CMS-1488-P-147

Submitter : **Mr. Michael Rodgers** **Date: 06/02/2006**

Organization : **Catholic Health Association**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment - applies to both 1488-P and 1488-P2

CMS-1488-P-147-Attach-1.DOC

THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES

WASHINGTON OFFICE
1875 Eye Street, NW
Suite 1000
Washington, DC 20006-5409
Phone 202-296-3993
Fax 202-296-3997
www.chausa.org

#147

June 2, 2006

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

REF: CMS-1488-P and CMS-1488-P2

RE: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 Payment Rates; Proposed Rule.

Dear Dr. McClellan:

The Catholic Health Association of the United States (CHA) is pleased to submit the following comments on the notice of proposed rulemaking (NPRM) for the Fiscal Year 2007 Hospital Inpatient Prospective Payment System (*Federal Register*, Vol. 71, No. 79) published April 25, 2006, as revised by the May 17, 2006 Centers for Medicare and Medicaid Services (CMS) notice "Medicare Program; Hospital Inpatient Prospective Payment Systems Implementation of the Fiscal Year 2007 Occupational Mix Adjustment to the Wage Index." We also note the notice of the two typographical clarifications published May 9, 2006 on the CMS website.

The proposed rule, if adopted as proposed, would make the most significant changes to the hospital inpatient prospective payment system (IPPS) since its implementation.

The major factors in the proposed rule include:

1. Significant changes in the methodologies used to calculate the relative weights of the diagnostic related groups (DRGs). Such weights determine Medicare's payments for hospital inpatient services. The proposed changes include a move, beginning FY 2007, to an estimated "cost-based" system, rather than a charge-based system (used since 1983), for determining the payment weights for each diagnostic category.
2. Changes in the method for identifying the variation in patients' severity of illness. CMS said that the latter change would be implemented in FY 2008, but possibly earlier.
3. The court-mandated expansion of the occupational mix adjustment to apply to 100 percent of the wage index. The initial proposal for FY 2007 would have applied the occupational mix adjustment to 10 percent of the wage index, however, the May 17, 2006 revision to the initial proposed rule would apply the occupational mix adjustment to 100 percent of the wage index.

These changes, due to their re-distributional impact, will certainly bring as many as three potentially major de-stabilizing factors (if implemented simultaneously) to bear on the financial situation of many hospitals. Our recommendations and comments on these and other aspects of the proposed rule are as follows:

DRG Reclassifications

1. ***We recommend that CMS postpone until at least FY 2008 implementation of the proposed hospital specific cost-based DRG relative weight determination policy. During this extended period, CMS should complete an analysis, which includes a parallel pilot test of the proposed changes in order to identify any unintended consequences.***
2. ***We further recommend that the proposed hospital specific cost-based DRG relative weight determination policy and the proposed severity adjustment policy be implemented simultaneously but no earlier than FY 2008. This simultaneous implementation approach should help to insure that redistribution of hospital payments is not unduly disruptive to selected individual hospitals..***
3. ***Finally, we recommend that CMS provides at least a three year transition period of the proposed policies during which hospitals are protected from major payment disruptions.***

This recommendation for postponement also reflects our concerns regarding the need for an appropriate lead time to modify hospitals' coding systems.

And, recognizing that the court mandate limits CMS implementation flexibility of the proposed FY 2007 occupational mix adjusted wage index, the above recommendation also reflects our desire to minimize the impact of the potentially disruptive major policy changes on hospitals.

The proposed hospital specific DRG relative value weight policy change would base the DRG relative weights on the estimated cost of providing care. Such weights would be based on the national average of the hospital specific relative values for each DRG. CMS says that the purpose of the proposed change is to help reduce the bias by accounting for the differences in charge markups across cost centers. The proposed change was initially recommended by the Medicare Payment Assessment Commission (MedPAC), however, while agreeing with MedPAC, CMS did not accept MedPAC's proposed methodology. Instead, CMS asked for comments on an alternative methodology, which it proposed to fully implement October 1, 2006.

While we appreciate CMS's concern with MedPAC's recommended methodology, i.e., the administrative burden on hospitals to develop and maintain, we are concerned that the alternative methodology being proposed by CMS has not been thoroughly evaluated. For instance, the CMS methodology assumes a uniform hospital markup – but in fact, markups vary from product to product. In addition, the proposed changes would further distort the estimation of accurate costs by combining multiple costs centers on hospital cost reports into ten CMS-designated cost centers. CMS would then determine ten national average cost-to-charge ratios for each of the designated costs centers, however, such ratios would not be weighted by each hospital's Medicare charges. This would allow very small hospitals to have just as much of an impact on the national cost-to-charges ratios as larger hospitals. These and other methodological issues seem reason enough to invest additional time and energies in the assessment and, as appropriate, further refinement of this proposed change.

In addition, CMS is proposing to implement October 1, 2007, if not earlier, another major payment policy change to refine DRGs based on severity of illness. And here again, while accepting a MedPAC recommendation, CMS did not propose to adopt the already widely applied All Patients Refined DRGs (APR DRGs) endorsed by MedPAC, but rather proposed to adopt a CMS-developed Consolidate Severity-Adjusted DRGs (CSA DRGs).

And, as regards the latter, we are concerned about the implications related to the subject of adjusting for case-mix "creep." While not specifically saying that it would impose an across-the-board behavior adjustment offset in response to or anticipation of case-mix increases stemming from improved documentation and coding, CMS nonetheless left an impression that it would include a behavioral adjustment offset when the severity adjustment is implemented. Rather than impose such an adjustment on all hospitals, we urge that such offsets be applied on a case-by-case basis. This will prevent all hospitals from being arbitrarily penalized for the practices of a relative few.

We are concerned about the potential unintended consequences and implications of such unproven and essentially untested payment changes on hospitals. Given obvious potential impact on hospitals' payments, we respectively urge CMS to postpone implementing both these proposals pending thorough analysis. Such analysis should include

running the proposed changes side-by-side with the current payment policies in order to better track and discern any unexpected patterns or impact.

This postponement is all the more essential in light of the newly proposed, but court-mandated, occupational mix adjustment to the area wage index.

Implementation of Proposed FY 2007 Occupational Mix Adjustment (as published in the Federal Register, May 17, 2006)

While we understand the unusual restraints stemming from the court-mandated order as regards the application of the occupational mix adjustment to 100 percent of the wage index, we strongly urge CMS to use its discretionary authority to insure that implementation is not unduly disruptive to selected individual hospitals. That could be addressed by the use of a multi-year transition or the use of corridors, as CMS has utilized in the past.

Obviously we are concerned about the implications of the court-mandated application of the occupational mix adjustment to 100 percent of the wage index beginning FY 2007. Previously, CMS applied the occupational mix adjustment using only 10 percent of the adjustment factor in calculating the wage index values.

To comply with the court's order, CMS is proposing to use the first three months (January 1, 2006 through March 31, 2006) of the survey data collected on the 2006 Medicare Wage Index Occupational Mix Survey and apply that adjustment to 100 percent of the FY 2007 wage index. Hospitals are required to submit this occupational mix data no later than June 1, 2006. Thus, while CMS will use new data to apply a 100 percent occupational mix adjustment factor, such adjustments will only be as accurate as the data reported. Considering the very short time frame to report the new data, make adjustments, and the fact that this is only the second time such data are being requested, accurate information and results could still pose a problem.

Value-Based Purchasing

CMS noted that the Act required it to develop a plan to implement value-based purchasing beginning with FY 2009. CMS went on to say that the plan must consider a number of issues, including an incentive methodology, and asked a number of questions.

Before addressing these incentive methodology questions, we wanted to raise a more fundamental question - "What is the goal of value-based purchasing?" Is it to improve quality of care? Or is it to reduce Medicare spending? We feel the goal should be to improve the overall quality of care. And, if in the process, Medicare savings are realized, then such savings should be considered an unexpected value, but one that does not take precedence over the primary goal.

The above perspective is what guides our responses to the incentive methodology questions that follow. Our recommendations follow the statement of the respective question posed by CMS:

1. "How should incentives be structured?" ***Hospitals should be rewarded for continued improvement over time.*** This approach is preferred over one that sets an absolute standard of performance. Use of the latter option could either discourage hospitals, especially small and rural hospitals, because it failed to reflect the hospital's unique situation and/or it failed to appropriately stimulate other hospitals.

2. "What level of incentive is needed?" ***We concur with the use of a 1 to 2 percent bonus incentive but feel strongly that penalties for "poor performance" would not be in keeping with the quality improvement spirit.*** And if such penalties are adopted, they should not, however, be determined based on only one year of performance. Rather, such a determination should consider a hospital's continued improvement over more than one year because one year may just be too short of an evaluation period to obtain a reliable performance determination.

3. "What should be the source of the incentives?" ***We encourage CMS to examine the possibilities of improving care coordination as an incentive funding source.*** In particular, CMS, as it noticed in the

proposal, would need to determine whether such an effort could produce measurable savings and whether some of the savings generated in one payment system could be used (as incentive payments) in another.

4. "What should the form of incentives be?" ***We believe, for simply practical purposes, that the incentive payments should be made on a periodic, lump sum, quarterly basis.*** First the logistics of making incentive payments on a per-service basis would, we believe, add an increased administrative burden on hospitals and could fracture a hospital's systemic effort to improve quality. Rather, a lump sum payment would serve to reward the entire hospital for its achievements. And setting up monthly lump sum payments would be inviting delays and complaints. It's better to take a little more time, i.e., every quarter, to get it right and on time.

5. "What should the timing of the incentives be in relation to performance?" ***(See #4 above.)***

6. "How should we develop composite scores?" ***We endorse the use of the highlighted composite scoring methodology currently being used for the Premier Hospital Quality Incentive Demonstration.*** We like this approach because it weighs individual measures by the volume of opportunities for the associated intervention by a particular hospitals; missing values for a particular aspect of care provided by an individual hospital would not prevent that hospital from being represented in a public report; and composite measures may easily accommodate the addition of individual measures.

In closing, we want to thank you for the opportunity to comment on the proposed FY 2007 IPPS rule. If enacted as proposed, this rule will have the largest impact on hospitals since the inception of the IPPS in 1983. Not only does the rule propose major changes to the DRG weight determination process but also proposes substantive severity of illness refinements. And if these changes were not enough, the rule, responding to a court mandate, also proposes to substantially revise the methodology for calculating the occupational mix adjustment of the hospital area wage index. Given these proposed changes we again urge CMS to defer implementation of the DRG related changes for at least a year in order to better assess the potential unintended consequences.

Sincerely,

Michael Rodgers
Senior Vice President, Public Policy and Advocacy

CMS-1488-P-147

Submitter : Mr. Michael Rodgers

Organization : Catholic Health Association

Category : Hospital

Date: 06/02/2006

Hefter
Hartstein
Miller
Kenley

WI/OM

Issue Areas/Comments

GENERAL

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See Attachment - applies to both 1488-P and 1488-P2

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Sincerely,

Michael Rodgers
Senior Vice President, Public Policy and Advocacy

Submitter : **Julia Murphy**

Date: **05/18/2006**

Organization : **Logan Memorial Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Please reconsider going back to 1st quarter 2006 to begin abstraction of the 21 measures that will be required for market update. Retro abstraction will put a tremendous strain on small rural hospital staff such as ours. Adding the measures at the time the vote is taken would benefit all of us.

Submitter : **Ms. Lynda Payton** **Date: 05/23/2006**

Organization : **The Nebraska Medical Center**

Category : **Hospital**

Issue Areas/Comments

Calculation of the Proposed FY 2007 Occupational Mix Adjustment

Calculation of the Proposed FY 2007 Occupational Mix Adjustment

As a facility that is following the regulations and submitting the occupational wage index information in an accurate and timely fashion, we feel that it would be unfair to assign an occupational mix adjustment of 1.0000 to facilities that do not submit data. Of the four options proposed in CMS-1488-P2, options 3 and 4 would be more appropriate. Facilities need to be penalized for not submitting their data. If a facility feels that they may be below 1.0, they have no incentive to submit their data if they know they will default to 1.0. However, if the lowest Occupational Mix Adjustment for their area or provider type is applied then they have more of an incentive to supply their own information.

Submitter : **Chris Sauder** **Date: 05/23/2006**

Organization : **Adventist Health - West**

Category : **Hospital**

Issue Areas/Comments

Implementation of Proposed FY 2007 Occupational Mix Adjustment

Implementation of Proposed FY 2007 Occupational Mix Adjustment

It does not seem appropriate to adjust old cost report data with current occupational mix data. For example, California has since implemented nurse-to-patient ratios which would not be reflected in the base cost report data but would show up in the current occupational mix survey. This is a mismatch of data and it would be unfair to adjust the base data for current staffing mixes that were not in effect during the cost reporting periods used to develop the wage index.

Submitter : **Mr. James Tomlinson** **Date: 05/26/2006**

Organization : **Sioux Valley USD Medical Center**

Category : **Hospital**

Issue Areas/Comments

Calculation of the Proposed FY 2007
Occupational Mix Adjustment

Calculation of the Proposed FY 2007 Occupational Mix Adjustment

May 26, 2006

CMS
DHHS
Attention:CMS-1488-P2
PO Box 8012
Baltimore, MD 21244-8012

Dear Sir:

Reference: CALCULATION OF THE PROPOSED FY 2007 OCCUPATIONAL MIX ADJUSTMENT

In order to comply with the Bellevue Court s order, CMS proposes to collect new survey data instead of using the 2003 survey data proposed in the FY 2007 IPPS proposed rule. CMS proposes to use the first 3 months of 2006 from January 1, 2006 through March 31, 2006.

The 2003 survey data was a complete calendar year, a full 12 months. During that survey, hospitals were allowed to claim annual bonuses without any additional hours. So, any and all hospitals had a chance to report those dollars. However, because this new survey will only be 3 months, it would be unfair to those hospitals that do not pay bonuses during this time period (but who do pay bonuses at a later time in the year). That is to say that their adjusted average hourly rate and occupational mix adjustment factor would be reduced as a percent of total national salaries in setting the wage index.

Therefore, for this and any short period time survey, bonuses paid by hospitals should not be allowed to be recorded in total salaries.

Sincerely,

James G. Tomlinson
Director of Reimbursement

Submitter : **Mr. James Tomlinson** **Date: 05/26/2006**

Organization : **Sioux Valley USD Medical Center**

Category : **Hospital**

Issue Areas/Comments

Calculation of the Proposed FY 2007 Occupational Mix Adjustment

Calculation of the Proposed FY 2007 Occupational Mix Adjustment

Attention:CMS-1488-P2
PO Box 8012
Baltimore, MD 21244-8012

Referencc: CALCULATION OF THE PROPOSED FY 2007 OCCUPATIONAL MIX ADJUSTMENT

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The 2003 survey data was a complete calendar year, a full 12 months. During that survey, hospitals were allowed to claim annual bonuses without any additional hours. So, any and all hospitals had a chance to report those dollars. However, because this new survey will only be 3 months, it would be unfair to those hospitals that do not pay bonuses during this time period (but who do pay bonuses at a later time in the year). That is because their adjusted average hourly rate and occupational mix adjustment factor would be reduced as a percent of total national salaries in setting the wage index.

Therefore, for this and any short period time survey, bonuses paid by hospitals should not be allowed to be recorded in total salaries.

James G. Tomlinson
Director of Reimbursement

Submitter : Dr. Brian Olshansky

Date: 05/30/2006

Organization : University of Iowa

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Re: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates

I am the Director of Cardiac Electorphsyiology a the University of Iowa. My hospital is a large acute care hospital located in Iowa City Iowa. As a major health care provider in our area, we implant medical devices and perform other cardiac procedures on a significant number of Medicare beneficiaries in the inpatient setting. Because inpatient services are a key component of what we provide, I am writing to express my concerns regarding the inpatient payment proposed rule and its recommendations to change the way Medicare pays for inpatient services.

First, it adopts a methodology called hospital-specific relative values that is specifically known to have an adverse impact on payments to hospitals that deliver cardiology services. Second, it adopts a new and untested approach to what are known as cost-based DRG weights that inappropriately reduces payments for cardiology procedures featuring device implants such as drug-eluting stents, ICDs, and pacemakers. In fact, these are the hardest hit of all procedures in the DRG system. And finally, even within the new CMS methodology, there are technical errors and assumptions that worsen the overall payment cuts to cardiology. Any move to a cost-based system from the current charge-based system should be predicated on requirements for improved cost reporting by hospitals. Hospital cost reports were never intended to be used to develop accurate procedure-specific payment weights.

The impact of the CMS proposal will reduce reimbursement to cardiac services across all hospitals by about 10%. Application of hospital specific values to the current DRG system would result in an overall average decrease of approximately 6% to surgical DRGs, while increasing medical DRGs by 6%. In addition, technology intensive DRGs will also be significantly reduced under the CMS proposals. As a result of these changes, the proposed DRGs for stents will be reduced 24 to 34%, ICD implants will be reduced 22 to 24% and pacemakers will be reduced 12 to 14% severely impacting these services.

With regard to the severity adjustment proposed for next year (FY08), severity does not include the technology costs paid by hospitals for more complex cases. As a result, my technology costs could be underpaid.

The payment methodology changes that CMS has proposed would have a severe financial impact on my hospital without accurate data to justify the change. This is particularly true for device intensive cardiology DRGs where the proposed payment level is often significantly less than my hospital s actual cost to deliver the service.

The reduction in payment for cardiology services would also have a severe impact on the infrastructure I have built up over the years to treat the number one killer in America today - heart disease. In addition to requiring the potential dismantling of this infrastructure I would now face the uncertainty of knowing that next year, or any other year, CMS could decide to under-fund whatever service area I build up next to meet patient needs. Obviously, as I'm forced to scale back or not develop service capacity due to payment swings and financial uncertainties, patient access could be negatively affected.

I respectfully request that CMS delay the proposed inpatient payment revision, with a return to the current methodology, until the methodology and underlying cost data are improved to ensure the accuracy of payments. Similarly, severity adjusted DRGs should not be implemented until the technology costs incurred by my hospital can be appropriately reflected in the DRG payments.

Thank you for your consideration.

Sincerely,

Brian Olshansky, MD
Professor of Medicine
Director of Cardiac Electrophysiology
University of Iwoa Hosps
200 Hawkins Drive
Iowa City, IA 52242
319-356-2344
brian-olshansky@uiowa.edu

Submitter : Dr. Karen Broquet **Date:** 05/30/2006

Organization : Southern Illinois University School of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P2-82-Attach-1.DOC

Submitter : **Dr. Sheila Englebardt** **Date: 05/31/2006**

Organization : **Dr. Sheila Englebardt**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

I strongly support the submission of the University Of South Carolina (Charleston) to include nuring intensity in the calcuation of DRG rates.Since nursing care based on patient acuity represent the largest financial impact to the organization, the inclusion of nursing intensity in the DRG rate is long overdue. Thank you for the opportunity to comment

Submitter : **Dr. Thomas Saladin**

Date: 05/31/2006

Organization : **TriHealth**

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P2-102-Attach-1.DOC

28 May 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

Attention: **CMS-1488—P "Resident Time in Patient-Related Activities"**

Dear Administrator McClellan:

The Bethesda and Good Samaritan Hospitals (components of TriHealth in Cincinnati) welcome 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 2007 Rates."* 71 Fed. Reg. 23996 (April 25, 2006). We strongly urge the Agency to rescind the purported "clarification" in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background

The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position is in stark contrast to the Agency's position as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. We concur with the Agency's 1999 position. The activities cited in the 1999 letter and cited again in the purported clarification are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care

With the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of a fully-trained physician. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

For example, the surgical requirements mandate that residents spend 5 hours each week in didactic activities. The reason for this requirement is to assure that trainees and faculty alike spend time discussing and analyzing their clinical work with the objective that this activity will enhance patient care. It is intuitively clear that failure to measure what we do against the experience of others, as recorded in the literature as well as expressed verbally at conferences and related activities, will result in repetition of errors or failure to continually improve our clinical work. I could give examples of how the other residencies use conferences to improve patient care as well as to teach but I think this one is sufficient. Incidentally, I'm sure your calculations are based upon a 40 hr. workweek. The residents spend more than that in direct patient care; the conferences are a miniscule add on from their point of view.

Clearly, we shall continue this didactic work whether CMS pays for it or not, but every reduction in payment will take its toll on the system. At a time when experts are projecting a shortage of physicians and medical knowledge is increasing dramatically each year, CMS patients will feel this pinch eventually. Some programs may have to close or reduce their commitment in some way. Others may be forced to "make do" with fewer faculty or learning aids. Simulators come to mind as one example.

To reiterate, we urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Thomas A. Saladin, MD
VP Academic Affairs
TriHealth
Cincinnati, Ohio

Submitter : **Ms. Linda DeLozier** **Date: 06/05/2006**

Organization : **Cushing Memorial Hospital**

Category : **Hospital**

Issue Areas/Comments

Implementation of Proposed FY 2007 Occupational Mix Adjustment

Implementation of Proposed FY 2007 Occupational Mix Adjustment

We are interested in providing feedback on the proposed Deficit Reduction
Action of 2005 which will reduce the Annual Payment Update (APU) to hospitals that fail to report the required measures of quality. If the proposed legislation goes through, it will have a significant financial impact on our hospital and we believe it is important that we provide feedback related to this important piece of legislation. Please find our comments below:

1. As proposed, the number of quality measures will increase from 10 to 21. This will require additional staff support to collect and transmit this additional information.
2. This proposed legislation requires hospitals to go back and abstract data from January 1, 2006. This is an alarming precedent to set and places an undue burden on a hospital to provide this additional data. In addition, our data will be publicly reported dating back before we had process improvement initiatives in place to address our performance.
3. In reviewing the hospital data, CMS plans to combine the samples for first quarter, second quarter and third quarter of 2005 into a single stratified sample to determine whether or not the 80-percent reliability level is met. We believe this is problematic because hospitals have not had an opportunity to appeal CMS Clinical Data Abstraction Center (CDAC) errors if the error did not result in the hospital failing for the given time period. As a result, a hospital may be negatively impacted by the decision to combine these three quarters into a single stratified sample as proposed. For example, a hospital could have errors (as abstracted by CMS) in their 1st and 2nd quarter report providing them with an 80% passing rate (which they could not appeal) and actually fail the third quarter which would result in failure of all 3 quarters based on the plan to combine the first three quarters as proposed).
4. The payment update for 2007 will be reduced by 2.0 percentage points for indicator performance that has a track record of poor reliability, especially working diagnosis of pneumonia. Some hospitals resort to answering working diagnosis for pneumonia as a yes for all pneumonia charts regardless of actual documentation, since the penalty is disproportionately more severe if the no answer is found to be incorrect. A couple of mismatches on the no to working diagnosis can drive the hospital to the brink of losing their APU.
5. Under the proposed timeline, January, February and March 2006 data will need to be abstracted and successfully submitted to CMS no later than July 31, 2006. With the CMS comment period deadline of June 12, 2006 and an anticipated response time of 60 days by CMS, the outcome may not be known until August 12, 2006. Hospitals will have to proactively submit data on the 21 indicators & in anticipation of the legislation going into effect. The proposed timelines as outlined are problematic.

Thank you for the opportunity to provide feedback on this important legislation. We believe it will have a negative impact on our organization and wanted CMS to consider the weaknesses and understand the implications. We look forward to your comments and feedback.

Submitter : **Mr. Jerome Rivet**

Date: 06/05/2006

Organization : **Covenant HealthCare**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P2-12-Attach-1.PDF

ATTACHMENT TO # 12

June 6, 2006

Mark McClellan, M.D., Ph.D, Administrator

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention:CMS-1488-P2
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Proposed Revision to the 2006 Occupational Mix Survey CMS-1488-P2

Dear Dr. McClellan:

Thank you for the opportunity to comment to Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule that revised the methodology and calculation of the occupational mix adjustment.

Covenant HealthCare is concerned about the impact of this proposed rule for the following reasons:

- Fiscal intermediaries were only given 5 hours to review each hospitals data, which is likely inadequate for ensuring the data quality and consistency among hospitals.
- The methodology used by CMS in developing the occupational mix adjustment is contrary to the CMS focus on hospital quality. It penalizes hospitals for having a higher skill mix of employees compared to national average.
- We disagree with the introduction of the three additional adjustment methods for hospitals that do not submit a survey. We are concerned about implementing any of the proposals if a significant number of hospitals do not complete the survey. This could inappropriately benefit or harm a hospital that did not submit the survey.

Again, we appreciate this opportunity to comment to CMS on regarding the occupational mix proposed rule and urge you to please take them into consideration. If you have any questions regarding this comment, please contact me at jrivet@chs-mi.com or (989) 583-4847.

Sincerely,

Jerome A. Rivet
Reimbursement Administrator
515 N. Michigan Ave
Saginaw, MI. 48602

Submitter : **Mr. Craig Hunt** **Date: 06/07/2006**

Organization : **The Pottsville Hospital and Warne Clinic**

Category : **Hospital**

Issue Areas/Comments

Background

Background

In addition to the attachment included in this comment to The Hospital Association of Pennsylvania, I have also had a converstation with a representative from The American Hospital Association about my position and urging both AHA and HAP to support the implementation of the cost-based portion of the IPPS Proposed Rule for Fy 2007.

Since AHA has is now recommending a delay in the Rule, it is imperative to our hospital that CMS be aware that AHA'a position does not speak for all of its members.

While I understand that there are still many concerns that need to be addressed on the severity changes to the DRG system and an understanding of the financial impact that this change will have, the financial impact of the change to the cost-based methodology is known. It is no surprise that the larger hospitals with cardiac programs do not support this change. The inequity of the current system has negatively impacted hospitals such as ours since inception, while the larger facilities have enjoyed very favorable margins on those cardiac related procedures.

In conclusion, The Pottsville Hospital and Warne Clinic, Schuylkill County Pennsylvania, is in favor of the implementation of IPPS Proposed Rule for FY 2007.

Thank you.

GENERAL

GENERAL

See Attachment

CMS-1488-P2-13-Attach-1.DOC

May 31, 2006

Ms. Melissa Speck
Director of Policy Development
Mr. Robert E. Greenwood
Vice President of Healthcare
Administration and Finance
The Hospital & Health System Association of Pennsylvania

It is imperative that CMS' IPPS Proposed Rule for Fiscal Year 2007 proceed as planned and not be delayed for further review. The proposed change in weighting from a charge-based methodology to cost-based weights specifically addresses the inequities that have existed in the DRG system by removing the bias created by hospital characteristics.

Since the inception of the DRG-based system, community hospitals like The Pottsville Hospital and Warne Clinic have struggled with a payment system that rewards the higher charge, surgical facilities while lower charge predominately medical facilities have had to accept payments that often do not cover costs. This resulted in those larger, higher charge hospitals generating significant margins while the smaller hospitals have struggled to break even.

As HHAP considers the many comments that it will receive on this critical issue, it must not be overly influenced by those large hospitals that already have large operating margins, but would receive lower reimbursement as a result of the Proposed Rule. The calculations that HHAP has done showing the favorable impact of this Rule for community hospitals cannot be ignored. The increased reimbursements for hospitals such as ours are vital to our financial viability.

The audio conference that was conducted by HHAP on the 25th of May, gave me the impression that HHAP and The American Hospital Association may be favoring a delay in the implementation of the FY 2007 Proposed Rule because of objections raised by the larger, tertiary facilities. In my opinion, HHAP and AHA must support the Rule as it now stands for FY 2007 implementation. This Rule makes a real difference for The Pottsville Hospital and Warne Clinic and hospitals like ours. I can understand the need to study in more detail the expansion of DRG's to a severity-adjusted system, but the impact of that is an unknown. The proposal for FY 2007 represents a real number.

I hope to get a better understanding of HHAP's and AHA's position on this issue at tomorrow's audio conference. I would welcome further discussion on this important issue. Please contact me by telephone at 570 621-5101.

Craig Hunt
Vice President –Operations and Finance
The Pottsville Hospital and Warne Clinic

Submitter : **Dr. Joseph Mrphy** **Date: 06/07/2006**

Organization : **Mayo Clinic College of Mdicine**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

June 7, 2006

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

Re: File Code CMS-1488-P

Comments to Proposed Rule 71 FR 23995, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule

I appreciate the opportunity to provide comments on the proposed changes to the Inpatient Prospective Payment System (IPPS) that were published in the April 25, 2006 Federal Register.

HSRV Weights

I agree with the intention of increasing payment accuracy of claims. However, I disagree with the timing of the implementation of the DRG weight calculation changes that are proposed for FY 2007. Please postpone the implementation of the DRG weight changes proposed for FY 2007 until at least FY 2008:

The proposal to move to a hospital specific relative value (HSRV) weighting method will have material impacts to tertiary hospitals, and more significant impacts to the cardiology departments of these hospitals. Because of the significant impact to hospitals, CMS should ensure that the new methodology is correct and improves payment accuracy. Several professional associations and analysts have reported errors in the methodology, including the following: non-inclusion of several hundred hospitals in the analysis, using unweighted cost to charge ratios rather than weighted cost to charge ratios, and pre-transplant costs were included in the calculation of the transplant DRGs. Postponing the implementation will allow CMS and stakeholders adequate time to analyze the proposal and revise any potential inadequacies in the proposed methodology.

The implementation of the DRG weight calculation to the proposed HSRVs is inappropriate without implementation of corrections to all identified payment inaccuracies. MedPAC, the American Hospital Association, and others have all suggested implementing all proposed changes simultaneously to avoid payment swings. Implementation of only HSRVs will actually decrease the overall payment accuracy of the DRG system at a facility level for most hospitals. Table K of the Proposed Rule (72 FR 24024) reports that implementation of only the HSRVs for FY 2007 will result in larger payment inaccuracies across hospitals than not implementing the correction. Since the implementation of the consolidated severity adjusted DRGs is not possible by the beginning of FY 2007, I respectfully request postponing the implementation of HSRVs until all proposed changes can be implemented.

In the FY 2006 final rule, CMS discussed that several cardiovascular DRGs requiring stent insertion were not paid appropriately because the DRGs reflect charges for only one stent. Practically, it is recognized that on average, multiple stents are used during procedures. However, those costs are not recognized by the current DRG weight calculation process. The FY 2006 Final Rule described that data would be available for the FY 2008 rule that would adequately reflect the charges/costs of the DRGs. Postponing the implementation of the HSRVs will allow time for CMS to adequately determine the costs of the DRGs that are most impacted by this proposal.

The change in proposed calculations of DRG payments are described as the most significant to the inpatient payment system since DRGs were implemented. The significance and complexity of the proposed changes require adequate time for all stakeholders to analyze the rule, and ensure potential inadequacies of the proposed methodology are corrected before implementation. I recommend postponing the implementation of the HSRV weighting method, proposing the changes in a separate Federal Register issuance, and providing an extended period of time for comment period. I suggest a phase-in of the proposals to limit the negative impact on hospitals and physicians.

Submitter : **Mr. Thomas Stone** **Date: 06/07/2006**

Organization : **Linclon General Hospital**

Category : **Hospital**

Issue Areas/Comments

Impact

Impact

After reviewing the potenital impact of these changes as a sole community provider we believe that the negative financial reductions in payment will result in the potential reduction of services. Our concern is that some of the data is old and there have been significant changes in the way many of these service are provided and significant changes in the cost of providing these services. We believe it is imparative that there be at least a one year delay in initiating these changes to allow for more significant determination of the long term effect of these changes.

Submitter : **Dr. David Ruiz** **Date: 06/07/2006**

Organization : **Southwest Washington Medical Center**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

As a family medicine residency program director, I appreciate the 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 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006). I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments. BackgroundThe proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care". This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency
programs. Residency Program Activities and Patient CareI firmly
believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner. In addition, as director of this program, I cannot conceive of how I would be able to administratively comply with this requirement. It would require documentation that would be extremely burdensome, if possible at all. To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Where am I to find the funding to pay for the staff person that would be needed to sit in on each of these didactic sessions and keep count of patient care time? The documentation requirements that this position would necessitate are unreasonable and would cause an extremely large administrative burden. To reiterate, I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency
programs.

Sincerely,

David R. Ruiz, M.D.
Residency Program Director
Family Medicine of Southwest Washington
Clinical Associate Professor
Dept. of Family Medicine
University of Washington School of Medicine

Submitter : **Dr. Michael McGoon** **Date: 06/08/2006**

Organization : **Mayo Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

June 7, 2006

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

Re: File Code CMS-1488-P

Comments to Proposed Rule 71 FR 23995, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule

Thank you for allowing me to comment on the proposed revisions of the Inpatient Prospective Payment System (IPPS) that were published in the April 25, 2006 Federal Register.

While I understand the need to ensure payment accuracy of claims, I am very concerned with the timing of the implementation of the DRG weight calculation changes that are proposed for FY 2007. I would request that implementation of the DRG weight changes proposed for FY 2007 be postponed until at least FY 2008:

Application of a hospital specific relative value (HSRV) weighting method will have disproportionate impact on tertiary hospitals, and most critically on the cardiology departments of these hospitals. Because of the significant effect on hospitals, CMS should make certain that the new schema is correct and improves payment accuracy. Based on analysis of data from several professional associations there are errors in the methodology, including but not limited to:
(1) non-inclusion of several hundred hospitals in the analysis
(2) using unweighted cost to charge ratios rather than weighted cost to charge ratios
(3) pre-transplant costs were included in the calculation of the transplant DRGs.

Delaying implementation will allow both CMS and all participants sufficient time to analyze the proposal and revise inadequacies in the projected methodology.

Implementation of the DRG weight calculation to the proposed HSRVs is inappropriate without implementation of corrections to all identified payment inaccuracies. MedPAC, the American Hospital Association, and others have all recommended operationalizing all proposed changes simultaneously to avoid payment fluctuation. Implementation of only HSRVs would in effect decrease the payment accuracy of the DRG system at a facility level for most hospitals. Table K of the Proposed Rule (72 FR 24024) reports that implementation of only the HSRVs for FY 2007 will result in larger payment inaccuracies across hospitals than not implementing the correction at all! Since the implementation of the consolidated severity adjusted DRGs is not possible by the beginning of FY 2007, I respectfully request postponing the implementation of HSRVs until all proposed changes can be implemented.

In the FY 2006 final rule, CMS addressed the issue that several cardiovascular DRGs requiring stent insertion were not paid appropriately because the DRGs reflect charges for only one stent. Multiple stents are, by medical necessity, usually required during procedures. However, the cost of multiple stents are not recognized by the current DRG weight calculation process. The FY 2006 Final Rule suggested that data would be available for the FY 2008 rule that would adequately reflect the charges/costs of the DRGs. Thus, postponement of HSRVs implementation will allow time for CMS to adequately determine the costs of the DRGs that are most impacted by this proposal. I concur with those who advise (1) delaying the implementation of the HSRV weighting method, (2) proposing the changes in a separate Federal Register issuance, and (3) providing an extended period of time for comment, (4) that CMS implement all proposed payment corrections simultaneously, and (5) a phase-in in order to limit the negative impact on hospitals by providing time to adjust their practice to the new reimbursement environment.

Thank you for the opportunity to comment on this proposed rule and for consideration of my comments. If you have any questions, please contact me at 200 1sr St SW, Rochester, MN 55905 (507)-284-3683.

Respectfully yours,

Michael D. McGoon

Submitter : Dr. Bill McIntyre

Date: 06/08/2006

Organization : AHEC-SW

Category : Health Care Professional or Association

Issue Areas/Comments

Impact

Impact

attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Ms. Mary Whitbread** **Date: 06/08/2006**

Organization : **Henry Ford Health System**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment for comments

CMS-1488-P2-19-Attach-1.DOC

CMS-1488-P2-19-Attach-2.DOC

Mary Whitbread, Vice President
Reimbursement & Contracting
One Ford Place, 5F
Detroit, MI 48202
Office (313) 874-9533
Fax (313) 876-9220

June 8, 2006

Mark McClellan, M.D., Ph.D, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P2
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Proposed Revisions to the 2006 Occupational Mix Survey CMS-1488-P2

Dear Dr. McClellan:

On behalf Henry Ford Health System, thank you for the opportunity to comment to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule that revised the timeframe for hospital completion of the occupational mix survey and the methodology for calculating the occupational mix adjustment. This proposed rule supersedes the occupational mix language included in the FY 2007 inpatient prospective payment system proposed rule.

Subsequent to release of the FY 2007 IPPS proposed rule, a decision was issued by the U.S. Court of Appeals, Second Circuit, in *Bellevue Hospital Center v. Leavitt*. This court decision required CMS to collect new occupational mix data from hospitals and fully adjust the Medicare wage index effective October 1, 2006. As a result, hospitals were required to complete and submit by June 1 the hours and wages for employees for the period, January 1 through March 31, 2006, with this data to be used for developing the FY 2007 occupational mix adjustment. In addition, hospitals are required to complete the occupational mix survey by August 31, 2006, for the second calendar quarter. CMS intends to utilize the data for the full six month period, January 1 to June 30, 2006, for developing the FY 2008 occupational mix adjustment.

Henry Ford Health System (HFHS) has the following concerns regarding the impact of this proposed rule:

- Completion of the survey resulted in an undue administrative burden on hospital staff, especially those with fiscal year ends of December 31st who were in the process of completing cost reports thought to be due by May 31st before the cost report deadline was extended. CMS has estimated that, on average, it will take each hospital on average 160 hours to complete the

survey. Hospitals were given a short turnaround time for completing the survey, particularly for the first quarter of 2006.

- Fiscal intermediaries were only given 5 hours to review each hospital's data, which is likely inadequate for ensuring data quality and consistency among hospitals.
- HFHS feels the methodology used by CMS in developing the occupational mix adjustment is contrary to the CMS focus on hospital quality, since it penalizes hospitals for having a higher skill mix of employees compared to the national average.

CMS has requested comments regarding how to handle hospitals that do not submit occupational mix data by the June 1 deadline. In the past, CMS substituted the national average, meaning that the hospital received no adjustment based on their occupational mix. However, in the recent proposed rule, CMS proposes three additional options for assigning an adjustment to non-reporting hospitals:

1) the average occupational mix for its labor market area
2) the lowest occupational mix adjustment factor for its labor market area, or
3) the average occupational mix factor for similar hospitals based on factors such as geographic location, bed size, teaching versus non-teaching status and case mix.

HFHS is concerned about implementing any of these proposals if a significant number of hospitals do not provide data. Utilizing a subset of hospital data to calculate an occupational mix adjustment could inappropriately benefit or harm a hospital that did not submit data. Therefore, we would support the recommendation that CMS continue with its current practice of using the national average occupational mix adjustment, or a factor of 1.0, for hospitals that fail to submit the data.

Again, Henry Ford Health System appreciates this opportunity to provide comments to CMS regarding this occupational mix proposed rule and urge you to please take them into consideration. If you have questions on this comment letter, please contact me at (313) 874-9533 or mwhitbr1@hfhs.org.

Sincerely,

Mary Whitbread
Vice President, Reimbursement & Contracting
Henry Ford Health System

Submitter : **Dr. Daniel Knight** **Date: 06/08/2006**

Organization : **UAMS Dept of Family and Preventive Medicine**

Category : **Physician**

Issue Areas/Comments

Impact

Impact

June 8, 2006

Dear CMS:

As a family medicine residency program director, I appreciate the 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 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006). I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments. Background: The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a non-hospital setting, such as a physician's office or affiliated medical school.

The stated rationale for the exclusion of this time is that the time is not "related to patient care". This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty."[September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs. Residency Program Activities and Patient Care I firmly
believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner. In addition, as director of this program, I cannot conceive of how I would be able to administratively comply with this requirement. It would require documentation that would be extremely burdensome, if possible at all. To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Where am I to find the funding to pay for the staff person that would be needed to sit in on each of these didactic sessions and keep count of patient care time? The documentation requirements that this position would necessitate are unreasonable and would cause an extremely large administrative burden.
To reiterate, I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency
program.

Sincerely,

Daniel Knight, M.D.
Program Director,
Associate Professor
University of Arkansas for
Medical Sciences
Dept. of Family and Preventive Medicine
4301 W. Markham, slot 530
Little Rock, AR 72205

Submitter : **Dr. Floyd Willis** **Date: 06/08/2006**

Organization : **Mayo Clinic Jacksonville**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

As a family physician, I appreciate the 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 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Submitter : **Dr. angela gibson** **Date: 06/08/2006**

Organization : **baylor health care system**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

As a family physician, I appreciate the 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 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background

The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care

I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Submitter : **Dr. Mark Shalauta** **Date: 06/08/2006**

Organization : **UC San Diego**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

GME Payments

As a family physician, I appreciate the 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 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care."

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Mark D Shalauta, MD
Assistant Clinical Professor of Family Medicine
UC San Diego

Submitter : **Dr. Jeffrey Mandel** **Date: 06/09/2006**

Organization : **Dr. Jeffrey Mandel**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

As a family physician, I appreciate the 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 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Jeffrey A. Mandel, MD

Submitter : **Ms. Marilyn Litka-Klein** **Date: 06/09/2006**

Organization : **Michigan Health & Hospital Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Please see the attached comment letter regarding the Occupational Mix Adjustment proposed rule.

Thanks!

CMS-1488-P2-25-Attach-1.DOC

MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

June 9, 2006

Mark McClellan, M.D., Ph.D, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P2
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Proposed Revisions to the 2006 Occupational Mix Survey CMS-1488-P2

Dear Dr. McClellan:

On behalf of its 145 member hospitals, the Michigan Health & Hospital Association (MHA) welcomes this opportunity to comment to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule that revised the timeframe for hospital completion of the occupational mix survey and the methodology for calculating the occupational mix adjustment. This proposed rule supersedes the occupational mix language included in the FY 2007 inpatient prospective payment system proposed rule.

Subsequent to release of the FY 2007 IPPS proposed rule, a decision was issued by the U.S. Court of Appeals, Second Circuit, in *Bellevue Hospital Center v. Leavitt*. This court decision required the CMS to collect new occupational mix data from hospitals and fully adjust the Medicare wage index effective Oct. 1, 2006. As a result, hospitals were required to complete and submit by June 1 the hours and wages for employees for the period, Jan. 1 through Mar. 31, 2006, with this data to be used for developing the FY 2007 occupational mix adjustment. In addition, hospitals are required to complete the occupational mix survey by Aug. 31, 2006, for the second calendar quarter. The CMS intends to utilize the data for the full six month period, Jan. 1 to June 30, 2006, for developing the FY 2008 occupational mix adjustment.

The MHA is concerned about the impact of this proposed rule for the following reasons:

- Completion of the survey results in an undue administrative burden on hospital staff. The CMS has estimated that, on average, it will take each hospital on average 160 hours to complete the survey.
- Hospitals were given a short turnaround time for completing the survey, particularly for the first quarter of 2006.
- Fiscal intermediaries were only given 5 hours to review each hospital's data, which is likely inadequate for ensuring data quality and consistency among hospitals
- The methodology used by the CMS in developing the occupational mix adjustment is contrary to the CMS focus on hospital quality, since it penalizes hospitals for having a higher skill mix of employees compared to the national average.

SPENCER JOHNSON, PRESIDENT
CORPORATE HEADQUARTERS ◆ 6215 West St. Joseph Highway ◆ Lansing, Michigan 48917 ◆ (517) 323-3443 ◆ Fax (517) 323-0946
CAPITOL ADVOCACY CENTER ◆ 110 West Michigan Avenue, Suite 1200 ◆ Lansing, Michigan 48933 ◆ (517) 323-3443 ◆ Fax (517) 703-8620
www.mha.org

The CMS requested comments regarding how to handle hospitals that do not submit occupational mix data by the June 1 deadline. In the past, the CMS substituted the national average, meaning that the hospital received no adjustment based on their occupational mix. However, in the recent proposed rule, the CMS offers three additional optional for the upcoming adjustment assign the hospital:

1) the average occupational mix for its labor market area
2) the lowest occupational mix adjustment factor for its labor market area, or
3) the average occupational mix factor for similar hospitals based on factors such as geographic location, bed size, teaching versus non-teaching status and case mix.

The MHA is concerned about implementing any of these proposals if a significant number of hospitals do not provide data. Utilizing a subset of hospital data to calculate an occupational mix adjustment could inappropriately benefit or harm a hospital that did not submit data. **Therefore, the MHA recommends that the CMS continue with its current practice of using the national average occupational mix adjustment, or a factor of 1.0, for hospitals that fail to submit the data.**

Data Corrections

The MHA urges the CMS to allow hospitals to submit both calendar quarters of data in August whether for the first time or with corrections. Since data collection for the first quarter was extremely rushed, this would allow hospitals an opportunity to improve the quality of the data that will be used in developing the occupational mix adjustment for fiscal years 2008 and 2009.

Comment Timeframe

While the MHA recognizes that the CMS is under extreme pressure due to the recent court decision, we do not believe that the 30-day comment period was sufficient, particularly given the fact that hospitals were busy trying to comply with the revised survey deadline and answering requests for additional information from the Medicare fiscal intermediaries. As a result, we believe it would be appropriate for the CMS to accept comments regarding the calculation upon availability of the initial survey results since the survey results could be material. While we recognize the mandated timeframe may not allow the CMS to implement such changes **for FY 2007,we believe the agency should entertain comments regarding the implementation for future years. As a result, we urge the CMS to publish the occupational mix adjustment changes as an interim-final rule in August with an associated comment period.**

Again, the MHA appreciates this opportunity to provide comments to the CMS regarding this occupational mix proposed rule and urge you to please take them into consideration. If you have questions on this comment letter, please contact me at (517) 703-8603 or mklein@mha.org.

Sincerely,

Marilyn Litka-Klein

Marilyn Litka-Klein
Senior Director, Health Policy

Submitter : **Ms. Ellen Kugler** **Date: 06/09/2006**

Organization : **National Association of Urban Hospitals**

Category : **Hospital**

Issue Areas/Comments

Calculation of the Proposed FY 2007 Occupational Mix Adjustment

Calculation of the Proposed FY 2007 Occupational Mix Adjustment

See attached letter (Single letter comments on implementation and calculation of the proposed FY2007 Occupational Mix Adjustment)

Implementation of Proposed FY 2007 Occupational Mix Adjustment

Implementation of Proposed FY 2007 Occupational Mix Adjustment

See attached letter (Single letter comments on implementation and calculation of the proposed FY2007 Occupational Mix Adjustment)

CMS-1488-P2-26-Attach-1.DOC

NATIONAL ASSOCIATION OF URBAN HOSPITALS

Private Safety-Net Hospitals Caring for Needy Communities

June 9, 2006

Centers for Medicare & Medicaid Services
U. S. Department of Health and Human Services
Attention: CMS-1488-P2
Baltimore, Maryland 21244-1850

Subject: CMS-1488-P2
Issue Identifier: Occupational Mix Adjustment

To Whom it May Concern:

I am writing on behalf of the National Association of Urban Hospitals (NAUH) to express our views on the occupational mix adjustment that was presented in the proposed FY 2007 Medicare inpatient prospective payment system rule.

NAUH understands that the Centers for Medicare & Medicaid Services (CMS) was compelled to address this issue because of a recent federal court ruling and that the timing of that ruling left the agency with relatively little time to act. We also understand that CMS is dissatisfied with the current occupational mix survey because it does not produce the outcomes that the agency sought. Together, these factors have contributed to the proposed implementation of an occupational mix adjustment for FY 2007 that raises several concerns for urban safety-net hospitals.

NAUH's Concerns With the Proposed Occupational Mix Adjustment

NAUH believes that hospitals should be able to understand the impact that a proposed rule would have on them – and CMS has historically provided sufficient information to make such analysis possible. In this particular situation, however, it has not. Today, hospitals face the prospect of providing a specific set of data to CMS without any meaningful idea of how its use might affect their Medicare wage index. It appears, though, that the impact could be significant for some hospitals – but it is unclear for which hospitals this might be the case and it is unclear how great these effects might be. Consequently, hospitals cannot plan for how to adjust to whatever effect the occupational mix has on their wage index – and on their overall Medicare revenue.

We also are concerned about the potential impact of the occupational mix adjustment on hospitals in states that have mandatory nurse-to-patient ratios. Currently, this is only the case in California, but officials in other states are contemplating imposing such requirements as well (Massachusetts, for example, is now on the verge of doing so). We do not believe it is good public policy to punish providers for policies imposed on them by their state governments.

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

Next, we are concerned about CMS's plan to base occupational mix adjustments on only three months worth of data. This raises a number of potential problems. First, we do not believe three months worth of data will be enough to meet the agency's needs. Second, we question the ability of hospitals to provide the timely, quality data that CMS needs to make this work. Hospitals were expecting a survey in the coming year but did not expect to be required to submit data so soon. Consequently, they have not had time to plan adequately for it and devote the resources necessary to complete it in such a short period of time. Between the rush to collect the data and the decision to base calculations on only 25 percent of the usual amount of data, almost any results that CMS produces will be of questionable value.

Suggested Alternative Approaches

Instead of completely implementing the proposed occupational mix survey, with its potential shortcomings, NAUH recommends that CMS hold harmless all hospitals that would see their Medicare wage index decline as a result of the proposed occupational mix survey. We further propose that should CMS decide not to extend this hold harmless beyond one year, it should offer these same hospitals at least a two-year transition period to ease the unexpected burden imposed by the reduction in wage index as a result of this process.

* * *

NAUH recognizes that the impetus for this proposed aspect of the FY 2007 inpatient rule was a court ruling that left CMS relatively little time to act and relatively little discretion over the method of implementation. We believe it would be appropriate for the Secretary to exercise his authority to ease the blow of this unexpected, major change in Medicare policy.

We appreciate the opportunity to comment on this aspect of the proposed FY 2007 Medicare inpatient rule and welcome any questions you may have about our concerns or our recommendations.

Sincerely,

Ellen J. Kugler, Esq.
Executive Director

Submitter : **Dr. Paul Smith** **Date: 06/09/2006**

Organization : **Dr. Paul Smith**

Category : **Physician**

Issue Areas/Comments

Background

Background

As a family physician, I appreciate the 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 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background

The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care

I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Submitter : **Dr. Gary Dunkerley** **Date: 06/09/2006**

Organization : **St Clares Hospital**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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Sincerely,

Gary R Dunkerley MD

Submitter : **Mr.**

Organization : **Mr.**

Category : **Health Care Provider/Association**

Date: 06/09/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Dr. Carrie Nelson** **Date: 06/09/2006**

Organization : **Rush-Copley Family Medicine Program**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

GME Payments

As a family physician, I appreciate the 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 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,
Carrie Nelson

Submitter : **Dr. Arlene Brown** **Date: 06/09/2006**

Organization : **Ruidoso Family Medical Group**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time and time spent in patient care activities. The effect of the proposed rule is to exclude resident time spent in didactic activities in the calculation of DGME and indirect medical education payments.

Submitter :

Date: 06/09/2006

Organization :

Category : **Academic**

Issue Areas/Comments

GENERAL

GENERAL

I strongly urge CMS to rescind the language in the proposed rule. It is impossible to separate didactic activities from patient care time as they correlate closely during the residency program. How can we possibly train residents for future population needs, if we continue to "piece meal" the educational process? In the end we are causing further damage to the medical profession and the consumer!!

Submitter : **Date: 06/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

June 9, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

Attention: CMS-1488 P Resident Time in Patient Activities

Dear Administrator McClellan:

The University of Cincinnati/ University Hospital 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 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

We strongly urge the Agency to rescind the purported clarification in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments. The stated rationale for the exclusion of time devoted to these activities is that they are not related to patient care The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school.

The proposed rule position is in stark contrast to the Agency s position as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins].

We support the Agency s 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. We urge CMS to withdraw its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Amy Beth Kressel, MD

Submitter : **Michele DeSmet** **Date: 06/09/2006**

Organization : **Oaklawn Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P2-34-Attach-1.DOC

OaklawnHospital

200 North Madison
Marshall, Michigan 49068
269 781-4271

Advancing Medicine.
Compassionate Care.

June 12, 2006

Mark McClellan, M.D., Ph.D, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P2
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Proposed Revisions to the 2006 Occupational Mix Survey CMS-1488-P2

Dear Dr. McClellan:

Oaklawn Hospital welcomes this opportunity to comment to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule that revised the timeframe for hospital completion of the occupational mix survey and the methodology for calculating the occupational mix adjustment. This proposed rule supersedes the occupational mix language included in the FY 2007 inpatient prospective payment system proposed rule.

Subsequent to release of the FY 2007 IPPS proposed rule, a decision was issued by the U.S. Court of Appeals, Second Circuit, in *Bellevue Hospital Center v. Leavitt.* This court decision required the CMS to collect new occupational mix data from hospitals and fully adjust the Medicare wage index effective October 1, 2006. As a result, hospitals were required to complete and submit by June 1 the hours and wages for employees for the period, January 1 through March 31, 2006, with this data to be used for developing the FY 2007 occupational mix adjustment. In addition, hospitals are required to complete the occupational mix survey by Aug. 31, 2006, for the second calendar quarter. The CMS intends to utilize the data for the full six-month period, January 1 to June 30, 2006, for developing the FY 2008 occupational mix adjustment.

We are concerned about the impact of this proposed rule for the following reasons:

- Completion of the survey results in an undue administrative burden on hospital staff. The CMS has estimated that, on average, it will take each hospital on average 160 hours to complete the survey.
- Hospitals were given a short turnaround time for completing the survey, particularly for the first quarter of 2006.
- Fiscal intermediaries were only given 5 hours to review each hospital's data, which is likely inadequate for ensuring data quality and consistency among hospitals

- The methodology used by the CMS in developing the occupational mix adjustment is contrary to the CMS focus on hospital quality, since it penalizes hospitals for having a higher skill mix of employees compared to the national average.

Data Corrections

We urge the CMS to allow hospitals to submit both calendar quarters of data in August with corrections. Since data collection for the first quarter was extremely rushed, this would allow hospitals an opportunity to improve the quality of the data that will be used in developing the occupational mix adjustment for fiscal years 2008 and 2009.

Comment Timeframe

While Oaklawn Hospital recognizes that the CMS is under extreme pressure due to the recent court decision, we do not believe that the 30-day comment period was sufficient, particularly given the fact that hospitals were busy trying to comply with the revised survey deadline and answering requests for additional information from the Medicare fiscal intermediaries. As a result, we believe it would be appropriate for the CMS to accept comments regarding the calculation upon availability of the initial survey results since the survey results could be material. While we recognize the mandated timeframe may not allow the CMS to implement such changes **for FY 2007,we believe the agency should entertain comments regarding the implementation for future years. As a result, we urge the CMS to publish the occupational mix adjustment changes as an interim-final rule in August with an associated comment period.**

We appreciate this opportunity to provide comments to the CMS regarding this occupational mix proposed rule and urge you to please take them into consideration. If you have questions on this comment letter, please contact me at (269) 789-7021 or mdesmet@oaklawnhospital.com.

Respectfully,

Michele L. DeSmet
Financial Planning and Reimbursement Director

Submitter : **Date: 06/09/2006**

Organization :

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

As a family physician, I appreciate the 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 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background The proposed rule cites journal clubs, classroom lectures and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a non-hospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care."

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Heather Grant

Submitter : **Date: 06/10/2006**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

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Sincerely,
Greg Matlick

Submitter : **Dr. meredith polansky** **Date: 06/10/2006**

Organization : **mahec family medicine residency program**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Sincerely,
dr polansky

Submitter : **Dr. Warren Longmire** **Date: 06/10/2006**

Organization : **AAFP**

Category : **Physician**

Issue Areas/Comments

Implementation of Proposed FY 2007 Occupational Mix Adjustment

Implementation of Proposed FY 2007 Occupational Mix Adjustment

At a time when our ER departments are over run, WE must help those of us who attend the inpatients, reduction in payment will cause more physicians to leave and create greater shortages.

Submitter : **Date: 06/11/2006**

Organization :

Category : **Individual**

Issue Areas/Comments

GENERAL

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BACKGROUND
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Sincerely,
William T Hendricks

Submitter : **Dr. Robert Reade** **Date: 06/11/2006**

Organization : **Dr. Robert Reade**

Category : **Physician**

Issue Areas/Comments

GENERAL

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Sincerely,

Robert Reade

Submitter : Dr. Belinda Vail

Date: 06/11/2006

Organization : Dr. Belinda Vail

Category : Physician

Issue Areas/Comments

Calculation of the Proposed FY 2007 Occupational Mix Adjustment

Calculation of the Proposed FY 2007 Occupational Mix Adjustment

Do you have any idea how much it costs to educate a resident? We do it on the backs of our clinical revenue (that's why we're all going broke). Giving us tighter and tighter regulations and pinching us tighter and tighter to account for every hour of a resident's training is just not feasible. We're not trying to beat the system here, we're just trying to stay afloat.

Submitter : **Dr. Dana Perrin**

Organization : **Dr. Dana Perrin**

Date: 06/11/2006

Category : **Individual**

Issue Areas/Comments

GENERAL

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Submitter : **Melissa Lucas** **Date: 06/11/2006**

Organization : **Melissa Lucas**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Submitter : **kathleen rice** **Date: 06/11/2006**

Organization : **kathleen rice**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

I believe that the time residents spend directly with patients should be compensated as per current regulations comenserate with appropriate CPT guidelines. Eliminating payment for useful patient care is a poor way to save money, and will impact negatively on resident education.

Submitter : **Ms. Suzanne Orton**

Date: 06/11/2006

Organization : **Ms. Suzanne Orton**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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Please direct your questions or comments to 1 800 743-3951.

Submitter : **Dr. Marlene Capps** **Date: 06/11/2006**

Organization : **Dr. Marlene Capps**

Category : **Physician**

Issue Areas/Comments

GENERAL

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On the other hand, further cuts mean fewer residents in family medicine- leaving increasingly only the specialists treating our aging geriatric population- and when pulmonologists and rheumatologists have to treat the garden variety hemorrhoids too the system may truly see effective change.

Sincerely,

Dr. P. Marlene Capps

Submitter : **Dr. Thomas Speros** **Date: 06/11/2006**

Organization : **Dr. Thomas Speros**

Category : **Individual**

Issue Areas/Comments

GENERAL

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Sincerely,
Thomas L. Speros, M.D.

Submitter : **Ms. Karen Ryan** **Date: 06/11/2006**

Organization : **Geisinger Health System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See attachment for Geisinger Health System comments on CMS 1488-P2

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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Please direct your questions or comments to 1 800 743-3951.

Submitter : **Ms. Susan Prince**

Organization : **Huntsville Hospital**

Date: 06/11/2006

Category : **Nurse**

Issue Areas/Comments

Background

Background

Nursing accounts for 30% of hospital operating budgets yet no one accounts for the cost of nursing time and care. Studies have shown a correlation between nursing care and patient outcomes. States are trying to mandate nursing hours without ever measuring nursing intensity of care or direct care costs. We are simply asking that the profession of nursing be recognized and the impact of nursing care be measured in this effort to revamp DRG's and the reimbursement of patient care. Nursing Care Costs and Nursing Intensity can be and should be measured and counted in the true costs of patient care.

Submitter : Dr. Eva Klonowski **Date:** 06/11/2006

Organization : Dr. Eva Klonowski

Category : Individual

Issue Areas/Comments

GENERAL

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Sincerely,
Eva Klonowske, MD

Submitter : Dr. George Barth II, MD

Date: 06/12/2006

Organization : Dr. George Barth II, MD

Category : Physician

Issue Areas/Comments

Background

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This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are
an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate
medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician,
I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are

unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

George B Barth II, MD

Submitter : **Dr. Mary Meadows** **Date: 06/12/2006**

Organization : **Dr. Mary Meadows**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

RE: GME payments

As a family physician, I appreciate the 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 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Mary E. Meadows, MD

Submitter : **Dr. Mary Miller** **Date: 06/12/2006**

Organization : **Dr. Mary Miller**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

As a family physician, I appreciate the 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 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Mary Miller, M.D.

Submitter : **Dr. Jennifer Abbott** **Date: 06/12/2006**

Organization : **Dr. Jennifer Abbott**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

As a family physician, I appreciate the 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 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Jennifer Abbott MD
Asheville, NC

CMS-1488-P2-55

Submitter : **Mr. Samuel Camp** **Date: 06/12/2006**

Organization : **Sanford School of Medicine of USD**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

REGARDING GME PAYMENTS
As a student interested in family medicine and completing a residency in the field, I appreciate the 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 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

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Sincerely,
Samuel T. Camp, MSIII
Sanford School of Medicine of the University of South Dakota

Submitter : **Dr. Laura Fox** **Date: 06/12/2006**

Organization : **Providence Health System**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely, Laura Fox

Submitter : **Dr. Laura Fox** **Date: 06/12/2006**

Organization : **Providence Health System**

Category : **Physician**

Issue Areas/Comments

GENERAL

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely, Laura Fox

Submitter : **Mrs. Shirley Bishop** **Date: 06/12/2006**

Organization : **Clarian Health Partners, Inc.**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment (various comments)

CMS-1488-P2-58-Attach-1.DOC

June 8, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1488-P
P. O. Box 8011
Baltimore, MD 21244-1850

Re: CMS-1488-P and P2, Medicare Program; Proposed Changes to the Hospital Inpatient Perspective Payment systems and Fiscal Year 2007 Rates; Proposed Rule

Dear Dr. McClellan:

On behalf of Clarian Health Partners, Inc., I appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the fiscal year (FY) 2007 inpatient prospective payment system (IPPS).

Clarian Health Partners, Inc. supports meaningful changes to the IPPS, however, we have concerns regarding proposed changes related to:

- DRG Changes
- Methodology utilized in developing HSRVcc
- Severity of Illness classifications
- Proposed changes in "allowable" rotations of Medical Residents
- Future Changes related to Quality Measure & Reporting

We appreciate the opportunity to comment on the proposed changes and your consideration of those comments.

Attached, please find detailed comments.

Sincerely,

Shirley W. Bishop
Director, Revenue, Reimbursement & Government Programs

enclosures

Clarian Health Partners, Inc.
Comments on the FY 2004 IPPS Proposed Rule

Proposed Changes

HSRV Weights

We support the move to a cost based weighting system. However, the approach utilized by CMS aggregates the costing into 10 "national" cost centers (routine day, intensive care days, and eight ancillary cost centers); this is an over simplification of a hospital's operations and we believe could lead to increased variation as cost of services available only at high acuity facilities, such as tertiary and/or teaching facilities are "normalized" into 8 ancillary categories and thus factor into payment to providers that do not offer such services while harming those that do by diluting a "cost center" by defining too broadly. Review of cost center and related cost report line subscripting as they relate will reflect the variation of services and related cost.

More time is needed to determine a "best methodology" for cost-based weights. Clarian Health Partners is willing to work with CMS, as we believe most providers would be, to develop sound changes relative to such a conversion.

New Patient Classification: Severity of Illness

We support the move to a more refined DRG system which recognizes severity of the individual patient. However, we are concerned that implementing proposed changes to specialty DRG's, as proposed for FY 2007, without implementation of severity will further harm those general acute care facilities from which the "specialty" facilities diverted the less severe patients in those DRG's.

Additionally, we are concerned that another grouping system has been developed. We would suggest simply utilizing the APR DRG system that is already developed, and addresses severity issues and does not add more expense and administrative burden for many facilities.

Resident Time in Patient Activities

We strongly urge the Agency to rescind the purported "clarification" in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments. The stated rationale for the exclusion of time devoted to these activities is that they are not "related to patient care". The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a non-hospital setting, such as a physician's office or affiliated medical school.

The proposed rule position is in stark contrast to the Agency's position as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures...and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins].

We support the Agency's 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. We urge CMS to withdraw its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Other Future Concepts (Transparency of Health Care Information, Hospital Value-based Purchasing, Information Technology, Hospital-acquired Infections

We support the movement to such transparency and reporting, however we believe the comment period was too short to adequately evaluate and comment on such broad sweeping ideas and urge continued dialogue with providers and industry experts to develop these important measures.

Submitter : Gregory Forzley **Date: 06/12/2006**

Organization : Gregory Forzley

Category : Physician

Issue Areas/Comments

GENERAL

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This is contrary to the model for graduate medical education. This position would reverse the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
With the possible exception of extended time for bench research (not usually part of primaary care training), there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is patient care delivered under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner, including how to run a practice and work within regulations.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, this policy would likely require additional staff that would be responsible for monitoring each of these didactic sessions to keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

As a family physician, I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Gregory Forzley, MD,
Medical Director, Informatics
and Volunteer faculty, GRMERC and MSU

Submitter : **Dr. Ron Stock** **Date: 06/12/2006**

Organization : **PeaceHealth Oregon Region**

Category : **Physician**

Issue Areas/Comments

GENERAL

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As a family physician, I appreciate the 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 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

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I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Ron Stock, MD
Eugene, Oregon

Submitter : **Mr. Dennis Fuller** **Date: 06/12/2006**

Organization : **Shands HealthCare**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Mr. Scott Davis** **Date: 06/12/2006**

Organization : **Memorial Healthcare System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Please See Attachment.

Thank you for the opportunity to comment.

Scott Davis
Director of Revenue Cycle Management
Memorial Healthcare System
Hollywood, FL 33121
sdavis@mhs.net

CMS-1488-P2-62-Attach-1.DOC

MEMORIAL REGIONAL HOSPITAL • JOE DIMAGGIO CHILDREN'S HOSPITAL
MEMORIAL HOSPITAL WEST • MEMORIAL HOSPITAL MIRAMAR • MEMORIAL HOSPITAL PEMBROKE

June 12, 2006

Mr. Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1488-P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: CMS-1488-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule, and CMS-1488-PS, Medicare Program; Hospital Inpatient Prospective Payment Systems Implementation of the Fiscal Year 2007 Occupational Mix Adjustment to the Wage Index

Dear Dr. McClellan:

Thank you for this opportunity to submit comments to the Centers for Medicare and Medicaid Services (CMS) on the fiscal year 2007 inpatient prospective payment system and occupational mix adjustment proposed rules.

Memorial Healthcare System is a multi-hospital, governmental healthcare organization located in South Florida. We are comprised of four hospitals, a freestanding nursing home, and a number of outpatient clinics and health services. For the year ended April 30, 2006, we admitted almost 75,000 patients and furnished over 630,000 outpatient visits and more than 250,000 emergency room visits. Medicare patients (excluding those in Medicare managed care plans) represented almost 20 percent of our service population.

The sweeping changes proposed to the calculation of diagnosis-related group (DRG) relative weights and refinement of DRGs to account for patient severity will significantly redistribute Medicare funding among hospitals and across cases within hospitals. While our initial analysis indicates a marginal benefit to our health system, methodological and data problems in CMS's calculations leave us no confidence that this benefit is real.

We believe that refining the DRG system to provide more consistent returns across all DRGs is an appropriate goal and will help address current trends of steering highly profitable patients to limited service hospitals. However, we are seriously concerned that

3501 Johnson Street / Hollywood, FL 33021 / 954-987-2020

South Broward Hospital District

the methods proposed by CMS not only do not achieve this goal, but also have significant negative consequences.

Specifically, we request that you consider the following:

- **Simultaneous Adoption of Any Changes to Weights and Classifications:** If more effective methods for computing DRG weights and classifying cases are available, then we support adoption of them together, rather than sequentially, particularly since they largely offset each other. Separate implementation creates unnecessary volatility and uncertainty, counter to the goal of improving payment accuracy.

- **Valid Cost-based Weights:** We support the use of a cost-based weighting methodology for determining relative DRG weights, but the methodology proposed by CMS is flawed.

- **Selection of an Appropriate Classification System:** Any new system of classification needs to adequately address both clinical severity and resource consumption, and must be adopted only after it can be shown to be a real improvement over the current system. That analysis requires a system that is fully available to the public.

- **Delay Until Truly Ready:** We support CMS's efforts to improve the prospective payment system so that Medicare payments better reflect Medicare costs. However, analyses by a number of groups of the proposed cost-based weighting methodology and the CS-DRG system indicate there are many flaws yet to be addressed which cannot be adequately dealt with before the payment rules for fiscal year 2007 must be finalized. At a minimum, a one-year delay is advisable, which would also help synchronize adoption of both changes. If the goal is improved accuracy, we would caution against undue haste.

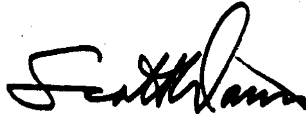
- **Transition Period:** Given the significant redistribution of payments expected as a result of these changes, and the degree of business evolution that will be required to adjust to those changes, we support implementation with a three-year transition period.

- **Mid-Year Wage Index Corrections:** Adoption of area wage index (AWI) values that incorporate a full occupational mix adjustment depends entirely on receipt of accurate and complete information. Given the rushed data collection process for the first three months data set, we recommend allowing data to be corrected and/or completed beyond July 13 as a resubmission with the second three months data set, and that the revised data for six months be used to establish weights as of January 1, 2008.

We have enclosed detailed comments that further explain our position on the points above.

Memorial Healthcare System appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me.

Sincerely,



Scott J. Davis, CPA FHFMA
Director of Revenue Cycle Management
Memorial Healthcare System
3501 Johnson Street
Hollywood, FL 33021

(954) 987-2020 ext. 5105
SDavis@mhs.net

Detailed Comments on Proposed Changes to the Hospital Inpatient Prospective Payment System for Fiscal Year 2007

DRG Reclassifications

DRGs: Carotid Artery Stents. We oppose the proposed delay in making any changes to carotid artery stent cases. The higher costs associated with carotid stents should be recognized within the existing DRG system, and not delayed until implementation of a new system. The cost of these stents ($2,100 each) plus the distal embolic protection devices required ($1,495 each) support a higher weight for these cases than for cases in these DRGs that do not include devices.

DRGs: Complications/Comorbidities (CC) Categories 403-404.

For categories 403 (Hypertensive Chronic Kidney Disease) and 404 (Hypertensive Heart and Chronic Kidney Disease), the fifth digit of the IDC-9-CM code relates to the patient's stage of chronic kidney disease. A fifth digit "0" is used to identify patients "with chronic kidney disease stage I through stage IV or unspecified," while fifth digit "1" identifies patients "with chronic kidney disease stage V or end stage renal disease." As such, Table 6E of the proposed rule has identified codes 403.10, 403.90, 404.10 and 404.90 as non-CCs. The stages of chronic kidney disease are a fairly new concept introduced into the ICD-9-CM classification last year, which physicians do not routinely document in the medical record. Many physicians still document the older and more common term "chronic renal failure," which translates into "unspecified stage" in the ICD-9-CM. Also, physicians differ in their opinion of what constitutes renal failure – whether it starts in the middle of stage III, stage IV or stage V.

While we understand that CMS may not want to consider a code that would include patients in the early stages of hypertensive kidney disease as a CC, because of the potential inclusion of more serious chronic renal failure patients in these codes, we recommend that CMS instead rely on the supplemental code from category 585 (Chronic Kidney Disease) to recognize the CC.

DRG System Changes

DRG Weights. CMS has proposed the use of hospital-specific relative values (HSRVs) and a modified version of cost-based weights rather than charge-based weights in fiscal year (FY) 2007. The methodology proposed by CMS differs significantly from the one proposed by MedPAC, based on the CMS concern that the MedPAC method is overly burdensome. However, analysis of the CMS proposal by the American Hospital Association, the Hospital Association of Greater New York, and others indicates serious flaws in both the methodology used for and accuracy in calculation of the proposed weights.

Insufficient details have been provided and too little validation has been done to show that this methodology actually improves payment accuracy over either the current system or the one proposed by MedPAC.

DRGs: Severity of Illness. CMS also proposes moving to a new patient classification system that would group patients into 861 consolidated severity-adjusted DRGs, or CS-DRGs. These CS-DRGs are designed to reflect the relative clinical severity of cases, but not the relative resource consumption of different types of cases, a step backwards from the current system. In addition, CMS's approach to consolidating 3M's all-patient refined DRGs (APR-DRGs) results in classifications that are neither clinically coherent or resource coherent. Finally, the actual grouper used by CMS for its analysis is a proprietary system that has not been subjected to public review and analysis.

With regard to both of the above CMS proposals, we recommend the following:

- **Simultaneous Adoption of Any Changes to Weights and Classifications:** If more effective methods for computing DRG weights and classifying cases are available, then we support adoption of them together, rather than sequentially, particularly since they largely offset each other. Separate implementation creates unnecessary volatility and uncertainty, counter to the goal of improving payment accuracy.

- **Valid Cost-based Weights:** We support the use of a cost-based weighting methodology for determining relative DRG weights, but the methodology proposed by CMS is flawed.

- **Selection of an Appropriate Classification System:** Any new system of classification needs to adequately address both clinical severity and resource consumption, and must be adopted only after it can be shown to be a real improvement over the current system. That analysis requires a system that is fully available to the public.

- **Delay Until Truly Ready:** We support CMS's efforts to improve the prospective payment system so that Medicare payments better reflect Medicare costs. However, analyses by a number of groups of the proposed cost-based weighting methodology and the CS-DRG system indicate there are many flaws yet to be addressed which cannot be adequately dealt with before the payment rules for fiscal year 2007 must be finalized. At a minimum, a one-year delay is advisable, which would also help synchronize adoption of both changes. If the goal is improved accuracy, we would caution against undue haste.

- **Transition Period:** Given the significant redistribution of payments expected as a result of these changes, and the degree of business evolution that will be required to adjust to those changes, we support implementation with a three-year transition period.

Other Proposed Rules

Occupational Mix Adjustment. CMS is required to collect data every three years on the occupational mix of employees from hospitals subject to the inpatient PPS in order to construct an occupational mix adjustment to the wage index to control for the effect of hospitals' employment choices rather than geographic differences in the costs of labor.

CMS initially stated in the proposed rule that it would again limit the occupational mix adjustment to 10 percent because of concerns regarding the validity of the data and the potential financial impact on hospitals. However, as a result of the decision handed down by the U.S. Court of Appeals for the Second Circuit on April 3 in *Bellevue Hospital Center v. Leavitt*, CMS on May 12 released a proposed rule revising the occupational mix adjustment portion of the FY 2007 inpatient PPS proposed rule. Under the court ruling, CMS must collect new data on the occupational mix of hospital employees and fully adjust the area wage index (AWI) for FY 2007.

Hospitals are required to collect the hours and wages for employees from January 1 through June 30, 2006. Data initially was supposed to be collected by July 31; however, hospitals were required to submit data by June 1 for the first calendar quarter of the year and by August 31 for the second calendar quarter. Data from the first quarter will be used to adjust the FY 2007 AWI, while data for the full six months will be used to adjust the AWI for FYs 2008 and 2009.

Because data from all hospitals is needed to construct an accurate national average hourly wage, full participation is critical. There is a general sentiment that hospitals that do not participate should not benefit from the participation of others. However, given the rushed collection and general confusion around the interim-collection, we believe that, to the extent possible, **CMS should substitute data from the previous survey for hospitals that did not turn in their data for the first calendar quarter of 2006.**

Hospitals will have more notice and time to submit data for the second calendar quarter in August. Thus, moving forward CMS should consider a methodology that penalizes hospitals that do not participate. We caution CMS not to simply substitute unfavorable data for these hospitals, as it also will impact other area hospitals that conscientiously reported data. CMS could alternatively substitute the national average hourly wage for non-responsive hospitals in calculating an area's wage index or omit those hospitals from the calculation, and then require hospitals that did not turn in data to use something lower than their area's wage index. This would avoid CMS having to create an extensive hospital-specific wage index table and would minimize the effects on the other hospitals in the area. **We urge CMS to construct an application of the occupational mix adjustment that encourages hospitals to report but does not unfairly penalize neighboring hospitals.**

Corrections. **We urge CMS to allow hospitals to turn in both calendar quarters of data in August whether for the first time or with corrections.** Again, as this

collection has been rushed, the idea is to allow hospitals to improve the data for the FYs 2008 and 2009 adjustment. For hospitals that were previously non-responsive, the submission of the first calendar quarter would remove any penalty, while those that continue to be non-responsive will continue to incur a penalty. In addition, if there is a significant difference between AWI values computed using the first quarter data and values computed using the full data set, then we encourage CMS to make a one-time mid-year correction to the AWI as of January 1, 2007.

Comment Timeframe. While we understand that CMS is under severe time pressure due to the timing of the court's decision, we do not believe that the 30-day comment period was sufficient, as hospitals were busy during this time trying to meet the new survey deadline and answering requests for information from the fiscal intermediaries. In addition, we believe it would be appropriate for CMS to take comments on the calculation after the initial results of the survey are tabulated and posted. The results of the survey could be material. For instance, if the segregation of RNs who are management versus RNs who are staff does not produce a reliable result, CMS might consider consolidating the two for the purposes of the calculation. While CMS might not have time to make such changes for FY 2007, it could entertain comments on the implementation for FYs 2008 and 2009. **Thus, we urge CMS to publish the occupational mix adjustment changes as an interim-final rule in August with an associated comment period.**

Outlier Payments. The rule proposes establishing a fixed-loss cost outlier threshold equal to the inpatient PPS rate for the DRG, including indirect medical education (IME), disproportionate share hospital (DSH), and new technology payments, plus $25,530. While this is not a particularly sizable increase from the FY 2006 payment threshold of $23,600, we are very concerned that the threshold is too high. According to analyses by the American Hospital Association, actual outlier payments for FY 2006 are estimated to be 0.47 percentage points lower than the 5.1 percent of funds withheld from hospitals to fund outlier payments. CMS spent only 3.8 percent, or $1.15 billion less than set aside in FY 2005, and only 3.5 percent, or $1.3 billion less than the funds withheld in 2004.

In the rule, CMS proposes to use a one-year average annual rate-of-change in charges per case from the last quarter of 2004, in combination with the first quarter of 2005, to the last quarter of 2005, in combination with the first quarter of 2006, to establish an average rate of increase in charges. This results in a 7.57 percent rate of change over one year, or 15.15 percent over two years.

We appreciate that CMS is proposing this methodology in an effort to avoid using data from 2003 when charges may have been atypically high. **However, using the proposed charge inflation methodology will only result in an inappropriately high outlier threshold and a real payment cut to hospitals. We strongly oppose using this methodology to estimate the outlier threshold.**

The AHA conducted a series of analyses to identify a more appropriate methodology and included a description of their methodology in their comments to this proposed rule. The AHA methodology accounts not only for inflation in charges, but also inflation in costs, so that an "apples-to-apples" comparison is made. The estimated fixed-loss amount that would result in 5.1 percent outlier payments under this methodology is $24,000. **We urge CMS to strongly consider using the methodology described by the AHA.**

Hospital Quality Data. CMS proposes expanding the list of quality measures that must be reported in order to receive a full market basket update to a hospital's payment rate. While we support the expansion of the indicator list, the proposed rule, as written, would require hospitals to reopen files from which data have already been abstracted, renegotiate agreements with the vendors that assist them in collecting and processing the required information, and resubmit information to the clinical data warehouse. Such retroactive alterations in the data files are difficult and costly, and open the door for the introduction of many new kinds of errors in the data. To require this reopening of the files makes no sense. **CMS should make the data collection prospective. This could be accomplished by requiring that hospitals that want a full market basket update pledge to submit the relevant data for all 21 measures for patients beginning on or after July 1.**

Transparency of Health Care Information. The proposed rule includes the introduction of a proposed initiative to expand the public availability of consumer information on health care quality and pricing. In the proposed rule, CMS details four options for providing pricing information to health care consumers, including:

- Publishing a list of hospital charges, either for every region of the country or selected regions of the country;

- Publishing the rates that Medicare actually pays to a particular hospital for every DRG, or for selected DRGs, which could be adjusted to account for the hospital's labor market area, teaching hospital status and DSH status;

- Establishing conditions of participation for hospitals that relate to the posting of prices and/or the posting of their policies regarding discounts or other assistance for uninsured patients; and

- Posting total Medicare payments for an episode of care. Under this proposal, CMS could include the costs for an inpatient hospital stay, physician payments (including the surgeon and the anesthesiologist), and payments for post-acute care services such as those provided in an inpatient rehabilitation facility, skilled nursing facility or LTCH for a certain service (such as hip replacement).

On June 1, 2006, CMS announced the posting of hospital payment information on its web site. This posting shows the Medicare payment rate, by DRG for all hospitals. It is presented as a range from the 25th to 75th percentiles, and is grouped by payment area

(metropolitan area or rural area), and so is not hospital-specific, but it does make progress toward the second option, above.
Publishing a list of hospital charges, either nationally or in the hospital, is not likely to yield information that is meaningful to most patients. Memorial Healthcare System's charge listing includes over 90,000 items, a necessity for dealing with the billing requirements of Medicare and other payors.

The prices attached to these items generally do not reflect the amount a patient would pay, since insured patient liability is limited to copayment amounts unique to each policy, and uninsured patients are eligible for significant discounts from charges according to their income level. In addition, patients usually do not consume the same resources, even when classified into the same DRG or when receiving the same surgery, so exact quotes of prices would not be possible in advance.

Most States have already initiated processes for obtaining and publicizing information on hospital prices. The majority of these processes are relatively new, and have not yet had time to be evaluated for their effectiveness. For example, www.floridacomparecare.gov provides both quality and charge data.

Before CMS steps in to regulate on this subject, we encourage CMS to review the efforts already undertaken at the State level and evaluate whether State regulation is more representative of local consumer needs, more effective, and more cost-effective.

Submitter : **Ms. Donna Katen-Banhensky**
Organization : **University of Iowa Hospitals & Clinics**
Category : **Hospital**

Date: 06/12/2006

Issue Areas/Comments

GENERAL

GENERAL

"See comments in the attachment"

CMS-1488-P2-63-Attach-1.RTF

UNIVERSITY of IOWA HOSPITALS & CLINICS
University of Iowa Health Care

University of Iowa Hospitals and Clinics

Hospital Administration
200 Hawkins Drive, 1353 JCP
Iowa City, Iowa 52242-1009
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319-356-3862 ***Fax***
www.uihealthcare.com

June 12, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Service
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Via electronic comment: http://www.cms.hhs.gov/eRulemaking

Attention: CMS–1488–P

Dear Dr. McClellan:

The University of Iowa Hospitals & Clinics (UIHC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled, *"Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates"* 71 Fed. Reg. 23996 (April 25, 2006).

We strongly urge CMS to rescind the clarification in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments and to recognize the integral nature of these activities to the patient care experiences of residents during their residency programs. The proposed rule position is in stark contrast to the Agency's position as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins].

The UIHC is not opposed to moving to a DRG weighting methodology based on the costs of providing care so long as it improves the accuracy of the payment system and the methodology is sound, stable, and reliable. However, developing "cost based" weights is a complex undertaking and the methodology developed by the Medicare Payment Advisory Commission (MedPAC) is significantly different than the HSRVcc methodology. Considering the significance of the proposed changes to relative weights, the UIHC believes more work is needed to determine the best way to develop cost-based weights. Implementation of a cost-based methodology should be delayed to permit additional work

with the hospital field and then cost-based weights should be implemented simultaneously with an appropriate expansion of the current DRGs.

Refinement of DRGS to better reflect patient severity and complexity is a desirable goal. The UIHC, however, has serious concerns whether the proposed CS-DRGs achieve this goal. This too is an area where further study and refinement is necessary.

As CMS considers changes in the Medicare program likely to result in a significant payment redistribution across DRGs and hospitals, the UIHC advocates that an appropriate transition period accompany the changes. This practice has been utilized by CMS in the past and would also be warranted here.

Thank you for your consideration of these comments. Should you have any questions, Please feel free to contact me at donna-katen-bahensky@uiowa.edu or (319) 356-3155.

Sincerely,

Donna Katen-Bahensky
Director and Chief Executive Officer

Submitter : **Ms. Heather Hulscher**

Date: 06/12/2006

Organization : **Iowa Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Ms. Suzanne Heck** **Date: 06/12/2006**

Organization : **Memorial Health University Medical Center, Inc.**

Category : **Hospital**

Issue Areas/Comments

Implementation of Proposed FY 2007 Occupational Mix Adjustment

Implementation of Proposed FY 2007 Occupational Mix Adjustment

See Attached

CMS-1488-P2-65-Attach-1.DOC

June 12, 2006

The Honorable Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS –1488– P2
P.O. Box 8012
Baltimore, MD 21244-8012

Occupational Mix Adjustment to Wage Index Background

Section 1886(d)(3)(E) of the Act provides for the collection of data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. The purpose of the occupational mix adjustment is to control for the effect of hospitals' employment choices on the wage index. For example, hospitals may choose to employ different combinations of registered nurses, licensed practical nurses, nursing aides, and medical assistants for the purpose of providing nursing care to their patients. CMS contends that the varying labor costs associated with these choices reflect hospital management decisions rather than geographic differences in the costs of labor. This proposed rule would revise the methodology for calculating the occupational mix adjustment announced in the Fiscal Year (FY) 2007 Hospital Inpatient Prospective Payment System (IPPS) proposed rule by applying the occupational mix adjustment to 100

"Implementation of the Proposed FY 2007 Occupational Mix Adjusted Wage Index"

Although we understand that the intent of the occupational mix adjustment is to control for the effects of managements employment choices, the application of this methodology penalizes providers whose mission is to provide for the healthcare needs of the community, and rewards those providers that do not. MHUMC is the regions safety net hospital and the exclusive provider of vital services such as Level I Trauma, Neonatal Intensive Care, Pediatric Nephrology, High Risk Obstetrics, and Pediatric Cardiology just to mention a few. It is MHUMC's decision to provide these vital but non-profitable services to our community based on the healthcare needs of our population. Higher skill levels are required and higher labor costs are inherent to services such as these.

When adjusting the wage index to remove occupational mix differences, the adjustment fails to recognize differences between providers in the kinds of services that they provide, services that require a higher skill mix. Unfortunately, the only thing the occupational mix is accomplishing is the unjustified reduction in reimbursement to hospitals providing vital services to their community, services that are provided based on community need rather than profitability. In order to successfully remove the effects of occupational mix differences, the hospitals would have to deliver the exact same kinds of services with the same skill level requirements.

In addition, the intent to publish the final rule before CMS is able to make available to providers the final Occupational Mix Adjusted Wage Index is utterly ridiculous and reckless. Without the opportunity to review, it is inevitable that these adjusted wage indices will be riddled with errors. These errors could cost a provider millions in reimbursement and hundreds of thousands in litigation to rectify.

The recent decision by the Second Circuit Court of Appeals ordering CMS to apply the occupational mix adjustment to 100% of the wage index in fiscal year 2007 only exasperates this detrimental policy. The Courts decision obviously neglected to consider the negative ramifications of its actions. This is a biased decision that benefits one at the expense of many. The CBSA Wage Index, with all of its flaws and inequities, is a better indication of a provider's Wage Index than the current Occupational Mix Adjusted Wage Index fiasco. CMS should immediately repeal the Occupational Mix Adjustment to the Wage Index and begin work on a wage index methodology that is sound.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 section 501(c) directs the General Accounting Office to conduct a study upon enactment to determine (1) the appropriate level and distribution of Medicare payment in relation to costs for short-term general hospitals under the inpatient prospective payment system and (2) the need for geographic adjustments to reflect legitimate differences in hospital costs across geographic areas, kinds of hospitals, and types of cases. The lack of consideration given by the Occupational Mix Adjustment to the Wage Index to the kinds of hospitals and types of cases is a complete disregard to the intent of the MMA.

MHUMC supports the development of a hospital specific wage index methodology adjusted to reflect legitimate differences in hospital costs across geographic areas, kinds of hospitals, and types of cases. Any Wage Index Methodology must eliminate the current inequities; the biggest of all being the ability of providers that are less committed to their community from receiving undeserved reimbursement by simply riding the coattails of the more advanced hospitals within their CBSA.

Thank you for considering our remarks on the proposed rule. If you have any questions about our comments, please feel free to contact me.

Sincerely,

Suzanne Heck
CFO, MHUMC

CC: Bob Colvin, President and CEO, MHUMC
Darcy Davis, VP of Finance, MHUMC
Margaret Gill, Senior VP of Operations, MHUMC
Amy Hughes, VP of Government Relations, MHUMC

Submitter : **Ms. Heather Hulscher** **Date: 06/12/2006**

Organization : **Iowa Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P2-66-Attach-1.WPD

IOWA HOSPITAL ASSOCIATION

June 12, 2006

Dr. Mark McClellan, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 1488-P2
P.O. Box 8012
Baltimore, MD 21244-8012

Ref: CMS—1488-P2 Medicare Program; Hospital Inpatient Prospective Payment Systems Implementation of the Fiscal Year 2007 Occupational Mix Adjustment to the Wage Index. (71 *Federal Register* 28644), May 17, 2006.

Dear Dr. McClellan,

On behalf of Iowa's 35 hospitals reimbursed under the Medicare Inpatient Prospective Payment System (PPS), the Iowa Hospital Association (IHA) is pleased to take this opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the FY 2007 Occupational Mix Adjustment to the Wage Index published in the May 17, 2006 *Federal Register.*

Occupational Mix Adjustment

In response to a Medicare Payment Advisory Commission (MedPAC) recommendation, Congress passed legislation creating the occupational mix component of the wage index calculation to adjust for this payment inequity. Section 304 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) requires the Secretary of Health and Human Services to collect data every three years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program (excluding Critical Access Hospitals), in order to construct an adjustment to the wage index beginning October 1, 2004.

IHA supports the legislation Congress passed creating an occupational mix adjustment to ease the payment inequities caused by the Medicare wage index. However, to date, CMS has been unsuccessful in developing a methodology or data collection tool that achieves the intention of the legislation and mitigates payment inequity. In fact, the methodology implemented by CMS has exacerbated the inequity in most geographic locations. **Eight of Iowa's 10 geographic locations have been financially harmed by the occupational mix adjustment.**

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www.ihaonline.org

From 2001 to present, CMS has attempted several times to develop a reliable data collection tool and methodology to apply the occupational mix adjustment. The first application of the occupational mix adjustment occurred in fiscal year (FY) 2005. Due to substantial data integrity concerns, CMS only applied 10 percent of the occupational mix adjustment to the area wage index. The methodology applied in FY 2005 and FY 2006 resulted in 17 rural areas experiencing a decrease in wage indices, while 178 urban areas experienced an increase in wage indices nationwide. One third of rural hospitals actually fare worse under this occupational mix methodology. The state of Iowa, which is largely rural, has long experienced payment inequities in the Medicare program and continues to experience payment inequities despite Congressional action intended to ease the financial burden.

CMS intended to apply the same data and adjustment percentage applied to the FY 2005 and FY 2006 wage indices to adjust the FY 2007 wage data. However, as a result of the April 2006 Court of Appeals decision, *Bellevue Hospital Center v. Leavitt*, CMS issued a proposed rule to apply the occupational mix adjustment to 100 percent of the wage index effective for FY 2007. According to the proposed rule, CMS intends to base the FY 2007 occupational mix adjustment on only three months of un-audited data. Further, the methodology by which CMS will apply the occupational mix adjustment in FY 2007 is not yet known, making it impossible for hospitals to quantify and prepare financially. **What is known is the calculation in place today, if applied at 100 percent, would reduce payments to Iowa's 35 PPS hospitals by over <u>$4 million annually</u>.**

The inverse outcome of the occupational mix adjustment appears to result from data collected by CMS and the assumptions the agency is utilizing in the process. For example, it is unclear why CMS has chosen to focus on nursing hours and wages, yet has excluded other staff such as laboratory and radiology personnel. Management decisions do not solely account for the number of registered nurses a hospital employs as compared to licensed practical nurses due to supervision ratios dictated by CMS rules. By not recognizing the occupational mix of hospital ancillary departments such as radiology, laboratory, and therapy, CMS fails to capture data for staffing patterns that are a result of management decisions. IHA supports data collection of expanded employment categories to recognize different staffing patterns in rural areas.

IHA also has concerns that CMS intends to apply the occupational mix adjustment for FY 2007 based upon three months of un-audited data. IHA firmly believes it is crucial for hospitals to have an opportunity to review the finalized occupational mix data submitted to ensure its accuracy and appeal incorrect information. IHA also asserts that the data collection should occur on a January 1 through December 31 time period to improve data accuracy by accounting for staffing fluctuations throughout the year and allow for comparisons with W-2 and other Internal Revenue Service filings. Furthermore, IHA supports the 2002 MedPAC recommendation to collect occupation-specific data on wages and hours using the hospital annual Medicare Cost report, as is done for other data collected for the wage index calculation. The use of the cost report would allow data used for the occupational mix adjustment to come from the same time period as the wage index data, instead of the current four-year gap.

IHA believes the current data collection and methodology for the Medicare occupational mix adjustment does not fulfill the intent of Congress and fails to mitigate payment inequity to rural areas such as Iowa. Rather, the methodology implemented by CMS has had the inverse outcome, generally increasing payment to urban areas and decreasing payment to rural areas. CMS needs to re-evaluate the data requested and the methodology for the Medicare occupational mix adjustment to result in more equitable payments for rural areas under the Medicare payment system.

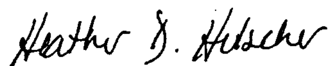
Specifically, a new occupational mix methodology should include the following:

- **The data collection tool should be expanded to ancillary employment categories such as radiology, laboratory, and therapy to recognize different staffing patterns in rural areas that are a result of management decisions.**
- **The data collection should occur on a January 1 through December 31 time period to improve data accuracy by accounting for staffing fluctuations throughout the year and allow for comparisons with W-2 and other Internal Revenue Service filings.**
- **CMS should collect occupation-specific data on wages and hours using the hospital annual Medicare Cost report, as is done for other data collected for the wage index calculation.**
- **An opportunity for hospitals to review the finalized occupational mix data submitted to ensure its accuracy and appeal incorrect information.**

While IHA appreciates that CMS is under severe time pressure due to the timing of the court's decision, we do not believe that the 30-day comment period was sufficient, as hospitals were busy during this time trying to meet the new survey deadline and answering requests for information from the Medicare fiscal intermediaries. In addition, it would be appropriate for CMS to take comments on the calculation after the initial results of the survey are tabulated and posted. While CMS might not have time to make such changes for the beginning of FY 2007, the agency has set a precedent for making corrections to wage indices throughout the year, and CMS could entertain comments on the implementation for FYs 2008 and 2009. **IHA urges CMS to publish the occupational mix adjustment changes as an interim-final rule in August with an associated comment period.**

Thank you for your review and consideration of these comments. If you have questions, please contact me at the Iowa Hospital Association at 515/288-1955.

Sincerely,



Director, Finance Policy

cc: Iowa Congressional Delegation
Iowa Hospital Association Board of Trustees
Iowa Hospitals
CMS Kansas City Regional Office

Submitter : **Ms. Jo Ann Webb** **Date: 06/12/2006**

Organization : **American Organization of Nurse Executives (AONE)**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

June 12, 2006

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services (CMS)
P.O. Box 8011
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Dr. McClellan:

I am writing to you on behalf of the over 5,000 members of the American Organization of Nurse Executives (AONE) who as Registered Professional Nurses provide executive nursing leadership in America s hospitals and in the health systems field.

As a professional nursing organization directly involved with the day-to-day operations and delivery of patient care, we appreciate this opportunity to comment on CMS proposed Diagnosis Related Groups (DRG) changes in the inpatient prospective payment system rule: RE CMS-1488-P Medicare Program: Proposed Changes to the Hospital Prospective Payment Systems for Fiscal Year 2007 Rates. Our interest in this proposal lies in the opportunity it presents to directly factor nursing into the DRG system. It also provides an opportunity to further validate research on the economic relationship of nursing care costs to staffing, education, quality and patient outcomes.

The CMS stated goal is to align future hospital payment with actual cost expenditures; however under the current system it is not possible to calculate the true cost or impact of nursing care. Under the original conceptualization of the DRG System, arguments were made to create a separate cost center for nursing; however, the final design subsumed these costs in what has evolved as room and board room costs. Since the design of the DRG system, nursing research has evolved to show the critical relationship between nursing education, the hours of professional nursing care, and patient outcomes. If the overall intent of CMS is to change the current prospective payment system to reflect the cost of care and accommodate varying levels of acuity, the contributions of nursing must be directly reflected in whatever system is developed and implemented.
As a practitioner, you are aware of the tremendous changes that have occurred in our nation s hospitals and the impact of this change on nursing chare intensity.

This change is most evident in the complexity of the patient mix and the nursing
skill and intensity that must be employed to effectively manage patients and save lives. In this context, we view the CMS proposal to develop a new patient classification system as an opportunity to begin a dialogue to examine and understand the true cost of nursing and its relationship to hospital costs. As CMS works to refine the classification system, nursing intensity should be considered along with diagnoses, procedures and other hospital resources as a factor that can distinguish new categories for patient classification. It is our hope that you will view our request as a call for action to bring a full and complete understanding to the complex world of hospital costs and provide recognition to the critical component of nursing care.

Thank you for the opportunity to comment. You may direct questions or comments concerning our remarks to me or Jo Ann Webb, senior director for federal relations and policy at (202) 626-2321 or jwebb@aha.org

Sincerely,

Kathleen D. Sanford, RN, MA, DBA, FACHE
President

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Mr. John Doherty** **Date: 06/12/2006**

Organization : **MeritCare Health System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P2-68-Attach-1.PDF

CMS-1488-P2-68-Attach-2.PDF

ATTACHMENT 1 TO #68

June 8, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1488-P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1488-P and P2, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule.

Dear Dr. McClellan:

On behalf of MeritCare Health System in Fargo, North Dakota I appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the fiscal year (FY) 2007 inpatient prospective payment system (PPS) and occupational mix adjustment proposed rules.

MeritCare Health System fully supports the comments and recommendations of the American Hospital Association (AHA) as outlined in their June 8, 2006 letter to CMS. As with AHA, MeritCare supports the intent of many of the proposed rule's provisions, however, we have serious concerns about the proposed methodology to implement the changes to the DRG weights and classifications. At this time, it is unclear what effect those changes will have on our ability to provide the best care to our patients.

Specifically MeritCare supports the following AHA recommendations:

- **One Year Delay:** MeritCare supports delaying the proposed DRG changes for one-year to address concerns with the HSRVcc and CS-DRG methodology.

- **Valid Cost-Based Weights:** MeritCare supports moving to a DRG- weighting methodology based on hospital costs rather than charges, but CMS' proposed HSRVcc method is seriously flawed.

- **New Classification System:**
  Much more work understanding the variation within DRGs and the best classification system to address that variation is still needed before CS-DRGs or any other system should be selected or advanced.

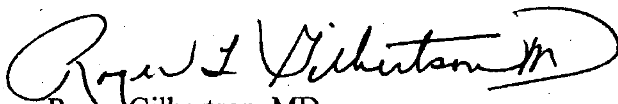
- **Simultaneous Adoption of Any Changes to Weights and Classifications:** If a more effective classification system is demonstrated and developed, it should be implemented simultaneously with the new weighting system to provide better predictability and smooth the volatility created by these two, generally off-setting changes.

- **Three-Year Transition:** Any changes should be implemented with a three-year transition, given the magnitude of payment redistribution across DRGs and hospitals. DRG criteria and information systems sound be made available in advance to allow preparation for implementation planning.

- **Provide Accounting Report:** "Budget neutrality" breakdown should be provided by CMS to demonstrate the accounting of the redistribution across DRGs and hospitals.

MeritCare appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me or Lisa Carlson, Chief Financial Officer at (701) 234-4811 or lisa.carlson@meritcare.com.

Sincerely,



Roger Gilbertson, MD
CEO/President

Cc: Honorable Senator Kent Conrad - North Dakota
Honorable Senator Byron Dorgan - North Dakota
Honorable Congressman Earl Pomeroy - North Dakota
Chip Thomas - North Dakota Healthcare Association

ATTACHMENT 2 TO #68

June 8, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1488-P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1488-P and P2, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule.

Dear Dr. McClellan:

On behalf of MeritCare Health System in Fargo, North Dakota I appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the fiscal year (FY) 2007 inpatient prospective payment system (PPS) and occupational mix adjustment proposed rules.

MeritCare Health System fully supports the comments and recommendations of the American Hospital Association (AHA) as outlined in their June 8, 2006 letter to CMS. As with AHA, MeritCare supports the intent of many of the proposed rule's provisions, however, we have serious concerns about the proposed methodology to implement the changes to the DRG weights and classifications. At this time, it is unclear what effect those changes will have on our ability to provide the best care to our patients.

Specifically MeritCare supports the following AHA recommendations:

- **One Year Delay:** MeritCare supports delaying the proposed DRG changes for one-year to address concerns with the HSRVcc and CS-DRG methodology.

- **Valid Cost-Based Weights:** MeritCare supports moving to a DRG- weighting methodology based on hospital costs rather than charges, but CMS' proposed HSRVcc method is seriously flawed.

- **New Classification System:**
  Much more work understanding the variation within DRGs and the best classification system to address that variation is still needed before CS-DRGs or any other system should be selected or advanced.

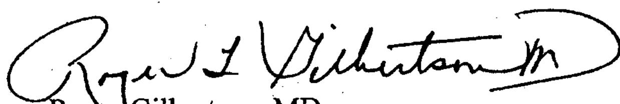
- **Simultaneous Adoption of Any Changes to Weights and Classifications:** If a more effective classification system is demonstrated and developed, it should be implemented simultaneously with the new weighting system to provide better predictability and smooth the volatility created by these two, generally off-setting changes.

- **Three-Year Transition:** Any changes should be implemented with a three-year transition, given the magnitude of payment redistribution across DRGs and hospitals. DRG criteria and information systems sound be made available in advance to allow preparation for implementation planning.

- **Provide Accounting Report:** "Budget neutrality" breakdown should be provided by CMS to demonstrate the accounting of the redistribution across DRGs and hospitals.

MeritCare appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me or Lisa Carlson, Chief Financial Officer at (701) 234-4811 or lisa.carlson@meritcare.com.

Sincerely,



Roger Gilbertson, MD
CEO/President

Cc: Honorable Senator Kent Conrad - North Dakota
Honorable Senator Byron Dorgan - North Dakota
Honorable Congressman Earl Pomeroy - North Dakota
Chip Thomas - North Dakota Healthcare Association

Submitter : **Dr. Jessica Barnhill** **Date: 06/12/2006**

Organization : **GLFHC**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

As a family physician, I appreciate the 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 2007 Rates." 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in "patient care activities." The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician's office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not "related to patient care".

This position reverses the Agency's position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty." [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency's 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for "bench research," there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician's educational development into an autonomous practitioner.

To separate out CMS's newly defined "patient care time" from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Sincerely,

Dr. Jessica Barnhill

Submitter : **Mrs. Marilyn Lawrence**

Date: 06/12/2006

Organization : **Lee Memorial Health System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attention: CMS-1488-P2

Date: 6/12/06

Category: DRG s: MCV s and Defibrillators

Regarding the decision to not split DRG 515 and 536 based on the presence of a MCV: I strongly urge you to re-evaluate changes in the inclusion criteria for reimbursement for defibrillator implant in recent years (G0299, G0300). Based on research (i.e. MADIT II study), there is a large population of the nation that may be at risk for sudden cardiac death. To protect its citizens, CMS reacted accordingly by broadening the acceptable inclusion criteria for reimbursement. As a result, our organization s volume of ICD implants experienced a phenomenal 66% growth from FY 04 to FY 05.
It is understood when examining your statistics, (only $3430 difference in charges for those with a MCV), why you are reluctant to split DRG 515. From an organizational standpoint however, any increase in reimbursement based on MCV is critical to remain solvent while serving our community.

Regarding the decision not to split DRG 535 based on the MCV list would place all of the cases in a DRG with a MCV: While this may be true, I question whether all cases would fall into a DRG with MCV. If this is true, the population needing a defibrillator is medically complex and as a result, organizations should be reimbursed compensatory with the complexity of patients being treated.

Submitter:
Marilyn Lawrence MS, RT(R), RCIS
Financial Services: Charge Master/APC Specialist- Cardiology Services
Lee Memorial Health System
224 Santa Barbara, Suite 203
Cape Coral, FL 33991-2031 .

Submitter : **Mr. Ronald Ashworth**

Date: 06/12/2006

Organization : **Sisters of Mercy Health System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P2-71-Attach-1.PDF

ATTACHMENT TO # 71

SISTERS OF MERCY
HEALTH SYSTEM

June 12, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-PN2
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-8012

RE: "Medicare Program; Hospital Inpatient Prospective Payment Systems Implementation of the Fiscal Year 2007 Occupational Mix Adjustment to the Wage Index"

The Sisters of Mercy Health System (Mercy) is a 19-hospital system operating in Missouri, Kansas, Oklahoma, and Arkansas. We have a significant number of inpatient stays and rely heavily on Medicare as a major payor for those services. We are writing to provide comments in areas of concern relating to the proposed rule. Thank you for considering our comments.

Specifically, we offer the following comments:

Background

We are concerned about the implications of the court-mandated application of the occupational mix adjustment to 100 percent of the wage index beginning FY 2007. Previously, CMS only applied the occupational mix adjustment using 10 percent of the adjustment factor in calculating the wage index values as they recognized the inaccuracies in the data collected in the past. We understand the restraint CMS is under in light of the court order to utilize 100% of the occupational mix adjustment. However, the extremely tight timeframe provided to the hospital community to supply the new data for the occupational mix survey combined with the potential for large variances to occur when calculating the final wage index factor for FY 2007 is of great concern. At this point, there has been no projected impact made to determine what constraints this may have on the provider's ability to continue to provide care. Therefore, we respectfully request CMS implement a multi-year transition or the use of corridors in order to ensure hospitals will be able to handle all financial implications this revision could have.

In addition to the transition or use of corridors, Mercy would like to propose that the "wage index reviews" be bid out to one "national" fiscal intermediary as part of the Medicare Administrative Contract (MAC) bidding process scheduled to continue (for Jurisdictions 1, 2, 4, 5, 7, 12 and 13) in September 2006. A single "national" intermediary selection would provide both CMS and the provider community a "consistent" approach to the wage index process. Historically, providers located in the same state (or even the same MSA) have been subject to a wage index "review/approval" by different fiscal intermediaries. While the MAC bidding process should create consistency from an FI perspective going forward for those providers in a common geographic location (or jurisdiction), there will still be the ability for inconsistencies to occur among providers within varying jurisdictions. As Medicare continues to evolve, and the health care industry continues to operate within extremely tight financial constraints, we believe consistency in application of Medicare rules, regulations, and reviews is imperative. A one percent change in a provider's wage index can mean hundreds of thousands of dollars to one provider. This one percent change could be determined by what kind of documentation one fiscal intermediary either allowed or denied in one jurisdiction versus another. Wage index calculations are utilized for payment of every Medicare inpatient claim and variation among fiscal intermediaries (even across jurisdictions) could be detrimental to hospitals located within a certain geographic region.

We respectfully request CMS strongly consider using the MAC process to solicit a single "national" fiscal intermediary to ensure wage index reviews are handled consistently and accurately so that all providers are subject to the same Medicare interpretation. We believe the inclusion of 100% of the occupational mix wage index results intensifies the need for this approach going forward. The 100% inclusion of occupational mix data means additional scrutiny, education, and emphasis will be necessary from both a fiscal intermediary and provider prospective. Fluctuations in wage index percentages for any provider can prove to be extremely volatile and therefore must be handled with extreme care. We believe a national nomination for a single wage index intermediary would bring us closer to ensuring this process is handled effectively.

Thank you again for considering our comments. Should you have additional questions you may contact Bill Colletta at 314-364-3525.

Sincerely,

Ron Ashworth
President / Chief Executive Officer

Submitter : **Mr. Glenn Hackbarth** **Date: 06/12/2006**

Organization : **Medicare Payment Advisory Commission**

Category : **Federal Government**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P2-72-Attach-1.DOC

Mark McClellan, Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1488-P
Box 8011
Baltimore, Maryland 21244-1850

June 12, 2006

Re: file Codes CMS-1488-P and CMS 1488-P2

Dear Dr. McClellan:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on CMS's proposed rule entitled *Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 Rates*, Federal Register Vol. 71, No. 79, pages 23996-24472 (April 25, 2006) and its proposed rule entitled *Medicare Program: Hospital Inpatient Prospective Payment System Implementation of the Fiscal Year 2007 Occupation Mix Adjustment of the Wage Index*, Federal Register Vol. 71, No. 95, pages 28644-28653 (May 17, 2006). We appreciate your staff's ongoing efforts to administer and improve the payment system for acute inpatient services, particularly considering the agency's competing demands.

In this letter, we comment on changes to the DRG classification system and relative weights, payments for long-term care hospitals, adjustment for occupational mix in the hospital wage index, and outlier payments. In a letter dated June 2nd, we provided comments on two other issues: hospital quality data and value-based purchasing.

As we indicated in our letter dated April 19, 2006, we are pleased that CMS has proposed three of MedPAC's four recommended payment refinements to the inpatient PPS. The one change that CMS did not propose (outlier financing) would require legislation from the Congress. We have specific comments and suggestions on payment refinements:

- Refining the proposed method of calculating relative weights,
- Designing a transition policy to phase in the impact of case-mix refinements on hospitals' payments,
- Addressing the impact of changes in case-mix reporting, and
- Making future refinements to the consolidated, severity-adjusted DRGs.

We believe the concrete suggestions we offer will help CMS to resolve important short-term issues in time to adopt in fiscal year 2007 both the proposed changes in the relative weights and the consolidated, severity-adjusted DRGs (CDRGs). Adopting cost-based hospital-specific relative value (HSRV) weights and CDRGs together would result in substantial improvements in payment accuracy. The current payment system encourages community hospitals to allocate capital to profitable services such as cardiology and

stimulates the formation of specialty hospitals that often focus on providing profitable services and tend to care for low-severity patients. In addition, the current system does not adequately compensate the community hospitals that focus on less profitable medical services and tend to care for high-severity patients.

As we have pointed out previously, concerns about giving hospitals time to adapt to the changes and perfecting all aspects of the CDRGs would be best managed by implementing all changes now with a transition period instead of implementing changes sequentially as CMS has proposed. A transition would allow all stakeholders ample opportunity to adapt to and further refine the proposed reforms and prevent hospitals from facing unnecessary shifts in their payments that would occur under sequential adoption of these payment reforms. Thus, we again urge you to move ahead immediately to begin to capture the benefits of these policy changes that can be accomplished through regulation.

HSRV weights, DRGs, and severity of illness
We commend CMS on its commitment to improve the accuracy of Medicare payments for hospital acute inpatient services. The CMS staff has made great strides toward achieving this goal with the proposal for calculating HSRV weights and the development of CDRGs.

While the fundamental framework CMS has proposed is innovative and will work, specific computations within that framework need technical refinement. Our refinements to the proposed CMS method for calculating relative weights would improve the accuracy of payments. Furthermore, our refinements to the CMS method would result in less dramatic changes to payment weights than the CMS proposed methodology.

In our March 2005 report to the Congress on physician-owned specialty hospitals, we described our detailed methods for computing cost-based relative weights for severity classes of all-patient refined diagnosis related groups (APR-DRGs). In the proposed rule, CMS outlined a simplified version of our method that is easier to compute and allows CMS to use the most recent available claims data. In the spring of 2006, CMS used 2003 cost reports and 2004 claims data to compute proposed payment weights. To evaluate the method proposed by CMS, we first used the data from our earlier study to test the degree to which the CMS proposed method produces different weights than our more detailed method. Second, we developed some refinements to the CMS method that would retain its timeliness while producing relative weights that are closer to the weights generated by the more detailed method we originally used.

In the discussion that follows, we describe and compare the three different weighting methods. For clarity, we call them:

- MedPAC original—the cost-based HSRV weights developed in our March 2005 report to Congress on physician-owned specialty hospitals;

- CMS proposed—the cost-based HSRV weights that CMS developed using ten revenue centers (groups of hospital departments in which hospitals charge patients for services) in the fiscal year 2007 proposed rule, and
- Refined CMS—cost-based HSRV weights that incorporate MedPAC's refinements to the CMS proposed method.

MedPAC original relative weights

Over a year ago, to compute MedPAC original relative weights, we started with hospitals' latest available cost reports (primarily fiscal year 2002) and then obtained claims that precisely matched each hospital's cost report timeframe. We obtained charges by revenue code for each claim in the Standard Analytic File (SAF) and cost-to-charge ratios (CCRs) by revenue center from the hospital cost reports. We multiplied the charges for each revenue code on each claim by the hospital's CCR for the corresponding revenue center to obtain costs for specific services on each claim. Then we summed the costs of services provided in different revenue centers to get the total cost for each discharge. We compared the costs of different types of discharges within each hospital to its average cost per discharge for all Medicare claims to create hospital-specific relative values. We then applied the HSRV method to calculate a set of national relative weights for APR-DRG severity classes.

Adjusting hospitals' charges by their revenue centers' CCRs removes most of the distortions in relative costliness across types of discharges that occur because hospitals use different markups across services (and have different overall markup levels). Distortions in relative costliness remain, however, because certain types of cases tend to be treated predominately in high- or low-cost hospitals. This results in relative weights that are too high for some types of cases and too low for others. The advantage of the HSRV method is that it removes all differences in the level of costs across hospitals, thereby preventing the weight for any case type from being raised or lowered because of where patients in that category happen to be treated.

The less desirable alternative to the HSRV method is to standardize costs for regional differences in wage rates, medical education costs, and differences in the types of inputs used in different markets. These adjustments would be incomplete and introduce unnecessary error into the computation of payment weights.

CMS proposed relative weights

In the proposed rule, CMS obtained cost-to-charge ratios from the latest complete file of cost report data (for fiscal year 2003) and charge data from fiscal year 2004 MedPAR claims. The MedPAR claims provide an aggregated version of the detailed charges by revenue code in the Standard Analytic File (SAF) claims. Under the CMS proposal, DRG relative weights are computed in two stages. In the first stage, CMS produces national relative values for each of ten revenue centers for each DRG. The ten revenue centers are broad groupings of hospital departments, such as routine days, supplies and equipment, or operating room. In the second stage, CMS calculates a national cost share for each of the ten revenue centers. Then they use the ten revenue center cost shares to

weight the ten revenue center relative values within each DRG, which they sum to get a single national weight for each DRG.

In the first stage, CMS trimmed (excluded) MedPAR claims within each DRG to eliminate statistical outliers—claims with extremely high or low total charges. CMS used the charges on the remaining claims to compute hospital-specific relative values (within each revenue center) for each claim. Then CMS applied the HSRV method to the relative values for each revenue center on all claims. This step yielded 10 national relative values (by revenue center) for each DRG.

In the second stage, CMS used hospital cost reports to create ten consolidated revenue center CCRs. CMS trimmed these CCRs if they were more than two standard deviations from the national geometric mean CCR for the same revenue center. They used the remaining CCR values to recalculate the national geometric mean CCR for each revenue center. Then CMS computed national cost shares for the ten revenue centers based on the national total costs in each revenue center. CMS calculated national total costs by multiplying the national total charges for each revenue center (from the MedPAR claims) by the national geometric mean CCR for the same revenue center. To create a national relative weight for each DRG, CMS then multiplied the national revenue center relative values in each DRG by the revenue centers' corresponding national cost shares and summed the results. Finally, CMS recalibrated the DRG weights to maintain budget neutrality.

Developing refined CMS weights
We found that the proposed CMS method outlined above has some limitations that reduce the accuracy of the relative weights and payments. However, these limitations have fairly simple solutions, which we applied to develop the refined CMS weights. The issues and related refinements are summarized below:

1) *Issue:* CMS appears to have inadvertently included organ acquisition charges in calculating the revenue center relatives for transplant DRGs. However, organ acquisition costs are paid on a "pass through" basis, so the related charges should not be included in calculating the DRG weights.

   Correction: CMS should correct this error in the final rule.

2) *Issue:* CMS trimmed claims that were more than three standard deviations from the geometric mean of total charges within each DRG. In the past, CMS has adjusted total charges for differences in local wage rates and other factors, such as the indirect costs of operating medical education programs (IME). The failure to adjust for these factors here may result in trimming a disproportionate number of claims from urban teaching hospitals located in high-wage areas and small rural hospitals located in low-wage areas.

Refinement: CMS should first standardize charges for the area wage index, IME, and DSH costs. Then they should trim claims that have standardized charges in excess of 3 standard deviations from the geometric mean in each patient category.

3) *Issue*: CMS consolidated some revenue centers that have significantly different CCRs.

   Refinement: CMS should expand the number of revenue centers from 10 to 13.
   i) Make anesthesia a separate revenue center. Anesthesia has a lower CCR (0.16) than the CCR (0.32) for the other services consolidated in the operating room revenue center.
   ii) Make inhalation therapy a separate revenue center. It has a lower CCR (0.20) than other therapy services (0.44).
   iii) Make labor and delivery a separate revenue center from operating room. Labor and delivery has a higher CCR (0.47) than other services included in the operating room center (.32). [1]

4) Issue: CMS trimmed hospital CCRs in each revenue center using a criterion of 1.96 standard deviations from the national geometric mean for the revenue center. Given the extensive differences in markup policies among hospitals, this trim probably removes CCRs for too many hospitals and may be biased toward removing larger teaching hospitals with larger markups. Further, the national CCRs should be based on aggregate Medicare costs and charges because they are being multiplied by aggregate Medicare charges from all claims to calculate national cost shares for the revenue centers.

Refinement: CMS should compute national revenue center cost shares based on national aggregate average Medicare CCRs by revenue center from the cost reports. The recommended steps are:

i) Calculate all-payer CCRs for the 13 revenue centers at each hospital.
ii) Trim the all-payer CCRs for each revenue center:
   (1) First normalize (divide) each CCR by the hospital's overall average CCR (cost report Worksheet C, line 101).
   (2) Then take logs and flag CCRs that are more than $\pm$ 3 standard deviations from the national mean of the log CCRs within each revenue center.
iii) Compute hospital-specific Medicare costs using the all-payer revenue center CCR and the Medicare charges for the revenue center on the cost report.
iv) Compute national aggregate average CCRs:
   (1) Sum Medicare charges and costs for each revenue center across all hospitals in the nation.
   (2) Divide total Medicare costs by total Medicare charges.
v) Compute national cost shares and relative weights:

[1] Labor and delivery charges include operating room charges and clinic visits for MedPAR claims in MDC 14.

(1) For all 13 revenue centers, use the national total charges from the trimmed MedPAR claims as discussed above, and the aggregate average CCRs to estimate the national share of costs for each revenue center.
(2) Compute weights as CMS proposed, but using the refined national cost shares and the refined revenue center relative values for each patient category (DRG or CDRG).

Improved accuracy of payments

How do the CMS proposed weights and the refined CMS weights compare to the MedPAC original weights that we recommended in our March 2005 report to the Congress on physician-owned specialty hospitals? Neither alternative set of weights will exactly match the MedPAC original weights because the original weights are based on more detailed cost estimates. To see how the two alternatives differ from the MedPAC original weights, we used our fiscal year 2002 data set of matched claims and cost reports to estimate a set of weights for DRGs and another for CDRGs based on each of the three methods (CMS proposed, refined CMS, and MedPAC original). We then calculated the percentage differences between each substitute set of weights and the MedPAC original weights (separately for all DRGs and all CDRGs). We converted the percentage differences to absolute values and calculated the weighted average of the absolute values over all DRGs (CDRGs), weighting by the volume of cases in each category. The resulting weighted average absolute differences in Table 1 summarize the extent of the differences in the weights, comparing the CMS proposed and the refined CMS weights with the MedPAC original weights for DRGs and CDRGs.

Table 1. Weighted average absolute difference from MedPAC original weights

Method:	DRGs	CDRGs
CMS proposed	3.8%	4.8%
Refined CMS	2.6	2.9

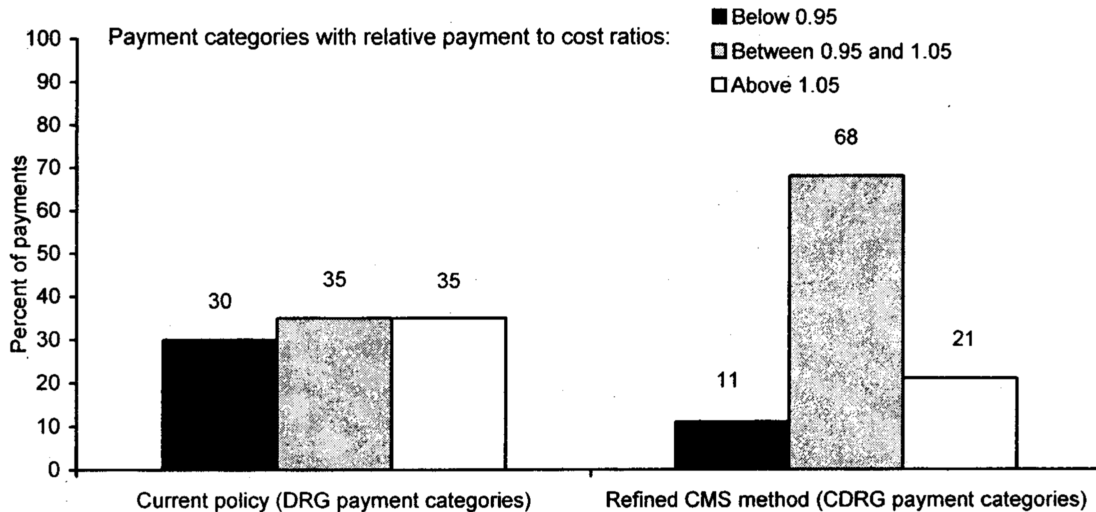
Source: MedPAC analysis of Medicare hospital inpatient claims and cost reports from CMS, primarily fiscal year 2002.

Whether we compared weights based on DRGs or CDRGs, we found that the weights based on the refined CMS method more closely matched the MedPAC original weights than did the weights based on CMS's proposed method.

As shown in Figure 1 below, we also used our study data and MedPAC's acute inpatient PPS payment model to compare accuracy of payments (how closely payments track relative costs) under a refined version of the Medicare acute inpatient PPS and current policy. In the refined CMS method, payments would be based on CDRGs.

Payment accuracy increased substantially when moving from the prior (DRG-based) current policy to the refined CDRG payment system. Under the DRG system only 35 percent of total payments fall in DRGs that have payments that are within 5 percent of the cost target. In the case of CDRGs with the refined CMS weights, 68 percent of payments fall in CDRGs that meet this standard (Figure 1). Accuracy would improve even further if the Congress were to change the way outlier payments are financed as the Commission has recommended. The outlier issue is discussed further on page 12.

Figure 1. Improving the accuracy of payments

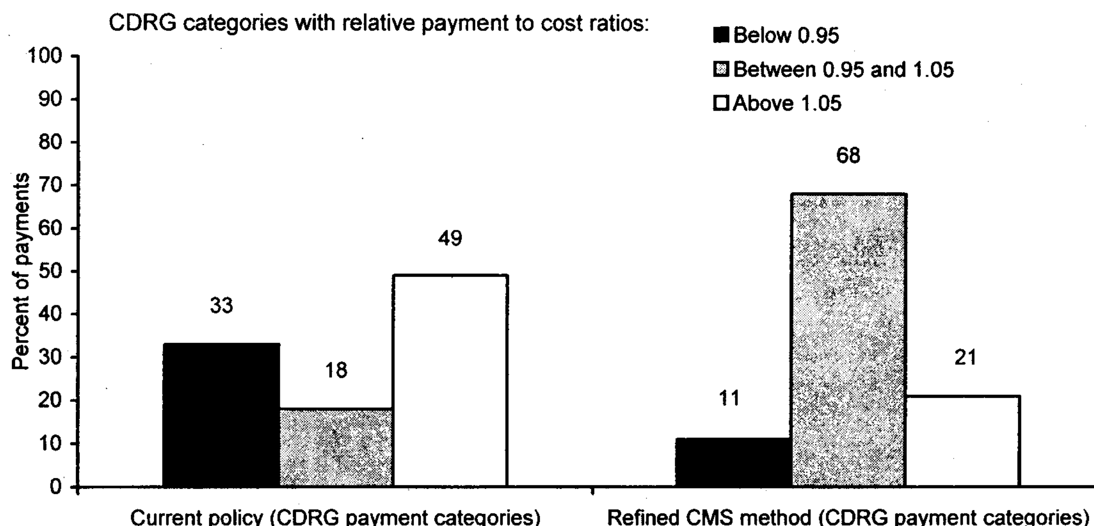


Note: DRG (diagnosis-related group). Refined CMS method for CDRGs (MedPAC's proposed revisions to the CMS method for computing cost-based HSRV weights, applied to CDRGs). CDRGs (consolidated severity-adjusted diagnosis-related groups).

Source: MedPAC analysis of Medicare hospital inpatient claims and cost reports from CMS, primarily fiscal year 2002

Figure 1, however, overstates the accuracy of the current DRG system. Some DRGs appear to pay fairly for care only because they include low-severity cases for which we overpay offsetting high-severity cases for which we underpay. To separate out the high-severity and low-severity cases, Figure 2 uses the CDRG categories to compare current payment policies with the refined CMS method. We see that only 18 percent of total payments are in CDRG categories that are appropriately paid under the current system. Refining the payment system dramatically improves the accuracy of payments.

Figure 2. The importance of severity adjustment



Note: The distribution labeled "current policy" compares the average charge-based DRG payments that would have been paid in 2002 for cases in each CDRG category to the cost of those cases. The distribution labeled "refined CMS" compares the refined cost-based HSRV payments for cases in each CDRG category to the cost of those cases. CDRGs (consolidated severity adjusted DRGs).

Source: MedPAC analysis of Medicare hospital inpatient claims and cost reports from CMS, primarily fiscal year 2002.

Grouping claims by CDRG

One objective of the DRG patient classification system was to group cases with similar resource use into a common DRG. We used MedPAC's case level cost estimates for cases from 2001 and 2002 to calculate the amount of variation in estimated costs among cases within the DRGs. We then assigned each case to the appropriate CDRG and recalculated the amount of cost variation among cases within CDRGs. The coefficient of variation (standard deviation divided by the mean cost) for the CDRGs was 12 percent lower than for the old DRGs. In other words, the CDRGs did a better job of grouping cases with similar costs into the same category. This was expected because the CDRGs separate the high severity (and high cost) cases into separate categories. While the CDRGs are not perfect, and may need to be revised over time to better account for the changing cost of technology (as discussed below), they represent a significant improvement over the DRGs.

Impact of all refinements

The refined CMS method discussed above would bring the CDRG weights closer to those that MedPAC estimated using more detailed charges and CCRs from precisely matched claims and cost reports. Table 2 below illustrates differences between the CMS proposed method of computing weights and our refined CMS method for four sets of CDRGs. For CDRG 232 (pacemaker implantation – SOI level 2), the MedPAC original method

generated a payment weight of 2.27. The CMS proposed method produced a weight of 1.99 (using 2002 data). The refined CMS method produces a weight of 2.26, which is much closer to weight generated by the MedPAC original method.

Table 2: Comparison of methods for computing weights

CDRG (severity level)	Current Policy	MedPAC Original (CDRG method)	CMS proposed method	Refined CMS method
Bypass with cardiac catheterization				
CDRG 216 (level 1)	5.37	3.55	3.27	3.53
CDRG 217 (level 2)	5.40	4.16	3.85	4.13
CDRG 218 (level 3)	5.53	5.48	5.24	5.55
CDRG 204 (level 4 cardiothoracic)	7.49	11.02	10.82	11.29
Cardiac pacemaker implantation w/o AMI				
CDRG 231 (level 1)	2.33	1.86	1.61	1.88
CDRG 232 (level 2)	2.34	2.27	1.99	2.26
CDRG 233 (level 3)	2.36	3.16	2.83	3.10
CDRG 206 (level 4 circulatory procedures)	3.48	5.26	4.90	5.17
Defibrillator or heart assist implant				
CDRG 207 (level 1)	6.30	4.69	3.93	4.84
CDRG 208 (level 2)	6.51	5.54	4.62	5.61
CDRG 209 (level 3)	6.53	6.86	5.92	6.91
CDRG 204 (level 4 cardiothoracic)	7.49	11.02	10.82	11.29
Major depressive, schizophrenia and bipolar disorders				
CDRG 769 (level 1)	0.74	0.92	1.13	1.00
CDRG 770 (level 2)	0.75	1.04	1.27	1.13
CDRG 771 (level 3)	0.76	1.45	1.60	1.45
CDRG 772 (level 4)	0.77	2.84	3.05	2.77
Diabetes				
CDRG 538 (level 1)	0.74	0.55	0.59	0.55
CDRG 539 (level 2)	0.75	0.71	0.75	0.71
CDRG 540 (level 3)	0.75	1.06	1.10	1.05
CDRG 537 (level 4 endocrine diagnoses)	0.95	2.41	2.22	2.15

Source: MedPAC analysis of Medicare hospital inpatient claims and cost report data from CMS, primarily fiscal year 2002.
Note: DRG weights may differ among CDRG severity classes due to each severity class having a different mix of DRGs (e.g. DRGs with or without complications) being grouped into each CDRG.

For CDRG 771 (Depression/schizophrenia – SOI level 3), the MedPAC original method produced a weight of 1.45. The CMS proposed method generated a weight of 1.60. The refined CMS method produced a weight that is equal to the MedPAC method. In general, the proposed CMS method resulted in too large of a reduction in the costs allocated to supplies and too big of an increase in costs allocated to routine services. The proposed CMS method made adjustments in the right direction, but the magnitude of the proposed adjustments was often too large.

The refined CMS system would have a modest impact on total Medicare inpatient payments to most classes of hospitals. Physician-owned specialty hospitals are the only major category that would see more than a 3 percent decrease in payments. They tend to have a less severe case mix of patients and would see a reduction of between 7 percent and 8 percent of payments, assuming their current case mix. Within each category of hospitals, there would be some winners and some losers. In particular, our simulations show that hospitals that currently have an unfavorable selection of patients (e.g. high severity patients) would experience an increase in payments, while hospitals that have a favorable selection of patients (e.g. low severity patients) would face a decline in payments under the proposed system. Because some hospitals would face a significant shift in payments after the payment system is refined, MedPAC recommended in its 2005 specialty hospital report that the payment refinements be implemented over a transition period.

The transition

The Commission suggests that CMS phase in the financial effect of the refinements to the payment system over a transition period of two to four years. To avoid subjecting hospitals to unnecessary shifts in payments, the CDRGs and the refined CMS weights should be adopted at the same time. Otherwise, if CDRGs were implemented after cost-based weights, some hospitals would see a large increase (or decrease) in payments in the first year only to see some of those gains (or losses) reversed in the next year if the cost-based weights were implemented in 2007 and CDRGs in 2008. We urge you to implement both policies simultaneously in fiscal year 2007, and provide a smooth transition.

We suggest that CMS blend the old and new weights during the transition period to limit the magnitude of payment changes faced by hospitals. Because each CDRG would have a single blended weight, it would not be necessary to run two payment systems simultaneously. For example, under a two year transition the relative weight for cases in a CDRG would be set equal to 50 percent of the refined CMS weight we described earlier and 50 percent of the average weight for cases in that category under current policy (in which charge-based weights are set for DRGs). That is, one-half of the weight for each CDRG would be based on the average DRG weight under current (FY 2006) policy for the cases grouped in that category. These average weights would be known in advance because they would be calculated using the same cases CMS uses to calculate the refined weight for each CDRG. Therefore, the CDRG weights in the first year would only partially reflect the impact of implementing both cost-based weights and CDRGs. If CMS implements a two year transition, roughly half of the effect of the transition would

occur in the first year and roughly half in the second. If CMS implements a three year transition, roughly one third of the effect would occur in the first year.

Table 3 shows the average aggregate effect of the refined CMS method on payments to different types of hospitals. The refined CMS payment system has similar impacts to MedPAC's three payment policy recommendations (HSRV, cost-based weights, and severity adjustment). The impacts in Table 3 differ slightly from the impacts in our April 19th letter we sent to you because our April 19th letter referred to the effect of implementing all four policy recommendations, including how CMS finances outliers. CMS cannot implement the outlier recommendation without new legislation. Outlier reform tends to benefit small hospitals (both urban and rural) that currently receive very little in outlier payments. The outlier issue is discussed on page 12.

Table 3: The distributional effects of the refined CDRG payment system

Category of hospital	Average percent change in payments	Percent of hospitals losing 5% or more	Percent of hospitals gaining 5% or more
All hospitals	0%	9%	15%
Urban hospitals	0	7	18
Rural hospitals	0	12	11
Teaching status			
Major teaching hospitals	-1	13	12
Other teaching hospitals	0	6	15
Non-teaching hospitals	+1	10	16
Physician-owned hospitals			
Heart hospitals	-8	75	0
Orthopedic hospitals	-7	77	0

Source: MedPAC analysis of Medicare hospital inpatient claims and cost reports from CMS, primarily fiscal year 2002. The impacts assume no change in casemix or coding from FY 2002. The average percent change represents the aggregate change in payments for the category of hospitals.

Anticipating changes in hospital coding

CMS also asked for comments regarding the need to make a prospective adjustment that would account for expected changes in diagnosis documentation and coding practices among hospitals. In the past, hospitals have changed their case-mix documentation and coding practices in response to major changes in the case-mix classification systems. The shift from DRGs to APR-DRGs in Maryland is probably the most recent classification change that is similar to the adoption of CDRGs in Medicare.

The state of Maryland sets payment rates for all payers and is exempt from Medicare's inpatient and outpatient PPSs. In 2002 Maryland started to adopt severity adjusted APR-DRGs, beginning with major teaching hospitals. In 2005, Maryland adopted APR-DRGs for all hospitals, allowing hospitals to obtain higher revenues for higher case mix indexes

based on APR-DRGs. Following the change in case-mix measurement methods, Maryland's increase in reported patient severity resulted in roughly a 4 percent increase in payments for hospitals paid based on APRDRGs. The Health Services Cost Review Commission attributed most of the change to more complete documentation of patients' medical records resulting in more reported diagnoses per patient, rather than an underlying increase in patient severity.

In order to recapture payment increases from changes in coding, CMS will have to reduce payments prospectively. The reduction may have to be as high as 2 to 4 percent to account for similar increases in documentation related to the use of CDRGs. The increase in case-mix and payments during the transition, however, is likely to be less than the full change that might ultimately occur for two reasons. First, hospitals will not instantaneously adapt their practices to the change in policy; many hospitals will require two or more years to fully adapt. Second, the use of blended weights will tend to dampen the impact of changes in coding. The blended weights rest partially on the average DRG weight under current policy; thus the effects of changes in CDRG assignments will not be as large as they will be when the refined CMS weights are fully implemented. Consequently, CMS may not need to immediately offset the full documentation and coding effects.

After the new CDRG payment system is in effect, CMS can also estimate the actual changes that have occurred by reviewing records to see if more complete coding has resulted in an increase in reported case mix. CMS could use information from the Clinical Data Abstraction Centers (CDACs) which collect medical records, reabstract these records, and independently assign diagnosis and procedure codes. CMS already uses this data to estimate coding errors by state.

Future Refinements
As we stated in our March 2005 report, there is a need to reform the financing of outlier payments. Currently, variation in the prevalence of high-cost outlier cases contributes to disparities in relative profitability across and within DRGs. These disparities can penalize hospitals (usually small hospitals) that treat patients in DRGs with a low prevalence of outliers. To level the playing field, Congress should amend the law to give the Secretary authority to adjust the DRG relative weights to account for differences by DRG in the prevalence of high-cost outlier cases.

Another problem that needs to be addressed in the future is the problem of "charge compression." This problem exists under the current charge based system and will continue to persist under the system of cost-based weights. From MedPAC's studies of charging practices, we have learned that hospitals tend to have higher percentage markups on lower cost items and lower percentage markups on higher cost items. These systematic differences in markups within a department lead to compressed estimates of the cost of supplies and devices. It is important to note that charge compression results from hospital mark-up practices. If each hospital would use a single markup for all supplies and devices charged to patients this problem would disappear. Improvements in price transparency may encourage hospitals to move toward more uniform markups, but

as long as they continue their historical charging practices, the use of a single departmental cost-to-charge ratio will result in inaccurate cost estimates, understating the costs of high cost items and overstating costs for low cost items.

Over the short term, the transition we proposed will limit the impact of payment changes associated with charge compression. During the transition phase, CMS could investigate two interim solutions. CMS could obtain survey information on the transaction prices of high-cost devices and determine if a temporary adjustment to the payment weights is needed. An alternative is to investigate the possibility of using the more detailed charge information on the SAF file (which divides charges for supplies into subcategories) to split the supplies revenue center into two or more subcategories. One of the two interim solutions could remain in place until the cost reports and the MedPAR files are revised to have more than one revenue center for supplies.

In addition, CMS may need to continually refine the CDRG categories (as it has DRGs) when new technologies become available. In the past, CMS has separated DRGs with significantly different device costs such as replacements of pacemakers versus replacements of defibrillators. Another example was CMS' decision to pay one rate for hip replacement and a higher rate for revisions of hip and knee replacement procedures due to their higher resource use. During the transition phase, CMS should consider splitting procedures with significantly different device costs into separate CDRGs.

Long-term care hospitals

We comment on two issues related to long-term care hospitals (LTCHs):

- The use of consolidated severity-adjusted DRGs for the LTCH PPS and
- How CMS recalibrates weights for that PPS.

In the proposed rule, CMS discussed using consolidated severity-adjusted DRGs developed for acute care hospitals for LTCHs if this classification system was found to be appropriate. In a preliminary analysis, we found that consolidated severity-adjusted DRGs may be useful for the LTCH PPS. For this analysis, we used both standardized charges and standardized hospital-specific costs (removing the effect of local wages) for LTCH cases for fiscal year 2004. We grouped the cases by a crosswalk from version 23 of the APR-DRG severity of illness categories to the new consolidated DRGs. We found that coefficients of variation for these groups generally were less than one (a criterion used for the original LTC DRGs), which suggests on a preliminary basis that consolidated DRGs are relatively homogeneous in resource use for the kinds of cases treated by LTCHs. We conclude that the case-mix system proposed for acute care hospitals may also be promising for LTCHs.

CMS recalibrates weights for the acute care PPS and LTCH PPS differently. For the acute care PPS, CMS uses a budget neutral process in recalibrating the weights for the year, so that recalibration will not affect aggregate payments. For the LTCH PPS, CMS does not currently use a budget neutral process and this method of recalibrating the weights has resulted in an estimated decrease in payments of 1.4 percent for fiscal year 2007. CMS should recalibrate the LTCH PPS weights in a budget neutral manner. This

would ensure that only changes in the mix of patients among patient categories would affect aggregate payments.

Occupational mix adjustment to the wage index

The wage index is intended to reflect geographic differences in the cost of labor. Adjusting wage index values for occupational mix in hospitals is meant to control for the effect of hospitals' employment choices on the wage index. CMS has proposed a method for doing so using information gathered in a survey of hospitals' hours and wages for the first three months of 2006. This represents a change from their earlier plan to use six months of data. The change was due to a recent court decision that requires CMS to apply the occupational mix adjustment in full beginning October 1, 2006.

Hospitals must report the survey data and CMS and its fiscal intermediaries have to process that data, with time for hospitals to review of the accuracy of CMS's processing for their facilities, before the new fiscal year begins. The schedule CMS proposes will result in the final wage index values being available sometime after the final rule is published in August but before the fiscal year starts in October.

You have asked for comments on how to calculate the occupational mix adjustment for non-responsive hospitals. We would agree with your fourth option: "Assign the hospital the average occupational mix factor for similar hospitals, based on factors such as geographic location, bed size, teaching status and case mix." This approach is most likely to produce a value that approximates the one the non-reporting hospital should have reported. Assuming a regression analysis approach is used for the imputation, you might add other variables to the specifications—such as share of ICU days and types of services offered—to increase the explanatory power.

In addition, the regulations governing geographic reclassification should be revised so that in the future the occupational mix adjusted average wage is used as the point of comparison for eligibility. This will make reclassification decisions consistent with the new basis for the wage index. Hospitals that do not provide complete occupational mix data should not be allowed to apply for reclassification, because they would not be able to demonstrate eligibility.

We also have a technical comment on the method used for calculating each hospital's occupational mix adjustment. In step 7 in the proposed rule, hours are used to allocate total wage-related costs between nursing and all other personnel. For example, if 30 percent of the hospital's hours come from nursing, then 30 percent of its wage-related costs (as reported on its Medicare cost report) will be subject to the occupational mix adjustment. That approach essentially assumes that wage rates are equal between nursing and other categories. We propose that "nursing paid salaries" and "all other occupations paid salaries" from the survey be used for this allocation. This would result in a more accurate determination of the costs that should be adjusted for occupational mix and those that should not.

Outlier payments
Each year CMS conducts a simulation to determine the fixed loss threshold it believes will result in outlier payments equaling 5.1 percent of base operating payments in the coming year. Because forecasting is involved, however, actual outlier payments are likely to come out somewhat above or below 5.1 percent of base payments in any given year. We would like to suggest an easily implemented change to CMS's policies for administering outlier payments that should increase the probability of outlier payments reaching the 5.1 percent target level.

CMS's method begins with projecting the charge for each Medicare case out to the policy year. Then the projected charges are converted to costs by applying each hospital's most recent cost-to-charge ratio (CCR). The cost for each case is compared to a modeled payment to estimate a gain or loss, and then through an iterative process, the loss threshold is identified that produces the desired outlier spending.

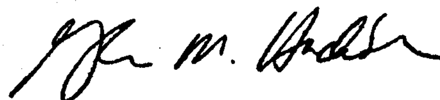
Generally the CCR data used in this simulation are somewhat older than the charge data, which can bias the results. If charges are rising faster than costs (which has been the case for many years), hospitals' CCRs will fall over time such that old CCRs will be too high relative to the charges to which they are applied. Using CCRs that are too high will overstate costs, resulting in a fixed-loss threshold that is too high. CMS minimizes the potential bias by repeating the simulation and updating its determination of the appropriate fixed-loss threshold between the draft and final rules, employing more recent CCRs that had become available for many hospitals. While the lag between the charge and CCR data has thus been reduced, at least a modest underpayment of outlier payments is still likely to occur.

CMS can improve the accuracy of its simulation by forecasting hospitals' CCRs to the policy year so that these data will match its forecasted charge data. This is best accomplished by separately forecasting each hospital's average charge per case and average cost per case, then recomputing the ratio of the two. CMS already projects average charge per case, and the results of that projection can be used here. The hospital market basket is intended to measure growth in the costs of the goods and services hospitals purchase to provide patient care, and CMS already publishes a forecast of the market basket which can be used for projecting average cost per case.

Conclusion
MedPAC appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

Submitter : **Mr. David McClure**

Date: 06/12/2006

Organization : **Tennessee Hospital Association**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P2-73-Attach-1.DOC

June 12, 2006

Centers for Medicare & Medicaid Services
Attention: CMS-1488-P2
P.O. Box 8012
Baltimore, MD 21244-8012

RE: CMS-1488-P2, Medicare Program; Hospital Inpatient PPS Implementation of the Fiscal Year 2007 Occupational Mix Adjustment to the Wage Index

Dear Sirs:

The Tennessee Hospital Association (THA), on behalf of our over 200 healthcare facilities, including hospitals, home care agencies, nursing homes, and health-related agencies and businesses, and over 2,000 employees of member healthcare institutions, such as administrators, board members, nurses and many other health professionals, appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services (CMS) on the fiscal year (FY) 2007 inpatient prospective payment system (PPS) proposed rule on implementation of the occupational mix adjustment to the wage index.

Calculation of the Proposed FY2007 Occupational Mix Adjustment
The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 requires CMS to collect data every three years on the occupational mix of employees from hospitals subject to the inpatient PPS in order to construct an occupational mix adjustment to the wage index to control for the effect of hospitals' employment choices – such as greater use of registered nurses (RNs) versus licensed practical nurses or certified nurse aides – rather than geographic differences in the costs of labor.

CMS initially stated in the proposed rule that it would again limit the occupational mix adjustment to 10 percent because of concerns regarding the validity of the data and the potential financial impact on hospitals. However, as a result of the decision handed down by the U.S. Court of Appeals for the Second Circuit on April 3 in *Bellevue Hospital Center v. Leavitt*, CMS on May 12 released a proposed rule revising the occupational mix adjustment portion of the FY 2007 inpatient PPS proposed rule. Under the court ruling, CMS must collect new data on the occupational mix of hospital employees and fully adjust the area wage index (AWI) for FY 2007.

Hospitals are required to collect the hours and wages for employees from January 1 through June 30, 2006. Data initially was supposed to be collected by July 31; however, hospitals are required to submit data by June 1 for the first calendar quarter of the year and by August 31 for the second calendar quarter. Data from the first quarter will be used to adjust the FY 2007 AWI, while data for the full six months will be used to adjust the AWI for FYs 2008 and 2009.

Non-responsive Hospitals. Because data from all hospitals is needed to construct an accurate national average hourly wage, full participation is critical. There is a general sentiment that hospitals that do not participate should not benefit from the participation of

others. However, given the rushed collection and general confusion around the interim-collection, we believe that, to the extent possible, **CMS should substitute data from the previous survey for hospitals that did not turn in their data for the first calendar quarter of 2006. Hospitals should not be penalized for lack of or untimely submission of the June 1, 2006 survey data.**

However, hospitals should have plenty of notice and time to submit data for the second calendar quarter in August. Thus, moving forward CMS should consider a methodology that does not reward hospitals that do not participate. We caution CMS not to simply substitute unfavorable data for these hospitals, as it also will impact other area hospitals that conscientiously reported data. CMS could alternatively substitute the national average hourly wage for non-responsive hospitals in calculating an area's wage index, and then require hospitals that did not turn in data to use something lower than their area's wage index. This would avoid CMS having to create an extensive hospital-specific wage index table and would minimize the effects on the other hospitals in the area. **We urge CMS to construct an application of the occupational mix adjustment that encourages hospitals to report but does not unfairly penalize neighboring hospitals.**

Timeline
The THA urges CMS to allow hospitals to turn in both calendar quarters of data in August whether for the first time or with corrections. Again, as this collection has been rushed, the idea is to allow hospitals to improve the data for the FYs 2008 and 2009 adjustment. **For hospitals that were previously non-responsive, the submission of the first calendar quarter would remove any penalty, while those that continue to be non-responsive will continue to incur a penalty.**

Comment Timeframe. While we understand that CMS is under severe time pressure due to the timing of the court's decision, we do not believe that the 30-day comment period was sufficient, as hospitals were busy during this time trying to meet the new survey deadline and answering requests for information from the FIs. In addition, we believe it would be appropriate for CMS to take comments on the calculation after the initial results of the survey are tabulated and posted. While CMS might not have time to make such changes for FY 2007, it could entertain comments on the implementation for FYs 2008 and 2009. **Thus, we urge CMS to publish the occupational mix adjustment changes as an interim-final rule in August with an associated comment period.**

The THA appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me or David McClure, THA vice president of finance, at (615) 256-8240 or dmcclure@tha.com.

Sincerely,

Craig Becker, FACHE
President

cc: Rick Pollack, AHA, Executive Vice President

Submitter : Mrs. Shirley Hsing

Date: 06/12/2006

Organization : North Oaks Health System

Category : Hospital

Issue Areas/Comments

Development of Data for the Proposed Occupational Mix Adjustment

Development of Data for the Proposed Occupational Mix Adjustment

Our hospital was affected by Hurricane Katrina. We have experienced significant labor shortage since Katrina. As a result, to continue providing services to our patients, we have been paying three times of the salary to travel nurses as we would pay to our regular staff nurse.
CMS requested that hospitals submit January 2006 thru March 2006 labor data for use in determining the occupational mix adjustment. I believe by using 1/06-3/06 data, it will distort our RN average hourly wage and thus negatively affecting our occupational mix adjustment.

Submitter : **Ms. Rose Gonzalez** **Date: 06/12/2006**

Organization : **American Nurses Association**

Category : **Nurse**

Issue Areas/Comments

Impact

Impact

See attached comments.

CMS-1488-P2-75-Attach-1.DOC

June 12, 2006

Mark B. McClelland, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
P.O. Box 8011
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-1488-P2 Medicare Program: Hospital Inpatient Prospective Payment Systems Implementation of the Fiscal Year 2007 Occupational Mix Adjustment to the Wage Index

Dear Dr. McClelland:

The American Nurses Association (ANA) appreciates the opportunity to submit comments on the proposed rule to make changes to Medicare's hospital inpatient prospective payment system for Federal fiscal year 2007. ANA, the only full-service professional organization representing the nation's registered nurses through its 54 constituent member nurses associations, advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and by advocating to Congress and regulatory agencies on health care issues affecting nurses and the public.

We are aware that as a consequence of the recent decision from the Second Circuit Court of Appeals, Bellevue Hospital Center v. Leavitt, CMS is required to apply the full 100 percent occupational skill mix by September 30, 2006 and collect the data necessary to do so by then. ANA's concerns focus on the overall impact of full implementation of the occupational skill mix adjustment which will provide a financial incentive to substitute less skilled personnel for more highly skilled personnel to obtain a more favorable adjustment to the Medicare wage index. The fact that some hospitals may have higher overall labor costs because their patient population requires a larger quantity of highly skilled employees is not reflected in this type of wage index.

The expected effect of the Medicare occupational skill mix adjustment was to increase the Medicare payments to small and rural hospitals that were believed to use fewer skilled personnel (as a percentage of total personnel) than larger tertiary care hospitals offering an array of specialized services. Analysts expected a decrease in the occupational mix adjusted wage index for areas with tertiary care and teaching facilities, and increases in the area wage indexes for areas with primarily small and rural hospitals. In reality, that did not happen for a number of reasons, chiefly the poor quality of the collected data.

ANA is now concerned that the application of a national average of the RN skill mix, based on only three months of data, will limit the ability of nursing administrators to determine appropriate RN staffing levels that reflect analysis of individual and aggregate

patient needs. Changes in staffing levels, including changes in the overall number and/or mix of nursing staff, should be based on analysis of standardized, nursing-sensitive indicators. The effect of these changes should be evaluated using the same criteria. ANA maintains that caution must be exercised in the interpretation of data related to staffing levels and patterns and patient outcomes in the absence of consistent and meaningful definitions of the variables for which data are being gathered.

While the actual result of the implementation of the 100 percent of the occupational skill mix adjustment is impossible to predict due to the potential effect on reimbursement and the quality of the data, ANA remains concerned and deems it necessary to comment that full implementation of the occupational skill mix adjustment could provide a strong incentive for hospitals to recruit and hire increasing numbers of less skilled nursing staff. RN staffing should be such that the quality of patient care is maintained, the quality of organizational outcomes are met and that the quality of nurses' worklife is acceptable.

Thank you for the opportunity to comment. If you have additional questions or need additional information, please feel free to contact me at rose.gonzalez@ana.org or by phone at 301-628-5098 or Sheila Abood, PhD, RN at sheila.abood@ana.org or by phone at 301-628-5093.

Sincerely,

Rose Gonzalez, MPS, RN
Director, Government Affairs

Submitter : **Dr. Janice Baker**

Date: 06/12/2006

Organization : **Altantic Health Systems**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

As a family physician, I appreciate the 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 2007 Rates. 71 Fed. Reg. 23996 (April 25, 2006).

I strongly urge CMS to rescind the language in the proposed rule that sets up an artificial dichotomy between resident training time spent in didactic activities and time spent in patient care activities. The effect of the proposed rule is to exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

Background
The proposed rule cites journal clubs, classroom lectures, and seminars as examples of didactic activities that must be excluded when determining the full-time equivalent resident counts for all IME payments (regardless of setting), and for DGME payments when the activities occur in a nonhospital setting, such as a physician s office or affiliated medical school. The stated rationale for the exclusion of this time is that the time is not related to patient care .

This position reverses the Agency s position expressed as recently as 1999, at which time the Director of Acute Care wrote in correspondence that patient care activities should be interpreted broadly to include scholarly activities, such as educational seminars, classroom lectures . . . and presentation of papers and research results to fellow residents, medical students, and faculty. [September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins]. I support the Agency s 1999 position. The activities cited in the 1999 letter and cited again in this proposal are an integral component of the patient care activities engaged in by residents during their residency programs.

Residency Program Activities and Patient Care
I firmly believe that with the possible exception of extended time for bench research, there is no residency experience that is not related to patient care activities. The learning model used in graduate medical education (GME) is delivery of care to patients under the supervision of fully-trained physicians. Everything that a resident physician learns as part of an approved residency training program is built upon the delivery of patient care and the resident physician s educational development into an autonomous practitioner.

To separate out CMS s newly defined patient care time from didactic sessions in which general issues devolve to discussions of particular patients seems an exercise in futility. Moreover, as a family physician, I believe this policy would require additional staff that would be responsible for sitting in on each of these didactic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an extremely large and unnecessary administrative burden.

I urge CMS to rescind its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments and recognize the integral nature of these activities to the patient care

experiences of residents during their residency programs.

Sincerely,

Janice Baker, MD

Submitter : **Mrs. Holly Snow** **Date: 06/12/2006**

Organization : **Piedmont Healthcare**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Background

Background

All issues addressed in attachment

CMS-1488-P2-77-Attach-1.DOC

June 12, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1488-P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1488-P and P2, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule.

Dear Dr. McClellan:

On behalf of the more than 6,000 employees and medical staff of Piedmont Healthcare, we are asking that CMS delay implementation of the proposed rule to the Hospital Inpatient Prospective System. Piedmont Healthcare consists of three Georgia hospitals located in Atlanta (a 450 bed facility), Fayetteville (a 100 bed facility), and Jasper (a 35 bed facility).

While Piedmont Healthcare supports many of the proposed rule's provisions, we have serious concerns about the proposed changes to the DRG weights and classifications and its impact on our hospitals and health care providers. We support meaningful improvements to Medicare's inpatient PPS by refining the current system to create an equal incentive to treat all types of patients and conditions. However, more time is needed to understand the significant proposed policy changes, which redistribute from $1.4 to $1.7 billion within the inpatient system. Analysis shows the impact of the proposed changes to be highly unstable, with small changes in method leading to large changes in hospital payment. And the validity of CMS' proposals versus potential alternatives to improve the DRG weights and classification system is uncertain.

2001 Peachtree Road, NE Suite 201 Atlanta, GA 30309 Phone 404-605-2484

We support the American Hospital Association and other hospitals from across the county in asking CMS to implement the following:

• **One-year Delay:** A one-year delay in the proposed DRG changes will allow CMS to address the serious concerns with the HSRVcc and CS-DRG methodology.

• **Valid Cost-based Weights:** We support moving to a DRG-weighting methodology based on hospital costs rather than charges, but CMS' proposed HSRVcc method is flawed.

• **A New Classification System Only if the Need Can Be Demonstrated:** At this time, we do not support a new classification system as the need for a new system is still unclear. Much more work understanding the variation within DRGs and the best classification system to address that variation is still needed before CS-DRGs or any other system should be selected or advanced.

• **Simultaneous Adoption of Any Changes to Weights and Classifications:** If the need for a new, more effective classification system is demonstrated and developed, it should be implemented simultaneously with the new weighting system to provide better predictability and smooth the volatility created by these two, generally off-setting changes.

• **Three-year Transition:** Any changes should be implemented with a three-year transition, given the magnitude of payment redistribution across DRGs and hospitals.

• **Collaborative Approach to Moving Forward**: We ask that CMS work with the AHA to develop and evaluate alternatives for new weights and classifications.

In summary, Piedmont Healthcare supports the goal of improving DRG payment accuracy. However, the CMS proposal goes too far, too fast with too many methodological problems that would be disruptive to patient care, hospitals, and physicians. Thank you for the opportunity to submit these comments. If you have any questions please feel free to contact me at Holly.Snow@Piedmont.org or 404/604-2484.

Sincerely,

Holly Bates Snow
Vice President of Government and External Affairs

2001 Peachtree Road, NE Suite 201 Atlanta, GA 30309 Phone 404-605-2484

Submitter : **Ms. Tina Ford**

Organization : **BESLER Consulting**

Category : **Health Care Industry**

Date: 06/12/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P2-78-Attach-1.DOC

BESLER
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June 8, 2006

Dr. Mark McClellan
CMS Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-PN2
Room C4-26-05
Central Building
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1488-P2

Dear Dr. McClellan:

BESLER Consulting (BESLER) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled *Medicare Program; Hospital Inpatient Prospective Payment Systems Implementation of the Fiscal Year 2007 Occupational Mix Adjustment to the Wage Index,* 71 Federal Register 28644 (May 17, 2006).

The following comments/questions will apply to the various labeled sections from the aforementioned proposed ruling:

- **"Calculation of the proposed FY 2007 occupational mix adjustment":**
  1. In prior years approximately 425 hospitals did not submit occupational mix data. BESLER Consulting believes that CMS should hold all Medicare certified PPS hospitals accountable to submit occupational mix data. It should be considered as part of their participation in the Medicare program and anything short of a submission of occupational mix data should put them in violation of adhering to the conditions of participation with the Medicare program.

  2. BESLER Consulting believes that the hospitals' designation in the base year should determine whether the hospital is considered a CAH or not. All CAHs that convert between the base year and the rate year should still be included in the occupational mix calculation. CAHs should not be eliminated from the

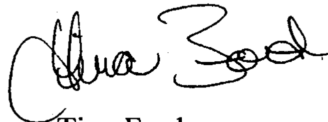
calculation until the hospital is considered a CAH in the base year used by CMS to calculate occupational mix adjustment.

- **"Timeline":**
  1. Hospitals had a short time frame in which to submit data to the intermediaries and the intermediaries have a short time frame in which to review all submitted data and correspond with hospitals to resolve any discrepancies that may be noted during their audit process. It is also unclear how consistent all intermediaries may be in auditing this data. Given this ambitious timeframe, the validity of the data may be questionable and it is certainly prone to have a redistributive impact on Medicare payments (along with the newly proposed DRG weighting methodology and potential severity DRG for FY 2007). CMS should consider deferring the implementation of the newly proposed DRG weighting methodology and potential severity DRG until at least FY 2008 to alleviate the burden on hospitals that will receive redistributive impacts on Medicare payments under the occupational mix adjustment.

  2. Corrected survey data, which is due by July 27, 2006 from the intermediaries should also be made available via public use files prior to the publication of the final amounts for the inpatient prospective payment system, which is scheduled to be published between the final rule and implementation date of October 1, 2006.

Thank you for this opportunity to comment.

Respectfully submitted,
BESLER Consulting



Tina Ford
Senior Manager

Submitter : **Mr. Joe Casey** **Date: 06/12/2006**

Organization : **Sturdy Memorial Hospital**

Category : **Hospital**

Issue Areas/Comments

Calculation of the Proposed FY 2007 Occupational Mix Adjustment

Calculation of the Proposed FY 2007 Occupational Mix Adjustment

Occupational Mix Adjustment Non-responsive Hospitals
In order to accurately implement the occupational adjustment to the average hourly wage, all hospitals must participate. Allowing hospital s that do not submit data to be fudged in as having a mix of 1.0 not only creates no incentive for hospitals to comply, but actually creates an incentive for hospital s with a more costly mix of labor not to complete the survey. Given the rushed collection and general confusion around the interim-collection, I support the use of the lesser of the regional average or 1.0 for hospitals not completing the survey.

However, hospitals will have plenty of notice and time to submit data for the second calendar quarter in August. For FY08 and later, CMS should consider a methodology that penalizes hospitals that do not participate, but does not unfairly penalize neighboring hospitals.

Submitter : **Ms. Robin LaBonte** **Date: 06/12/2006**

Organization : **York Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P2-80-Attach-1.DOC

CMS-1488-P2-80-Attach-2.PDF

June 8, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates : Occupational Mix Adjustment 71 FR 24075-24078, April 25, 2006

Dear Sir:

York Hospital appreciates the opportunity to comment on the proposed rule for hospital inpatient prospective payment systems for Federal Fiscal Year 2007 with respect to the occupational mix (OM) adjustment, as first published on April 25, 2006. This proposed rule would revise the methodology for calculating the occupational mix adjustment by applying it to 100% of the wage index and replacing in full the descriptions of the data and the methodology to be used in calculating the OM adjustment.

On April 3, 2006 in *Bellevue Hospital Ctr. v. Leavitt*, the Second Circuit Court of Appeals ordered the Centers for Medicare and Medicaid Services (CMS) to apply the OM adjustment to 100% of the wage index effective for fiscal year (FY) 2007. The Court further ordered CMS to collect data that was "sufficiently robust" to permit full application of the OM adjustment and that "data collection and measurement and any other preparations necessary for full application be completed by September 30, 2006, at which time the agency is to immediately apply the adjustment in full."

Because of this court order, CMS announced plans on April 21, 2006 to collect new OM data from hospitals. The purpose of the OM adjustment is to control for the effect of hospital's employment choices on the wage index, in that the varying labor costs associated with these choices reflect hospital management decisions rather than geographic differences in the costs of labor.

York Hospital is concerned about the OM adjustment to be used for FY 2007 for a variety of reasons, addressed below:

Development of Data for the Proposed OM Adjustment

- The Timeframe – The original revised survey provided for the collection of hospital-specific wage and hour data for a six month period, January 1, 2006 – June 30, 2006. After the court decision noted above, CMS shortened the initial collection of data to a three month period. York Hospital is concerned that three months' data may not adequately reflect a hospital's true OM, especially for those hospitals where seasonal fluctuations occur. We understand the rigid timeframes put forth by the Court, but also believe that a three month survey does not satisfy the Court's desire for "sufficiently robust" data. We recommend that CMS reconsider the use of only three months' data.

Timeline

- The timeline – On April 21, 2006, a Joint Signature Memorandum (JSM) was issued instructing fiscal intermediaries (FIs) to immediately alert hospitals to a revised schedule for the OM survey data. This JSM required hospitals to complete a three month survey for January 1, 2006 – March 31, 2006 with submission by June 1, 2006. With the original deadline for the survey of August 31, this left many hospitals scrambling to complete the survey timely. Additionally, by CMS's own admission, the new survey was to be used for FY 2008. York Hospital is concerned about the timeline from both the hospital's and CMS's perspective. The CMS estimate of 160 hours for completion of the survey inherently makes the reviewed timeline untenable given that the June 1 due date was not issued until April 21. This meant that hospitals likely could not give this very important document the appropriate consideration it deserved. We recommend that the three month survey not be used until and unless appropriate time is given to ensure its validity.

Withdrawing Reclassifications

- Procedures for withdrawing reclassification approvals – As a result of the Court order requiring the collection of OM data, the information relating to wage index and OM is obsolete. CMS is proposing to suspend the normal 45 day deadline and establish new procedures for withdrawals for FY 2007. These new procedures would include CMS determinations based on what would be most advantageous to the hospital. CMS is also proposing that once OM adjusted wage index data becomes available (sometime after August 1 and before October 1), hospitals would have 30 days to make final, informed decisions. York Hospital is pleased that CMS has recognized a need to do this and agrees with CMS's proposal.

Reclassification for Fiscal Year 2008

- Geographic reclassification for FY 2008 – In order for the Medicare Geographic Classification Review Board to properly evaluate a hospital's request for reclassification, it must use the final data for the FY 2007 wage index. Since this data may not be available by the reclassification application deadline of September 1, 2007, CMS is proposing that hospitals file a supplement to the reclassification application with official data used to develop the FY 2007 wage index no later than 30 days after the data is made available on the CMS website. In order for this to occur, however, hospitals must request an extension beyond September 1 to complete its application, even though an application continues to be required by September 1. York Hospital understands the statutory thirteen month deadline for reclassification applications, but believes, due to the many issues surrounding OM adjusted data, that the 30 day extension be granted automatically, rather than forcing hospitals to apply for the extension.

York Hospital appreciates the opportunity to comment on this proposed rule. If you have any questions or would like to discuss our comments further, please feel free to contact me at (207) 351-2391 or rlabonte@yorkhospital.com.

Very truly yours,

Robin W. LaBonte
Chief Financial Officer

Submitter : **Mr. Andrew Wigglesworth** **Date: 06/12/2006**

Organization : **Delaware Valley Healthcare Council**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

Please see attached Word document

CMS-1488-P2-81-Attach-1.DOC

DELAWARE VALLEY HEALTHCARE COUNCIL
of The Hospital & Healthsystem Association of Pennsylvania

June 12, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P2
P.O. Box 8012
Baltimore, MD 21244-8012

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems Implementation of the Fiscal Year 2007 Occupational Mix Adjustment to the Wage Index; (71 Federal Register 28644) May17, 2006, file code CMS 1488-P2.

Dear Dr. McClellan:

On behalf of the Delaware Valley Healthcare Council of HAP (DVHC) which represents more than 150 member hospitals, health systems and other health related organizations in Southeastern Pennsylvania, Southern New Jersey and Delaware, I am writing to convey our grave concerns on the Centers for Medicare and Medicaid Services' (CMS) revisions to the occupational mix survey as proposed in the *Federal Register* on May 17, 2006. In order to ensure continued access to high quality health care for Medicare beneficiaries to hospitals in the Delaware Valley, adequate hospital payments under the Medicare Prospective Payment System (PPS) is critical and the occupational mix adjustment to the wage index component is a key element affecting those payments.

The subject of this comment letter is the next adjustment that CMS has proposed for fiscal year (FY) 2007. In general, as per our comments to the proposed rule regarding the Occupational Mix Survey in October of 2005, DVHC appreciates CMS' efforts to streamline the occupational mix survey. We support the inclusion of both the paid hours associated with the employees in question and the wages paid. We believe there is value in calculating the national average hourly wage rates based on wage data collected at the same time as the hours paid, and that this data will improve the soundness of the occupational mix adjustment to the inpatient area wage index.

We are keenly aware of the fact that on April 3, 2006, in *Bellevue Hosp. Ctr v. Leavitt,* the Court of Appeals for the Second Circuit ordered CMS to apply the occupational mix adjustment to 100 percent of the wage index effective for FY 2007. In that Court Order, CMS was instructed to "immediately....collect data that are sufficiently robust to permit full application of the occupational mix adjustment" and that all "data collection and measurement and any other preparations necessary for full application be completed by September 30, 2006." Despite the

fact that CMS is under the Bellevue Court's order to proceed with a 100 percent implementation of the occupational mix adjustment for FFY 2007, we have several concerns about how CMS proposed to implement this change. We have problems with the shortened comment period, limited data sample and the timing of the data collection. This letter formally conveys our specific recommendations in the following aspects of the proposed rule:

1. **Development of the Data for the Proposed Occupational Mix Adjustment** - The DVHC has serious concerns that CMS is proposing that the data used for the occupational mix adjustment to the wage index for FY 2007 would be only three months of data from the first quarter of 2006. In order to have a meaningful occupational mix adjustment, CMS must use a full 12 months of data.
2. **Timeline** - The proposed survey deadline does not allow sufficient time for submission of accurate data. Hospitals need at least 90-days post the collection period to complete the occupational survey with contract labor information and to prepare it for submission to the fiscal intermediary.
3. **Calculation of the Proposed FY 2007 Occupational Mix Adjustment** - CMS should use the unadjusted wage data for hospitals that do not submit occupational mix data.
4. **Waiver of 60-day Comment Period** - We do not think that a 30-day comment period was sufficient particularly in light of the fact that hospitals were in the process of responding to an expedited timeline for data submission and were trying to comply with the comment deadline for the Medicare Inpatient Prospective Payment rule. Thus, we recommend that CMS publish the occupational mix adjustment changes as an interim-final rule in August with an associated comment period.

Background

As you know, Congress, with little discussion or debate included the occupational mix adjustment as section 304(c) of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). We understand that it requires the Secretary to collect data every three years on the occupational mix of hospital employees for each short-term, acute-care hospital participating in the Medicare program in order to construct an occupational mix adjustment to the inpatient area wage index. This adjustment controls for the effect of hospitals' employment choices – such as the use of registered nurses versus licensed practical nurses, or the employment of physicians – rather than geographic differences in the costs of labor. The adjustment appears to provide a financial incentive to substitute less skilled personnel for more highly skilled personnel to obtain a more favorable adjustment to the Medicare wage index. The expected effect of the Medicare occupational mix adjustment was to increase the Medicare payments to small and rural hospitals that were believed to use fewer skilled personnel (as a percentage of total personnel) than larger more sophisticated hospitals offering an array of specialized services. Analysts expected a decrease in the occupational mix adjusted wage index for areas with tertiary care and teaching facilities, and increases in the area wage indexes for areas with primarily small and rural hospitals. In reality for FFY 2006, 34 percent of statewide rural wage index areas experienced decreases in wage indexes caused by the occupational mix

adjustment and some major urban areas experienced increases in wage indexes as a result of the occupational mix adjustment. Because of the unanticipated results of the occupational mix survey data for FFY 2005, CMS decided not to adjust the entire wage index by the occupational mix but employed only a 10 percent occupational mix adjustment to the wage index for FFY 2005 and FFY 2006.

According to the Federal Register publication on April 25, 2006, CMS proposed to continue to apply only a 10 percent occupational mix adjustment to the wage index for FY 2007 as the plan was to rely on the same survey data as was used for FFY 2005 and FFY 2006 wage indices. However as we have previously mentioned, due to the Bellevue Court's order, CMS published a revision to the final rule in the May 17th publication of the Federal Register that proposed that CMS proceed with a 100 percent implementation of the occupational mix adjustment for FFY 2007 and that the adjustment would be based on data collected from the first quarter of 2006.

The following comments are DVHC's specific recommendations regarding the occupational mix adjustment that CMS has proposed for fiscal year (FY) 2007:

Development of the Data for the Proposed Occupational Mix Adjustment

As already stated, the DVHC appreciates CMS' efforts to streamline the occupational mix survey and we support the inclusion of both the paid hours associated with the employees in question and the wages paid. However, in our comments to the proposed rule regarding the Occupational Mix Survey that was published on October 14, 2005, the DVHC recommended there be a year's worth of data collected rather than only six-months of data so that the data collected would ensure that seasonal and other variations do not skew the results and that the data collected would easily tie back to the payroll system. In the FY 2005 Medicare inpatient prospective payments system final rule CMS noted that the "optimum data" would reflect wages and hours from a one-year period for all hospitals. We agree with CMS' stated position because a one-year time frame would improve the accuracy of the data as it could be compared with W-2 and other Internal Revenue Service (IRS) filings. Therefore **we have serious concerns that CMS is proposing that the data used for the occupational mix adjustment to the wage index for FY 2007 would be only three months of data from the first quarter of 2006**. This data would in no way reflect the seasonal changes in staffing patterns.

Timeline

As was previously mentioned, in CMS' proposal hospitals were required to make an initial submission of data from the first quarter of 2006 to the fiscal intermediaries by June 1, 2006, only fourteen days after the rule was published in the federal register. Needless to say this did not provide hospitals with sufficient time to prepare accurate submission of data. Likewise, the second set of data is expected to be submitted by August 31, 2006, which is only 62 days after the end of the second quarter. We believe that expecting hospitals to respond to a survey

with such short notice when the results of the survey would have a significant impact on Medicare reimbursement for inpatient services is unreasonable and unacceptable. Furthermore, given that data regarding contract labor is included in the survey, providers need time to receive invoices from their contractors and integrate that information into their systems and report it accordingly on the occupational mix survey. **We argue that the survey deadline for data submission was unacceptable and that hospitals need at least 90-days post the collection period to complete the occupational survey with contract labor information and to prepare it for submission to the fiscal intermediary.**

In addition to revising the deadline for completion of the Occupational Mix Survey, in the proposed rule CMS shortened the time frame that hospitals have to review the data after the fiscal intermediaries (FI) have made adjustments to it. Normally hospitals have at least 30 days to review data that is published by CMS in the public use file whereas this proposes that hospitals submit requests to their fiscal intermediaries for corrections to their interim occupational mix data within 2 weeks of the publication on the CMS website. The proposed rule indicates that the deadline for CMS to publish the data is June 29th and the deadline for hospitals to submit corrections is July 13th and during the brief period that hospitals would be given to review their data and submit corrections there is the national holiday of Independence Day when businesses are closed. Furthermore, we have a problem with the fact that not only does CMS propose a shortened time frame for hospitals to review their data and submit corrections, but also CMS proposes to penalize hospitals that fail to meet the deadline by denying them a right to appeal to the Provider Reimbursement Review Board. In the proposed rule, CMS states "hospitals that do not meet the procedural deadlines set forth above would not be afforded a later opportunity to submit occupational mix data corrections or to dispute the FI's decision with respect to requested changes." **In light of the condensed time to complete the Occupational Mix Survey the DVHC urges CMS to provide the hospitals with more time to submit corrections to the data.**

Calculation of the Proposed FY 2007 Occupational Mix Adjustment

For the FY 2005 and the FY 2006 final wage indices, the CMS used the unadjusted wage data for hospitals that did not submit occupational mix survey data. For calculation purposes, this equates to applying the national nursing mix to the wage data for these hospitals, because hospitals having the same mix as the Nation would have an occupational mix adjustment factor equaling 1.0000. For the FY 2007 wage index, CMS proposed to use 1 of 4 options for treating the occupational mix data for non-responsive hospitals: (1) Assign the hospital an occupational mix adjustment factor of 1.0000 as was done for FY 2005 and FY 2006; (2) assign the hospital the average occupational mix adjustment factor for its labor market area; (3) assign the hospital the lowest occupational mix adjustment factor for its labor market area; or (4) assign the hospital the average occupational mix factor for similar hospitals, based on factors such as, geographic location, bed size, teaching versus non-teaching status and case mix. It is impossible to evaluate the potential impact of implementing some of the suggested options for treating the occupational mix data for non-responsive hospitals because the Occupational Mix Survey that is being

conducted is so different from the one conducted previously. Therefore, we recommend that CMS use the same method for treating the occupational mix data for non-responsive hospitals as was used for the FY 20005 and FY 2006 final wage indices. **For the FY 2007 Wage Index, the DVHC suggests that CMS use the unadjusted wage data for the hospitals that do not submit occupational mix survey data.**

Waiver of 60-Day Comment Period

To be in compliance with the proposed rule, hospitals had to provide occupational mix data on an extremely expedited timeline, with little or no time for review, and no ability to see how the data will affect their FY07 payment rates. While we understand that CMS is under severe time pressure due to the timing of the court's decision, we do not believe that the 30-day comment period was sufficient, as hospitals were busy during this time trying to meet the new survey deadline and answering requests for information from the Fiscal Intermediaries. We feel strongly that CMS should take comments on the calculation after the initial results of the survey are tabulated and posted. The results of the survey could be material. For instance, if the segregation of Registered Nurses (RNs) who are management versus RNs who are staff does not produce a reliable result, CMS might consider consolidating the two for the purposes of the calculation. While CMS might not have time to make such changes for FY 2007, it could entertain comments on the implementation for FYs 2008 and 2009. We are concerned about the collective effect these changes will have on hospital payments and recommend that CMS provide opportunities for review, comment, and adjustment to the occupational mix data (including the ability to appeal or amend bad data), as needed, to the extent allowable under the Court order. **Thus, we urge CMS to publish the occupational mix adjustment changes as an interim-final rule in August with an associated comment period.**

Thank you for the opportunity to express our views on the occupational mix adjustment to the Medicare wage index as it will impact hospital services received by Medicare beneficiaries in the Philadelphia area as well as other parts of the Commonwealth and the nation. If you or your staff needs further clarification of our views, please do not hesitate to contact me at (215) 575-3737 or Pamela Clarke, DVHC's Vice President of Managed Care at (215) 575-5755.

Sincerely,

Andrew Wigglesworth
President

Submitter : **Dr. Herbert Pardes** **Date: 06/12/2006**

Organization : **New York Presbyterian Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P2-82-Attach-1.DOC

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

June 12, 2006

Dr. Mark McClellan
Centers for Medicare and Medicaid Services
Dept. of Health and Human Services
Mailstop C4-26-05
7500 Security Blvd
Baltimore MD 21244-1850

Re: CMS 1488-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates

Dear Dr. McClellan:

As President and CEO of NewYork-Presbyterian Hospital, I appreciate the opportunity to comment on the proposed changes to the Medicare inpatient PPS system published in Federal Register on April 25, 2006.

HSRV Weights:
We join with others in the hospital community in supporting meaningful improvement in Medicare's inpatient PPS system.. We feel, however, that the methodology underlying the proposed changes to the DRG weights is significantly flawed and has not been validated to ensure that the new system will rest on a sound foundation. The Health Economics and Outcomes Research Institute (THEORI) at the Greater New York Hospital Association (GNYHA) prepared a paper that will be submitted with the GNYHA comment letter. In that paper, THEORI assessed whether the HSRVcc methodology aligned payments with the costs of services. THEORI findings were that the proposed HSRVcc methodology performed substantially worse than the current methodology in aligning payments to cost. Their analysis proved that the HSRVcc proposed methodology greatly exacerbated margin inconsistency among the DRGs and caused excessive redistribution. We recommend, therefore, that the implementation of a new system be delayed at least one year in order to give more time for the industry to work with the Centers for Medicare & Medicaid Services (CMS) to be certain that any new system is based on sound assumptions, accurate data and clear objectives.

The impact of the proposed changes will be profound for many hospitals, my own included. NewYork-Presbyterian Hospital (NYPH) serves a varied patient population. Tertiary care patients use our facility for the highest world-wide levels of technological advances in medicine while NYPH also provides basic

primary care services to the impoverished neighboring Washington Heights community. NYPH stands to lose $15 to $20 million based on our initial analysis from Medicare patients alone and there will be additional losses for Medicare Managed Care patients, and from other payors that rely on the Medicare weights and grouper for payment calculations. A number of that magnitude obviously will have a severe impact on our finances and therefore unfortunately on the delivery of patient care. The intent of the revised weights was to improve cost margin consistency particularly for specialty hospitals. Because of this NYPH, which is not a specialty hospital but rather a hospital that provides such a comprehensive range of services, should not be impacted to the great degree that is anticipated. It is therefore incumbent on CMS to insure that the new system is as technically correct as possible, which is why we believe a delay in implementation is warranted. We also recommend that changes be phased in over a three year period to provide time for hospitals to absorb the impact of the changes gradually rather than abruptly.

In addition, of concern to us is a clearly flawed aspect of CMS HSRVcc methodology. Specifically, there is variation in hospital cost-reporting, which in combination with inconsistent and inattentive oversight by CMS intermediaries, has resulted in dramatically understated proposed DRG weights in certain areas, particularly interventional cardiology. Medical supplies such as stents and implantable defibrillators are often not properly reported by hospitals, and this has led to a mismatch between costs for such items and the charges submitted with patient claims. The HSRVcc development process therefore relied on seriously flawed charge to cost ratios in arriving at the currently proposed DRG weights.

With regard to the proposal for Consolidated Severity-Adjusted DRGs, we wish to point out a serious shortcoming particularly harmful to academic medical centers. Currently CMS has a limitation of nine patient diagnoses and six procedures for input to the "grouper" for purposes of DRG assignment. Our recent internal studies using the APR DRG grouper show that payments as determined with this arbitrary limit in place would be understated on approximately two percent of our Medicare claims. This skewing of severity levels downward occurs within the most complex patient populations, causing a disproportionately large negative financial impact. The resulting underpayments to our organization would amount to millions of dollars beyond the $15 to $20 million that was cited earlier. We believe this is contradictory to CMS' intent to more accurately reflect patient complexity in the reimbursement system. We would strongly advocate that the number of diagnoses and procedures used for DRG assignment be expanded to the maximum feasible number.

We also believe that there should be a reconsideration of implementing changes in two stages (once in FY07 for the HSRV weights and then again in FY08 for the Severity-adjusted DRGs), rather than simultaneously. The two year implementation process will cause two sets of revenue shifts. It seems more

complicated than necessary to force hospitals to change financial projections twice over a two year period, when the total net effect of all changes could be absorbed in a single implementation process incorporating all changes. The one year delay suggested above would provide time for corrections and validation and allow for simultaneous implementation of all changes.

Finally, let me reiterate our support for changes that can truly achieve a more balanced and equitable inpatient reimbursement system. Given time and the opportunity for open dialogue with CMS on establishing goals, designing systems, validating the results, and implementing changes gradually, I believe the hospital community will rally behind an improved reimbursement system.

Operating Payment Rates - Outlier Threshold:
Under the Medicare inpatient prospective payment system, if the costs of a particular Medicare case exceed the relevant DRG operating and capital payment (including any disproportionate share (DSH), IME, or new technology add-on payments) plus an outlier threshold, the hospital will receive an outlier payment. This payment equals 80% of the case's costs above the threshold calculation.

The outlier fixed-loss cost threshold is set at a level that is intended to result in outlier payments that are between 5% and 6%. Outlier payments are budget-neutral. Each year the Agency reduces the inpatient standardized amount by 5.1% and estimates a cost threshold that should result in outlier payments that equal 5.1%.

The proposed rule would increase the fixed-loss cost threshold for outlier payments to be equal to a case's DRG payment plus any IME and DSH payments, and any additional payments for new technologies, plus a $25,530 outlier threshold, an increase of 8.2% over the FFY 2006 threshold of $23,600.

CMS proposes an increase to the threshold even though the Agency estimates that outlier payments for FFY 2006 will represent only 4.71% of actual total DRG payments. Further, CMS estimates that outlier payments represented only 4.1% of total DRG payments in FFY 2005 and, according to the August 12, 2005 final rule, only 3.52% of total DRG payments in FFY 2004. Because outlier payments were less than the 5.1% reduction to the standardized amount, the result is less total Medicare payments to hospitals in all three consecutive years, contrary to the intent of the outlier payment policy.

We believe the FFY 2007 cost threshold must be reduced. CMS relies only on charge inflation to determine projected increases in per case costs, which determines outlier payment outlays. The AHA, AAMC and Federation of American Hospitals conducted an analysis that incorporates both cost and charge inflation, which we believe makes the threshold calculation more accurate

and reliable. We urge you to review and give serious consideration to the methodology, as described in more detail in the AHA's comment letter.

Resident Time in Patient-Related Activities:

This proposed rule also offers a clarification on time spent by residents in didactic activities. The proposed rule lists didactic activities occurring at hospital sites such as journal clubs, classroom lectures and seminars as examples of time that should be excluded in calculating the resident FTE for Indirect Medical Education payments. In this clarification, CMS also lists the same activities that occur in a non-hospital setting as excludable for Direct Graduate Medical Education.

These didactic ac tivities t hat CM S p roposes t o exclude for p ayment ar e an integral part of the resident learning experience centered on the delivery of patient care, and with the exception of discrete, extended time that is set aside for "bench research," there is no residency experience occurring at the hospital that is not related to patient care activities. We therefore strongly urge CMS to rescind the clarification regarding the exclusion of didactic time for IME and GME.

Again, I appreciate the opportunity to comment and look forward to further dialogue on these crucial issues.

All the best.

Sincerely,
Herbert Pardes M.D.

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

June 12, 2006

Dr. Mark McClellan
Centers for Medicare and Medicaid Services
Dept. of Health and Human Services
Mailstop C4-26-05
7500 Security Blvd
Baltimore MD 21244-1850

Re: CMS 1488-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates

Dear Dr. McClellan:

As President and CEO of NewYork-Presbyterian Hospital, I appreciate the opportunity to comment on the proposed changes to the Medicare inpatient PPS system published in Federal Register on April 25, 2006.

HSRV Weights:
We join with others in the hospital community in supporting meaningful improvement in Medicare's inpatient PPS system.. We feel, however, that the methodology underlying the proposed changes to the DRG weights is significantly flawed and has not been validated to ensure that the new system will rest on a sound foundation. The Health Economics and Outcomes Research Institute (THEORI) at the Greater New York Hospital Association (GNYHA) prepared a paper that will be submitted with the GNYHA comment letter. In that paper, THEORI assessed whether the HSRVcc methodology aligned payments with the costs of services. THEORI findings were that the proposed HSRVcc methodology performed substantially worse than the current methodology in aligning payments to cost. Their analysis proved that the HSRVcc proposed methodology greatly exacerbated margin inconsistency among the DRGs and caused excessive redistribution. We recommend, therefore, that the implementation of a new system be delayed at least one year in order to give more time for the industry to work with the Centers for Medicare & Medicaid Services (CMS) to be certain that any new system is based on sound assumptions, accurate data and clear objectives.

The impact of the proposed changes will be profound for many hospitals, my own included. NewYork-Presbyterian Hospital (NYPH) serves a varied patient population. Tertiary care patients use our facility for the highest world-wide levels of technological advances in medicine while NYPH also provides basic

primary care services to the impoverished neighboring Washington Heights community. NYPH stands to lose $15 to $20 million based on our initial analysis from Medicare patients alone and there will be additional losses for Medicare Managed Care patients, and from other payors that rely on the Medicare weights and grouper for payment calculations. A number of that magnitude obviously will have a severe impact on our finances and therefore unfortunately on the delivery of patient care. The intent of the revised weights was to improve cost margin consistency particularly for specialty hospitals. Because of this NYPH, which is not a specialty hospital but rather a hospital that provides such a comprehensive range of services, should not be impacted to the great degree that is anticipated. It is therefore incumbent on CMS to insure that the new system is as technically correct as possible, which is why we believe a delay in implementation is warranted. We also recommend that changes be phased in over a three year period to provide time for hospitals to absorb the impact of the changes gradually rather than abruptly.

In addition, of concern to us is a clearly flawed aspect of CMS HSRVcc methodology. Specifically, there is variation in hospital cost-reporting, which in combination with inconsistent and inattentive oversight by CMS intermediaries, has resulted in dramatically understated proposed DRG weights in certain areas, particularly interventional cardiology. Medical supplies such as stents and implantable defibrillators are often not properly reported by hospitals, and this has led to a mismatch between costs for such items and the charges submitted with patient claims. The HSRVcc development process therefore relied on seriously flawed charge to cost ratios in arriving at the currently proposed DRG weights.

With regard to the proposal for Consolidated Severity-Adjusted DRGs, we wish to point out a serious shortcoming particularly harmful to academic medical centers. Currently CMS has a limitation of nine patient diagnoses and six procedures for input to the "grouper" for purposes of DRG assignment. Our recent internal studies using the APR DRG grouper show that payments as determined with this arbitrary limit in place would be understated on approximately two percent of our Medicare claims. This skewing of severity levels downward occurs within the most complex patient populations, causing a disproportionately large negative financial impact. The resulting underpayments to our organization would amount to millions of dollars beyond the $15 to $20 million that was cited earlier. We believe this is contradictory to CMS' intent to more accurately reflect patient complexity in the reimbursement system. We would strongly advocate that the number of diagnoses and procedures used for DRG assignment be expanded to the maximum feasible number.

We also believe that there should be a reconsideration of implementing changes in two stages (once in FY07 for the HSRV weights and then again in FY08 for the Severity-adjusted DRGs), rather than simultaneously. The two year implementation process will cause two sets of revenue shifts. It seems more

complicated than necessary to force hospitals to change financial projections twice over a two year period, when the total net effect of all changes could be absorbed in a single implementation process incorporating all changes. The one year delay suggested above would provide time for corrections and validation and allow for simultaneous implementation of all changes.

Finally, let me reiterate our support for changes that can truly achieve a more balanced and equitable inpatient reimbursement system. Given time and the opportunity for open dialogue with CMS on establishing goals, designing systems, validating the results, and implementing changes gradually, I believe the hospital community will rally behind an improved reimbursement system.

Operating Payment Rates - Outlier Threshold:

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We believe the FFY 2007 cost threshold must be reduced. CMS relies only on charge inflation to determine projected increases in per case costs, which determines outlier payment outlays. The AHA, AAMC and Federation of American Hospitals conducted an analysis that incorporates both cost and charge inflation, which we believe makes the threshold calculation more accurate

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These didactic ac tivities t hat CM S p roposes t o exclude for p ayment ar e an integral part of the resident learning experience centered on the delivery of patient care, and with the exception of discrete, extended time that is set aside for "bench research," there is no residency experience occurring at the hospital that is not related to patient care activities. We therefore strongly urge CMS to rescind the clarification regarding the exclusion of didactic time for IME and GME.

Again, I appreciate the opportunity to comment and look forward to further dialogue on these crucial issues.

All the best.

Sincerely,
Herbert Pardes M.D.

Submitter : **Paul Sahney** **Date: 06/12/2006**

Organization : **Trinity Health**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Mr. Mark Thompson**

Date: 06/12/2006

Organization : **Rapid City Regional Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P2-84-Attach-1.PDF

ATTACHMENT TO #84

June 12, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
PO Box 8011
Baltimore, MD 21244-1850

Sent Electronically to: http://www.cms.hhs.gov/eRulemaking/

Subject: CMS-1488-P - Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates

Gentlemen:

I am writing to express concern regarding the CMS proposal to change the hospital inpatient payment rates. While I understand the proposed revision is intended to support recommendations of the Medicare Payment Advisory Commission (MedPAC) report on physician-owned specialty hospitals, it appears the proposed changes will not address the MedPAC recommendation as it relates to western South Dakota.

Recently, the South Dakota Association of Health Care Organizations (SDAHO) commissioned a study of the planned payment changes on South Dakota hospitals. The key findings of their study are:

1. While payments to cardiac specialty hospitals are reduced under the new rules, such payments are also reduced to facilities such as Rapid City Regional Hospital. In fact, the reduction in revenue for our cardiac bypass services is approximately 2.1%.
2. The impact of the proposed changes to Rapid City Regional Hospital reflect a $2.0 million to $2.6 million reimbursement reduction.

When DRG's were first introduced, a significant portion of the payment was impacted by labor costs and rural states such as South Dakota received significantly less reimbursement than urban areas. Technological changes and its related high cost have greatly impacted the delivery of health care with increasingly shorter lengths of stay, and in some cases, what was previously an inpatient procedure is now being done on an outpatient basis. For example, a patient who comes to the hospital to receive an Automatic Implantable Cardiac Deliberator (AICD) which costs between $26,000-$30,000 will stay one to two days and sometimes be treated as an outpatient. The majority of the cost for this DRG is related to the medical device itself and not the labor required. As previously noted due to the impact of the labor costs on reimbursement an urban institution will generally receive 20% more for this DRG than a rural South Dakota hospital.

Furthermore, analyses undertaken by the American Hospital Association (AHA) suggest that the proposed changes can result in severely adverse financial results for hospitals with only minor changes in the payment calculation methodology, an issue that requires further investigation.

While we acknowledge improved reimbursement for some medical, rehabilitation and psychological services, it is more than offset by the reimbursement reductions in surgical services such as cardiac surgery and interventional cardiology. In addition, the 2002 - 2003 data used in the invasive cardiac services pricing fails to take into account the cost increases we have experienced as a result of the patient-beneficial move to drug-eluting stents (which cost approximately $2,200 each vs. $800 for a bare metal stents). As we believe these results are contrary to the intent of Congress, we urgently request that your office assist us in dealing with these economic distortions.

In conclusion, we recognize the efforts CMS has made to address cost and fairness issues through this effort. However, given the complexity and uncertainty surrounding these issues, it is our recommendation that CMS defer implementation of the proposed payment system for a period of one year in order to provide time for further study and refinement. Furthermore, we would encourage CMS to consider a phased-in approach to such a significant change to the hospital inpatient payment system.

Sincerely,

Mark A. Thompson
Vice President Finance
Rapid City Regional Hospital

Cc: Senator Tim Johnson
SH-136 Hart Senate Office Building
Washington, DC 20510

Senator John Thune
383 Russell
Washington, DC 20510

Representative Stephanie Herseth
1504 Longworth HOB
Washington, DC 20515

Submitter : Ms. Erin Mass

Organization : The Nebraska Medical Center

Date: 06/12/2006

Category : Hospital

Issue Areas/Comments

Calculation of the Proposed FY 2007 Occupational Mix Adjustment

Calculation of the Proposed FY 2007 Occupational Mix Adjustment

As a facility that is following the regulations and submitting the occupational wage index information in an accurate and timely fashion, we feel that it would be unfair to assign an occupational mix adjustment of 1.0000 to facilities that do not submit data. Of the four options proposed in CMS-1488-P2, options 3 and 4 would be more appropriate. Facilities need to be penalized for not submitting their data. If a facility feels that they may be below 1.0, they have no incentive to submit their data if they know they will default to 1.0. However, if the lowest Occupational Mix Adjustment for their area or provider type is applied, then they have more of an incentive to supply their own information.

Submitter : **Mr. Richard Gundling** **Date: 06/12/2006**

Organization : **Healthcare Financial Management Association**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

Please see attached comment letter

CMS-1488-P2-86-Attach-1.PDF

ATTACHMENT TO #86

June 12, 2006

Mark McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1488-P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1488-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule.
and
CMS–1488–P2, Medicare Program; Hospital Inpatient Prospective Payment Systems Implementation of the Fiscal Year 2007 Occupational Mix Adjustment to the Wage Index; Proposed rule.

Dear Dr. McClellan:

The Healthcare Financial Management Association (HFMA) is pleased to submit, on behalf of our many members who are involved in the financial management of hospitals, the following comments regarding the proposed Medicare inpatient prospective payment system (PPS) regulations (CMS-1488-P) and the proposed rule on the inpatient PPS implementation of the FY07 occupational mix adjustment to the wage index. The rules were published in the April 25, 2006, and May 17, 2006, *Federal Registers*, respectively.

HFMA is the professional membership organization for individuals involved in the financial management of health care. HFMA's more than 34,000 members work in a variety of healthcare settings.

The inpatient PPS FY07 rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since DRGs were adopted. It would create what is being called cost-based weights using a newly developed hospital-specific relative values cost center methodology (HSRVcc). The rule also proposes expansion of the DRG system into consolidated severity adjusted DRGs (CS-DRGs) to account for patient severity and suggests such refinements could occur in FY08, "if not before."

We have serious concerns about the proposed changes to the DRG weights and classifications. While we believe CMS and HFMA share a common goal of refinements to the Medicare payment systems that will make for fairer and more equitable payments, our experience educating healthcare professionals tells us that even with perfect changes to the DRG-based system, more time is needed to understand not only the direct financial effects of such significant

proposed policy changes, but the many ramifications of the changes throughout hospital organizations.

CMS is receiving comments from the American Hospital Association, the Federation of American Hospitals, and the Association of American Medical Colleges, based upon significant research performed on their behalf. That research and analysis addresses such concerns as the instability of the impact of the proposed changes, that small changes in methodology could lead to large changes in hospital payment, and that the validity of CMS' proposals versus potential alternatives to improve the DRG weights and classification system is uncertain. We echo those concerns and urge your attention to that research.

HFMA asks that the following be part of the final inpatient PPS rule:

- **Additional study of the need for a new classification system.** HFMA believes additional understanding of the variation within DRGs and the capabilities of a classification system that will effectively address such variation is still needed before changes of the magnitude being proposed are put in place.

- **Delay cost-based weighting by at least one year.** While we support moving to a DRG-weighting methodology based on hospital costs rather than charges, we also believe the system should be simple, predictable, and stable over time. The PPS should also provide clinically cohesive and meaningful DRGs that are somewhat intuitive for providers and coders to follow, and that reflect similar resource use within DRGs. And, ultimately, the inpatient PPS should foster innovation and best practice in care delivery. The research and analysis undertaken for AHA, FAH, and AAMC found errors, inconsistencies, and flawed HSRVcc methodology that indicate more work and time is needed to determine the best way to create cost-based weights, develop a sound methodological approach, and to understand their potential impact. In addition, there should be analysis of proposed changes to clearly show they result in an improved system.

  HFMA sees a clear need for not less than a one-year delay, regardless of version of the proposed DRG changes, given the serious concerns with the HSRVcc and CS-DRG methodology, and appropriate consideration to the substantial education and training efforts the proposed changes would require.

- **Simultaneous adoption of changes to the weights and classifications.** HFMA supports the conclusion from the research commissioned by the AHA, FAH, and AAMC that if the need for a new, more effective classification system is demonstrated and developed, it should be implemented simultaneously with the new weighting system. Such implementation would provide better predictability, smooth the volatility created by the two, generally off-setting, changes and permit the training process to engage the logic of both changes.

- **A three-year transition.** When, adopted, weighting changes and refined DRGs should be implemented over a three-year transition period, given the magnitude of payment redistribution across DRGs and hospitals, and the extensive training the changes will entail.

We also have concerns about the proposed occupational mix rule. As a result of the decision handed down by the U.S. Court of Appeals for the Second Circuit on April 3 in *Bellevue Hospital Center v. Leavitt*, CMS on May 12 released a proposed rule revising the occupational mix adjustment portion of the FY07 inpatient PPS proposed rule. The court ruling requires CMS to collect new data on the occupational mix of hospital employees and fully adjust the area wage index (AWI) for FY07. Care must be taken to prevent the errors that can result from compressing a lot of work into a limited amount of time.

HFMA urges CMS to:

- Allow hospitals to turn in both calendar quarters of data in August whether they are submitting for the first time or with corrections.

- Take comments on the calculations after the initial results of the survey are tabulated and posted, and publish the occupational mix adjustment changes as an interim-final rule in August with an associated comment period.

Finally, HFMA takes this opportunity to note what appears to be an oversight in data manipulation pertaining to the wage index. CMS eliminates the critical access hospital (CAH) data from the wage index file it uses to compute the national average hourly wage (NAHW). Since CAHs have lower average hourly wages (AHWs) than the average PPS hospital, the elimination of their data produces an overstated NAHW. This artificial increase is included in the negative budget neutrality adjustment that consequently reduces payments and results in the national inpatient PPS operating payments being understated by an estimated $1.52 billion over five years (2003-2007). We call upon CMS to apply a positive budget neutrality adjustment in FY07 to compensate for the underpayments.

HFMA takes pride in its longstanding ability to provide technical expertise to Federal agencies. We hope that these comments prove useful.

We would welcome the opportunity to provide further assistance with these issues. Please do not hesitate to call on me at (202) 296-2920.

Sincerely,

Richard L. Gundling, FHFMA
Vice President

Submitter : **Mr. Richard Fries** **Date: 06/12/2006**

Organization : **West Penn Allegheny Health System**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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Please direct your questions or comments to 1 800 743-3951.

Submitter : **Mr. Don Snell**

Organization : **MCG Health, Inc.**

Category : **Hospital**

Date: 06/12/2006

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1488-P2-88-Attach-1.PDF

ATTACHMENT TO # 88

Don Snell
President and Chief Executive Officer

June 12, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1488-P and P2
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMC-1488-P and P2, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal year 2007 Rates; Proposed Rule.

Dear Dr. McClellan:

Our organization, MCG Health, Inc., greatly appreciates the opportunity to offer our comments to the Centers for Medicare & Medicaid Services (CMS) on the fiscal year (FY) 2007 inpatient prospective payment system (PPS) and occupational mix adjustment proposed rules.

The proposed changes represent a significant shift in the manner in which diagnostic-related groups (DRG) relative weights are calculated. In addition to utilizing the newly developed hospital-specific relative values cost center methodology (HSRVcc) to create a version of cost-based weights, the rule also proposes that the DRGs be enhanced to capture factors such as patient acuity. The rule would also allow for the provision of updated payment rates and would address several specific policies including (but not limited to) the outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education.

While MCG Health, Inc. supports many of the provisions of the proposed rule, we feel that because the changes regarding DRG weights and classifications present a substantial alteration in current methodology and will result in significant impact to the hospital industry, they must be approached with caution.

MCG Health, Inc.
1120 15th Street, Augusta, Georgia 30912 MCGHealth.org
Medical College of Georgia Health System

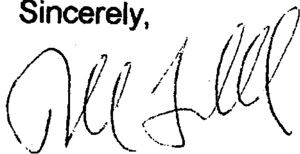
MCG Health, Inc. supports a one-year delay in the proposed DRG changes. This will allow for further investigation of the HSRVcc and CS-DRG methodologies. We support the implementation of a DRG-weighting methodology that is based on hospital costs rather than charges, but only if such methodology can be validated.

MCG Health, Inc. agrees with the assertion of the AHA that current evidence does not support the need for a new classification system at this time. We also believe that, should a new classification system become necessary, it should be developed and implemented concurrently with the new weighting system to ensure the efficient operation of each system.

Finally, given the considerable impact that the proposed changes will have on the hospital industry as a whole, MCG Health, Inc. suggests that any changes should be instituted utilizing a three-year transition period. This timeframe would allow institutions, both small and large, to alter existing procedures and practices effectively so that they may continue to offer excellent healthcare within the changing structure of the program.

MCG Health, Inc. appreciates the opportunity to submit our concerns. If you have any questions about our comments, please feel free to contact me.

Sincerely,



Don Snell
CEO & President
MCG Health, Inc.