving initial replacements (DRG 544) versus those receiving a revision of a previous joint replacement (DRG 545).

We also support continued analysis to further refine these DRGs as more information becomes available and as refinements are made to the treatment of orthopedic cases in general and complications and comorbidities in particular over the next year. We look forward to working with CMS, our hospitals, their medical staff, and the AAOS over the next year to refine the Orthopedic DRGs to better reflect today's referral and treatment patterns.

Artificial Disc

We are also writing to support creation of a new DRG for Artificial Discs. We recognize that this new technology is not as yet in MEDPAR data, in part due to time frames for implementing the new ICD-9-CM code 84.65, limitation to hospital clinical trial sites prior to the FDA approval of the Charite device, and the fact that elderly patients were excluded from the clinical trials to date. We did compare data from clinical trial sites with corresponding data for patients

receiving spinal fusion (DRGs 497-498) or Laminectomy/Laminotomy (DRGs 499-500).

We added costs of the artificial disc itself back in to the standardized costs of surgical and daily care (after adjusting for surgical and medical supply costs) in both sets of current DRGs. Total standardized costs for disc cases were approximately 13% above those of spinal fusion patients in DRGs 497-498, 20% higher than for the Laminectomy patients in DRGs 499-500, and 96% higher than proposed New Technology payments based on DRGs 499-500 and half the disc cost.

The insertion of an artificial disc implant is far more similar clinically to the open procedure used for spinal fusion (many of which also involve insertion of a fixed fusion device), rather than a simple Laminectomy or Laminotomy, many of which are now done laparoscopically.

The DRG category that this new procedure should be assigned is the one that:

- Is most similar to other procedures surgically (The FDA trials compared anterior fusion with artificial discs.)
- Is most similar to other procedures in terms of recovery time
- Is most similar to other procedures in terms of resources used
- Has the most similar target patient population

While we believe that ultimately, a separate DRG for these cases is appropriate, all of the above criteria support initial grouping artificial disc replacement with spinal fusion cases (DRGs 497-498), not with Laminectomies and Laminotomies in DRGs 499-500. If your medical experts disagree, please provide their contact information and their literature citations so that we can follow up with them to reconcile the evidence.

Thank you for your consideration. We look forward to further refinement of the DRGs to make payments reflect necessary resources and avoid perverse incentives.

Sincerely,

John D. Shaw
President

496 WALZ
~~HART~~
KNIGHT
KRAEMER
SEIFERT
TREITEL
KENLY
HEFTER
HARTSTEIN
Miller
Jones

Submitter : Dr. Herbert Pardes

Date: 06/24/2005

Organization : NewYork-Presbyterian Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-785-Attach-1.DOC

TRANSFERS
LABOR S/N
CBSAs
WI/Bd

NewYork-Presbyterian
The University Hospitals of Columbia and Cornell

Attachment to #785

June 23, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Hubert H. Humphrey Building, Room 443-G
200 Independence Avenue, S.W.
Washington, DC 20201

Subject: **Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 rates; Proposed Rule, Federal Register, Vol. 70, No. 85, May 4, 2005, pp. 23306-23673. [CMS-1500-P]**

Dear Dr. McClellan:

As President and CEO of NewYork-Presbyterian Hospital (the Hospital), I am writing to express our serious concerns with respect to the proposed changes to the Hospital Inpatient Prospective Payment Systems (IPPS) and Fiscal Year 2006 rates.

The Hospital is an acute care facility with more than 2,300 beds and 14,000 employees on several campuses in New York. Last year we had more than 103,000 inpatient discharges, and more than one million outpatient and emergency room visits. We are affiliated with two prestigious medical schools, Columbia University College of Physician and Surgeons and Weill Medical College of Cornell University. Our recommendations this year are as follows:

Post-acute Care Transfers:

The Centers for Medicare and Medicaid Services (CMS) proposed to increase the number of Diagnosis Related Groups (DRGs) in the IPPS that are subject to the post-acute transfer policy to 223, and subsequently on June 1 the policy was expanded to cover 231 DRGs. The origins of the expanded post-acute transfer policy were in the Balanced Budget Act of 1997 that directed the policy to start in 1999 for 10 DRGs. In FY 2004, CMS extended the policy to 29 DRGs, and now, for FY 2006, CMS is proposing to fully implement the policy by extending it to 231 DRGs, which are virtually all the DRGs to which the policy could practicably be applied.

Post-acute Care Transfer patients are deemed to be transfers if they are discharged to an inpatient rehabilitation facility, an inpatient psychiatric facility, a skilled nursing facility, or a home health agency. Transfer cases are reimbursed according to the transfer payment methodology. Under this methodology, the inlier payment is divided by the geometric mean length of stay of the DRG to which the patient is assigned in order to derive a per diem payment. Then the hospital receives

the lower of the per diem payment multiplied by the actual length of stay plus one day, or the full DRG amount.

By limiting payment to hospitals for lengths of stay that are lower than the geometric mean length of stay, CMS will be underpaying hospitals in total through this expanded Post-acute Care Transfer policy. Those patients with a length of stay below the geometric mean will be paid at a portion of the full DRG weight through the Post-acute Care Transfer policy. Correspondingly, those patients that are at or above the geometric mean will only receive the DRG rate, which is calculated by CMS at the average of all patients (below and above the geometric mean). Therefore hospitals will receive below the average payment for cases that are below the geometric mean and an averaged payment for those patients that have a length of stay greater than the geometric mean. As such, CMS should not expand the Post-acute Transfer policy.

The annual impact of the proposed FY06 Post-acute Care Transfer policy over the current policy has been estimated to be greater than $2.6 million to the Hospital. Additionally there is a similar annual impact in aggregate for the hospitals that are part of the NewYork-Presbyterian Healthcare System.

Labor-related Share:

For FY 2006, CMS has proposed to update the cost category weights in the hospital market basket to reflect FY 2002 data. This would have the effect of reducing the labor-related share from 71.1% to 69.7%. The impact to the Hospital of reducing the labor-related share from the current level to the proposed 69.7% would be greater than $1.5 million annually, and the impact to the other System hospitals would approach a comparable amount.

CMS should update the weights in FY 2006 only if the agency were also willing to re-designate professional liability insurance as a labor-related cost. These costs are clearly wage-related—they are included in the wage index—and clearly locally determined. The Hospital believes that the failure to include professional liability insurance in the wage-adjusted portion of the standardized amount in the past was a grave oversight. Including this important cost component in the labor share would bring it up to 71.3%, which is virtually the same as the current labor share of 71.1%.

CBSAs:

At the direction of Congress, CMS adjusts Medicare reimbursement rates to providers to account for regional variation in wage levels. The adjustment is based on each hospital's area wage index, which is computed as the ratio of the average hourly wage rate in each hospital's labor market to the national average hourly wage rate. Lacking data to define hospital labor markets at the inception of the inpatient PPS; the Health Care Financing Administration (HCFA) used the Census Bureau's metropolitan statistical areas (MSAs) as a proxy. The MSAs were defined for the sole purpose of reporting statistical data unrelated to Medicare reimbursement, and problems with their use as hospital labor markets immediately emerged.

After the 2000 census, the Census Bureau and the Office of Management and Budget (OMB) changed the definition of many of the nation's MSAs and renamed them "core-based statistical areas" (CBSAs). These changes were based upon population migration and general industry commuting patterns. Most MSA boundaries were not affected, however, some were tightened and others were expanded. The New York City MSA is an example of a statistical area that was expanded. OMB cautioned agencies not to use the CBSAs for purposes unrelated to statistical reporting unless the new boundaries were studied and found to be appropriate.

CMS sought to reflect the updated statistical areas in its definition of hospital labor markets and proposed to use them in place of the old MSAs. We thought this was inappropriate because it was arbitrary. The CBSAs were based on general commuting patterns rather than on hospital workforce commuting patterns.

The Hospital formally opposed CMS's proposal to replace the MSAs with the new CBSAs. We would have preferred that CMS somehow incorporate the new boundaries into the reclassification process. We did not object to conferring new benefits on additional hospitals per se; our objection was rather to the method of financing those new benefits—i.e., at the expense of a minority of hospitals. In response, CMS agreed to compute area wage indices based upon a blend of the old and new labor market definitions for disadvantaged hospitals during FY 2005. We were very appreciative of that accommodation. Nevertheless, CMS subsequently proposed to implement the new boundaries for its other prospective payment systems without a transition, and has proposed to end the blend in the inpatient PPS in FY 2006.

This course of action would unjustly harm the minority of hospitals and other health care providers that are located in areas whose boundaries were changed for federal statistical reporting purposes. It is particularly unfair to disproportionately cut payments to providers located in areas whose statistical boundaries were expanded, because a significant problem with using MSAs or CBSAs as proxies for hospital labor markets—as expressed on several occasions by the U.S. Government Accountability Office and the Medicare Payment Advisory Commission (MedPAC)—has been that they are too large to effectively discriminate between separate labor markets. NewYork-Presbyterian has estimated the financial impact to the Hospital to be over $7 million annually due to the creation of the new CBSA as compared to the old MSA, and over $6 million for the other System hospitals.

A review of the data for the New York-Wayne-White Plains, NY-NJ CBSA shows that the following average hourly wage rates by county:

	Wage Index Data		Average Hourly Wage	
County	Wages	Hours	FY 2006	3-Yr Avg.
Bronx	1,524,232,310	39,686,661	38.41	37.45
Manhattan	3,900,587,370	100,265,693	38.90	37.36
Queens	1,299,272,982	34,608,591	37.54	36.06
Brooklyn	2,209,888,915	58,357,666	37.87	35.51
Rockland	139,718,288	4,289,085	32.58	33.59
Staten Island	370,989,562	10,907,802	34.01	33.19
Westchester	783,438,960	23,201,387	33.77	32.31
Bergen	857,625,317	25,318,517	33.87	32.05
Putnam	35,460,102	1,165,595	30.42	29.61
Hudson	385,112,430	12,130,412	31.75	29.44
Passaic	301,796,365	10,227,538	29.51	28.73

Clearly the New York City counties (boroughs) have average hourly wage rates used for FY06 that are significantly higher than those from the New Jersey counties (Bergen, Hudson and Passaic) that were added during the advent of CBSAs so grouping these counties into the same CBSA is just not comparable. The NYC average hourly wage rates are as high as $38.90 with the lowest NYC average hourly wage rate at $34.01, which is still higher than any of the three New Jersey counties. To show that this was not an anomaly, we have also included 3 year average hourly wage rates that show NYC counties to be significantly higher than the New Jersey counties.

Therefore, just as CMS has used the MGCRB in the past to correct flaws in the hospital labor markets as defined by MSAs, we now urge CMS to use the MGCRB to correct flaws in the hospital labor markets as defined by the new CBSAs. The Hospital is therefore recommending that for MSAs that were hurt by the expansion to CBSAs, and have counties in CBSAs that have three year average hourly wage rates that are greater than 5% above the CBSA average, then those counties should be able to establish their own average hourly wage rate apart from the established CBSA average hourly rate.

It is important to note that this change made to the structure of the CBSA will not affect aggregate Medicare payments made by CMS, but rather would be a redistribution of dollars to the individual hospitals within the current CBSA, and would more properly reflect the wage expenditure costs for each hospital.

The Hospital thanks CMS for the opportunity to comment on these proposed regulations and we implore CMS to seriously review the issues above. If you should need additional information, please contact Phyllis Lantos, Chief Financial Officer at (212)-305-6845.

Sincerely,

Herbert Pardes, M.D.
President and Chief Executive Officer

497 BROOKS FAGAN GRUBER KELLY HUE HEFTER HARTSTEIN

Submitter : Dr. Alison King **Date:** 06/24/2005

Organization : Procter & Gamble Pharmaceuticals

Category : Drug Industry

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-783-Attach-1.DOC

DRG/GEN CC List

Attachment to #783

P&G Pharmaceuticals
P&G Pharmaceuticals
8700 Mason-Montgomery Rd.
Cincinnati, OH 45040

Alexion Pharmaceuticals Inc.
Alexion Pharmaceuticals
352 Knotter Drive
Cheshire, CT 06410

June 24, 2005

BY EMAIL

http://www.cms.hhs.gov/regulations/ecomments
Mark McClellan MD, PhD, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
Washington, DC 20201

Re: CMS-1500-P: CC List, DRG Reclassifications, MedPAC Recommendations;
Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006; Proposed Rule (70 FR 23305, May 4, 2005)

Dear Dr. McClellan:

Alexion Pharmaceuticals, Inc. and their collaboration partner for pexelizumab, Procter & Gamble Pharmaceuticals, Inc. (P&GP), appreciate the opportunity to comment on the proposed rule for the hospital inpatient prospective payment system (IPPS) for 2006. We are commenting on the CC list, DRG reclassifications and related MedPAC recommendations.

Alexion and P&GP support the Centers for Medicare & Medicaid Services (CMS) initiative, described in the proposed rule, to review the complications and comorbidities (CC) list for the IPPS rule for FY 2007. In addition to the CC list review, we support reclassification of cardiac DRGs to better account for differences in resource utilization and help ensure that hospitals receive appropriate Medicare payment.

We recommend that CMS evaluate CCs by sex to identify circumstances associated with elevated resource utilization among hospitalized Medicare beneficiaries. In research on patients with multiple risk factors who underwent coronary artery bypass graft (CABG) surgery, we found that female sex was associated with higher hospital charges and longer length of stay, which were statistically significant ($p < 0.001$) after controlling for CCs. In addition to a higher incidence of diabetes and other comorbidities, the smaller physical size of female CABG patients may increase the technical difficulty of cardiac surgery, predisposing to complications and higher resource utilization.[1]

[1] Fox AA, Nussmeier NA. Does gender influence the likelihood or types of complications following cardiac surgery? *Semin Cardiothorac Vasc Anesth* 2004 8(4):283-295.

During the 1990s, the frequency of comorbid risk factors increased significantly in Medicare-aged CABG patients and was associated with a 33% increase in predicted operative risk.[2] By the end of the decade, lower risk patients were increasingly referred for percutaneous procedures or medical therapy, contributing to a decline in the number of Medicare patients receiving CABG surgery. Although these CABG patients were older and sicker, surgical outcome improved by 41% over the decade. In contrast, Medicare reimbursement decreased by almost 40% (not inflation adjusted).[2]

In the hospital IPPS proposed rule for FY 2006, CMS proposed adding a CC split to complex cardiac procedures in DRGs 516 and 526. We recommend that CABG DRGs 106, 107, and 109 also be split into procedures with and without CCs because resource consumption and clinical characteristics of CABG patients with CCs are significantly different from patients without CCs. MedPAR data for 2003 show that for CABG patients with CCs, the average length of hospital stay (LOS) is 2.6 to 3.4 days longer and average charges are $14,000 to $29,000 higher than for CABG patients without CCs in the same DRGs (Exhibit A). For all three CABG DRGs, these differences exceed the "clear differentiation in average charges" of approximately $10,000 and LOS of 2.5 days for coronary stent DRGs 516 and 526, which CMS proposed splitting into paired DRGs (70 FR 23320). We urge CMS to similarly restructure DRGs 106, 107, and 109 into paired DRGs with and without CCs.

Exhibit A

			Mean			Difference* (w/CC – w/out CC)	
DRG	Subset	N	Total Charges	Std. Charges	LOS	Std. Charges	LOS
106	All Cases	3,497	$117,741	$105,449	11.27		
106	w/out CC	310	$84,978	$78,726	8.16		
106	w/ CC	3,187	$120,928	$108,024	11.57	$29,298	3.41
107	All Cases	78,585	$87,051	$77,795	10.55		
107	w/out CC	6,220	$67,230	$60,062	7.56		
107	w/ CC	72,365	$88,754	$79,319	10.80	$19,257	3.24
109	All Cases	54,630	$64,259	$57,148	7.75		
109	w/out CC	6,716	$49,957	$44,344	5.43		
109	w/ CC	47,914	$66,263	$58,936	8.07	$14,936	2.64

*p-values are all significant between w/out CC and w/ CC sub groups
**Complications/Comorbidities identified using Grouper software

A split of CABG DRGs into those with and without CCs, in combination with revision of the CC list, would address a 2005 MedPAC recommendation to improve hospital IPPS payment accuracy by refining DRGs to fully capture differences in severity of patients' illness.[3] In fiscal years 2000-2002, MedPAC found that relative profitability ratios for DRGs 107 and 109 ranged from to 1.47 and 1.34 (above average) for uncomplicated patients to 0.79 and 0.72 (below average) for the most severely ill patients, respectively, using a combined APR-DRG classification system with four severity classes.[4] MedPAC's March 2005 report on specialty hospitals was consistent with CMS research, which found that, "Overall, the Medicare cardiac patients treated in community hospitals are more severely ill than those treated in

[2] Ferguson et al. A decade of change-risk profiles and outcomes for isolated coronary artery bypass grafting procedures, 1990-1999. *Ann Thorac Surg* 2002:73:480-489.
[3] Medicare Payment Advisory Commission, Report to the Congress: physician-owned specialty hospitals, March 2005.
[4] APR-DRG, all-patient refined diagnosis-related group, 3M 1998.

cardiac specialty hospitals in most of the study sites."[5] We support CMS' proposal to selectively review and revise cardiac, orthopedic, and surgical DRGs, which could provide a targeted and expeditious fix for high-cost procedures and better ensure appropriate payment for specialty and community hospitals, based on the complexity of patients served.

To facilitate public input into refinement of the CC list and DRGs, we encourage CMS to conduct several open door meetings. The open door forums have been a valuable initiative to promote dialogue on emerging CMS policies and procedures. Open door forums might include, for example, an initial meeting to review CMS' proposed methodology for evaluating CCs and one to discuss results of the analysis and potential revisions to the CC list.

Thank you for your consideration of these comments. We would be happy to discuss them with you or provide additional information. Please feel free to call Alison King at 607 836-6675.

Sincerely,

Alison B. King, Ph.D.
Manager
Public Policy & Government Relations
Procter & Gamble Pharmaceuticals

Leslie Noble
Senior Director
Commercial Distribution, Pricing & Reimbursement.
Alexion Pharmaceuticals

[5] Testimony of Mark B. McClellan, MD, PhD, Administrator, Centers for Medicare & Medicaid Services, before the House Committee on Energy and Commerce hearing on specialty hospitals: assessing their role in the delivery of quality health care, 5/12/2005.

Log Both

CMS-1500-P-782

and CMS-1500P-778

498 COLLINS MOREY SMITH HEFTER HARTSTEIN

Submitter : Mr. Jerome Morasko

Organization : Bell Hospital

Category : Critical Access Hospital

Date: 06/24/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-782-Attach-1.DOC

CAH/RELOC

Attachment to #782

BELL HOSPITAL

June 24, 2005

Michael O. Leavitt
Secretary
U.S. Department of Health and Human Services
Hubert Humphrey Building, Room 416 G
200 Independence Ave, SW
Washington, DC 20201

Dear Secretary Leavitt:

As a designated Critical Access Hospital, we are writing this letter to state our opposition to the proposed construction ban on the vast majority of Critical Access Hospitals (CAH) in our state and across America. Bell Hospital is located in a rural area and is designated under the State of Michigan's classification criteria as a Critical Access Hospital. Previously, we were designated as a Sole Community Hospital in accordance with the applicable federal regulation, being 42 C.F.R. Section 412.92(a).

As you know, the federal critical access program allows rural hospitals to receive reimbursements from the Centers for Medicare and Medicaid Services (CMS) at 101% of their allowable cost rather than using the prospective payment program. Rural hospitals are eligible for the programs if they have 25 or fewer acute-care beds, have an average length of stay less than 96 hours, and are located at least 35 miles from another hospital or are designated by the State as a "necessary provider". As communities around the country will attest, CAH has literally been a lifesaving designation for rural towns.

The proposed regulation transfers control over the location decisions of the community hospital from the local boards to CMS. This would be unprecedented loss of control currently held by local boards and would threaten all hospitals in all communities. This regulation would require a provider move no more than 250 yards from the existing location, without any analysis of what works best for the community. We believe this arbitrary designation will do great harm to CAHs and rural communities.

Bell Hospital is located on a small campus in the middle of a surrounding residential neighborhood with no room to expand. Relocation proves to be the most appropriate and our only cost effective alternative. Ironically, the CMS proposal would cost Medicare more, not less, over time because the higher costs of operating in an outdated building and the additional cost to construct because of the site constraints. Bell's Board began plans to relocate our current facility a couple years ago. The site analysis showed it would cost substantially more to renovate the current 88 year old facility as opposed to building a new facility. It also showed the current location was land locked by residential housing and the cost of purchasing enough property would greatly increase the project

cost. Remodeling an 88 year old building, 40% larger than needed, with 4 floors is clearly not the best structure to meet the community's health care needs. The old building was also not designed to be outpatient driven or made to house current technology, such as CT scanners, MRI, etc. Utility cost alone in our current facility is $800,000 per year, which would probably go down to $200,000 with a new facility. The completed site analysis shows the best decision would be to move the new facility to a site 2 miles away from the current site. Arbitrary rules, such as the one proposed would be detrimental in the board's ability to provide the most efficient healthcare system for our community.

The CMS federal regulations allow designation as a CAH, if the hospital is more than 15 but within 35 miles of another Medicare certified hospital, in areas of mountainous terrain accessible only by secondary roads. We content this designation is also limiting and arbitrary and does not consider other factors such as predictable weather conditions and required travel time.

Bell Hospital is located in Marquette County in Michigan's Upper Peninsula. Marquette County is the largest county in Michigan by area located on the southern shore of Lake Superior. Service areas to our west are as much as 30 minutes travel time on good days to Bell Hospital and up to an hour and a half to the next nearest hospital. Based on National Weather Service statistics in our surrounding area, we regularly receive 200 inches or more of snow per year creating prolonged severe weather conditions making the other like hospital in Marquette County, during heavy snowfall, inaccessible. Though we have primary road access, because of these predicable weather conditions, distance, and posted speed limits, the travel time between our hospital and the nearest like hospital is at least 45 minutes. We believe the current interpretation of "accessibility" by CMS is limited in that it does not consider other circumstances specific to a provider's location and service area.

We appreciate this opportunity to submit our comments and would be pleased to be part of any discussion to assist in the resolution of this issue. We look forward to your response on this issue.

Sincerely,

Jerome Morasko
Chief Executive Officer

Submitter : **Mr. Jerome Morasko** **Date: 06/24/2005**

Organization : **Bell Hospital**

Category : **Critical Access Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

See CMS-1500-P 782 (#498)

CMS-1500-P-780

499

COLLINS
MOREY
SMITH
MILLER
WALZ
HART
NAVARRO
KENLY
JONES
MAZUMDAR
HEFTER
HARTSTEIN
Kraemer

Submitter : Mr. Michael Mazer

Date: 06/24/2005

Organization : Committee on Healthcare Financing

Category : Attorney/Law Firm

Issue Areas/Comments

GENERAL

GENERAL

See Attachments:

1. Letter Comments from Committee on Healthcare Financing
2. Member List Committee
3. National Rural Healthcare Association Letter on June 23, 2005

CMS-1500-P-780-Attach-1.DOC

CMS-1500-P-780-Attach-2.DOC

CMS-1500-P-780-Attach-3.DOC

CMS-1500-P-780-Attach-4.DOC

CAH/RELOC

WI/OM

TRANSFER

SCH

DSH

[redacted] HOSP REDES

CAH/LUGAR

RCHD

IMPACT

Attachment 1 to #780

COMMITTEE ON HEALTHCARE FINANCING

Chairman:
Edward L. Shapoff
Goldman Sachs & Co.

Vice Chairman
Joseph R. Marion
Merrill Lynch & Co.

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Michael E. Mazer
1850 M Street, N.W.
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June 23, 2005

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

Dear Administrator McClellan:

This letter is written on behalf of the Committee on Healthcare Financing ("Committee") with respect to the cited rulemaking (the "Proposed Rule"). The Proposed Rule would implement changes to the hospital inpatient prospective payment systems and fiscal year 2006 rates and have a substantial and, in our view, critical impact on the Department of Health and Human Services ("Department") Critical Access Hospital ("CAH(s)") program. It was published in the May 2005 Federal Register.

For your information, the Committee is an association of national investment and mortgage bankers and bond insurers, which actively participate in a substantial majority of both conventionally and federally supported financings for healthcare facility development throughout the United States. Such financings include major urban teaching hospitals, as well as facilities qualified under the CAH program. With respect to its participation in federal programs, since the early 1970s our members have worked closely with the Department of Housing and Urban Development with respect to its Section 242 financing program for the construction and rehabilitation of hospital facilities and with the Department with respect to its Hill Burton programs. A list of Committee members is attached.

Please know that the Committee has carefully watched the development of the CAH program since its inception and has found it to be an invaluable tool for assuring the availability of capital to finance the construction, replacement and rehabilitation of healthcare facilities that would assure the availability of accessible, affordable and quality healthcare in America's rural communities. Consistent with Congress' intent in creating the CAH program, our members have found the CAH program to be a particularly effective means for accessing low interest rate capital, or for that matter capital *per se,* in rural communities where capital for these purposes is

not readily accessible. We conclude that without a flexible and workable CAH program, capital for assuring quality and state of the art healthcare in many rural communities will be conspicuously absent.

With respect to the Proposed Rule, please know that the Committee has worked with the National Rural Health Association ("NRHA") over the years on various matters affecting rural healthcare capital formation and in light of its expertise in rural healthcare matters have carefully reviewed NRHA's letter to the Department dated June 23, 2005, with respect to the Proposed Rule. We are writing to indicate our strong concurrence with the concerns regarding the negative impact of the Proposed Rule on CAH capital formation expressed in those comments and urge the Department to adopt the changes set forth in the NRHA letter.

We appreciate the opportunity to submit this letter of support. Please do not hesitate to contact the undersigned at 202-293-8200 if you have any questions or require any additional information.

Very truly yours,

COMMITTEE ON HEALTHCARE FINANCING

By: _____
Michael E. Mazer
As Counsel to the Members
of the Committee

MEM:cs
Enclosures

cc: Hilda Heady
Alan Morgan
Edward Shapoff
Joseph Marion

Attachment 2 to #780

Headquarters
One West Armour Boulevard, Suite 203
Kansas City, Missouri 64111-2087
Telephone: [816] 756.3140
FAX: [816] 756.3144

Government Affairs Office
1600 Prince Street, Suite 100
Alexandria, Virginia 22314-2836
Telephone: [703] 519.7910
FAX: [703] 519.3865

NATIONAL RURAL HEALTH ASSOCIATION

June 23, 2005

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

Dear Administrator McClellan:

The National Rural Health Association (NRHA) appreciates the opportunity to comment on the proposed rule implementing changes to the hospital inpatient prospective payment systems and fiscal year 2006 rates published in the May 2005 **Federal Register**. We appreciate your ongoing commitment to rural health care, and the NRHA looks forward to working with you in our mutual goals of improving access and quality of health care for all rural Americans.

The NRHA is a national nonprofit membership organization that provides leadership on rural health issues. The association's mission is to improve the health of rural Americans and to provide leadership on rural health issues through advocacy, communications, education and research. The NRHA membership is made up of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health.

Of particular concern to NRHA is the Centers for Medicare and Medicaid Services (CMS) proposed rule regarding replacement or relocation of a Critical Assess Hospital (CAH) that have been designated as a Necessary Provider (NP).

Or comments are as follows:

CAH Replacement Facilities

1.) **We strongly oppose all deadlines for actions related to Critical Access Hospital (CAH) replacement or relocation in the Inpatient Prospective Payment System (IPPS) final rule.**

2.) **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 local rural health care, a loss of local control never before seen, and if allowed to stand, a precedent that threatens all hospitals and all communities.

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

3. Many rural hospitals are located on a small campus in the middle of residential neighborhoods with relocation being the most appropriate, and sometimes only, alternative since there is no room to expand on the existing site.

4. The proposed rule will force CAHs to allocate funds to renovate structures that no longer meet either the needs or the demands of modern health care. As inefficiencies are realized, CMS will be forced to provide more money through cost-based payment to maintain an aging and declining healthcare infrastructure in rural America. Ironically, the CMS proposal to ban a local community's ability to rebuild on an adjacent or nearby location will cost Medicare more over time, not less. The higher labor costs of operating in a retrofitted building more than offset the slightly higher initial cost of rebuilding. The proposal displays a short sighted thinking process by the rule makers and a dramatic misunderstanding of the health care setting in rural areas.

5. Many rural hospitals are in 40 to 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 facilities after they become outdated 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 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.

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 the relocation of 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 fundamentally changes its business (e.g., ceases its current operations) or is terminated by Medicare. It is a longstanding policy that the provider agreement describes the legal entity and services provided—not the physical structure or location.

On June 6, 2005, the NRHA facilitated a conference call between a sample of CAH hospital CEOs, to provide specific examples of the impact this proposed regulation is having on their facilities. See **Attachment A** for a detailed account of their examples.

Occupational Mix Adjustment

CMS proposes to continue adjusting 10% of the wage index by an occupational mix adjustment. CMS noted last year some confusion and inconsistency with the data accumulated in the first occupational mix survey. We recognize this survey process was new to providers, intermediaries and CMS, and agree that there is likely a great deal of inconsistency in the way different hospitals completed the survey.

We encourage CMS to revisit this process immediately and gather new data within the next year, rather than waiting two more years before obtaining such data. At the same time, more detailed instructions should be issued to clarify the types of data reported, and how occupational data should be recorded on the survey form. CMS notes that a **Federal Register** notice will be published outlining changes to the survey process, and we look forward to reviewing this notice.

Post acute Care Transfers

CMS once again proposes to expand the post acute care transfer (PACT) policy. In describing the proposed expansion CMS notes that, of 507 active DRGs, 220 have lengths of stay of less than 3.0 days and 64 have fewer than 100 short-stay transfer cases. CMS proposes to include the remaining 223 DRGs under the PACT policy. Based on revised data posted to the CMS website, we understand there are now 231 DRGs proposed to be included under the PACT policy. We do not believe the proposed changes are in compliance with Section 1886(d)(5)(J) of the Act. This section requires that DRGs included under this policy must have "a disproportionate use of post discharge services."

While CMS notes that each of the selected DRGs had at least 2,000 PACT cases, CMS does not explain how this represents a "disproportionate use" of post discharge services. The plain meaning of the word "disproportionate" would indicate that, for a DRG to be included under the

PACT policy, the usage of post discharge services would have to be outside the norm. CMS previously published criteria that somewhat accomplished this goal, by requiring 14,000 PACT cases for a DRG to be included under the policy. By excluding the 220 DRGs with lengths of stay of less than 3.0 days, CMS effectively proposes to include every other possible DRG under the policy that had 100 or more transfer cases.

To demonstrate that it has met the intent of the law, CMS should publish a complete list of all DRGs showing how many total cases each DRG had and how many of those cases included usage of post discharge services. The usage rate should also be computed for each DRG, as well as the overall average usage rate. We believe a usage rate at least one standard deviation above this average should be set as a minimum before a DRG is made subject to the PACT policy. We do not believe any change is needed in the current PACT policy. However, if CMS does propose such a change, we believe the clear intent of the law is to limit the PACT policy to DRGs with a disproportionate use of post discharge services, something CMS does not demonstrate with its proposal.

Further, we do not believe that CMS is required to implement changes to the PACT policy as actual reductions in Medicare spending. We request CMS make the postacute transfer policy a budget neutral policy, such that any reductions in Medicare spending through revisions to this policy be paid to providers through an increase in the PPS update factor.

Sole Community Hospitals and Medicare Dependent Hospitals

CMS proposes to modify the budget neutrality adjustment applied to hospital-specific payment rates for SCHs and MDHs to no longer consider changes in the wage index when applying the budget neutrality adjustment to hospital-specific payment rates. However, CMS fails to quantify the impact of this proposal. We request more detailed information regarding the impact of this change on fiscal 2006 payments, as well as the impact if this change was imposed retroactively.

DSH Adjustment Data

We appreciate the efforts CMS is making to comply with Section 951 of the Medicare Modernization Act, which required that CMS make certain DSH adjustment data available by December 8, 2004. CMS notes that a future **Federal Register** notice will publish more details on this issue. Due to the significance of this issue and the time that has already elapsed since December 8, 2004, we request that CMS expedite its efforts to make such data available.

Geographic Reclassifications

CMS proposes to update 42 CFR 412.103(a)(1) to use Rural-Urban Commuting Area codes to identify hospitals located in rural census tracts. However, it was difficult to locate these codes

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by going to the website identified in the proposed regulations. We request further clarification concerning these codes or a more detailed website reference to link to the codes.

Rural Hospitals Redesignated as Urban

As a result of the most recent labor market changes, some counties that were previously considered rural were redisignated as urban. Per the MMA, a rural county that is adjacent to one or more urban counties is considered to be located in the urban MSA to which the greatest number of workers in the county commutes, if certain conditions are met. These are known as "Lugar Counties." Thus, some CAHs are now located in Lugar counties and are unable to meet the rural location requirement, even through they were in full compliance at the time they were designated as critical access.

In response, CMS proposes that CAHs in counties that were designated Lugar counties effective October 1, 2004 because of the new labor market definitions will be allowed to maintain their CAH status until September 30, 2006. NRHA supports this continued transition to allow for the opportunity for these facilities to reclassify.

Budget neutrality and RCH demonstration

The NRHA supports the decision of CMS to achieve budget neutrality for the rural community hospital demonstration by adjusting the total of all PPS payments. This is a fair and reasonable means of balancing the modest cost of this demonstration.

Evaluation of the RCH demonstration

The NRHA looks forward to seeing the evaluation/assessment of the RCH program. We offer our assistance to the contractor awarded this task. We are concerned that all possible benefits and costs be considered, which we believe will require input from experts knowledgeable of special rural circumstances.

Registered Nursing: page 23375

The NRHA is deeply disturbed by the unsupported statement that hospitals are accounting for the shortage of physicians by hiring more registered nurses. We know of no instance of this occurring. The statement implies a practice of downgrading care, especially since it uses "registered nurses," not even nurse practitioners (who deliver primary care). We ask that this statement be stricken from the final rule.

Conclusion:

We believe at this time, it is important to address for the public record, a much larger issue concerning CMS's internal misunderstanding of the CAH program in general.

Through CMS actions regarding the CAH program over the past four years, it appears that the agency internally perceives the growth of the CAH program incorrectly. **This growth of the CAH program was specifically intended by Congress. Furthermore, the growth of the program is limited by the number of rural hospitals that reasonable have twenty-five or fewer beds.** Every reasonable estimate puts this potential universe at less than 1500 hospitals nation-wide. More that 1100 hospitals have already converted to CAH status., leaving fewer than 400 hospitals even potentially eligible for this designation. Attention should be paid to the total cost of the program (approximately $3B annually) and the additional cost as compared with all these CAHs being PPS hospitals (less than $800M according to MedPAC figures) compared with the total hospital budget this year for CMS of better than $239B.

The NRHA appreciates the opportunity to submit these comments on the proposed rule. Please do not hesitate to contact Alan Morgan, Interim Executive Director at 703-519-7910 if you have any questions about these comments.

Sincerely,

Hilda R. Heady

Hilda Heady
President