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Issue Areas/Comments

GENERAL

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See Attachment

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#1501

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Mark McClellan, Administrator, MD, PhD
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare program; proposed changes for severity stratification [CMS-1488-P]

Dear Dr. McClellan,

Cardinal Health is pleased to submit these comments in response to the recent CMS proposal for changes to incorporate severity of illness into both the current and any future DRG system. We applaud your ongoing efforts to improve the quality of care for Medicare and Medicaid—in particular, your work to improve accountability in health care by bringing severity stratification into the reimbursement process. This is an important element in the movement toward payment for performance. We share your desire to ensure that hospitals are paid fairly based on accurate assessment of severity of illness.

Cardinal Health, Inc. is a global company serving the health care industry. Through one of our divisions, MediQual, we have extensive experience that is particularly germane to the issues raised by CMS' proposed changes. In more than 20 years of supporting the Pennsylvania Healthcare Cost Containment Council (PHC4), we have worked with both claims data and objective, physiologic, clinical data that reflect hospital care delivered to millions of patients. This extensive experience provides us with the insight to address critical issues in the development and use of optimal risk-adjustment methodologies. The evidence and our experience underscore these critical lessons:

- The use of objective, physiologic data on admission to enhance claims data significantly improves the accuracy of any severity stratification.
- Outside of principal diagnosis, laboratory results are the single most important predictor of severity.
- The addition to claims data of time-stamped laboratory results on admission resolves a key problem in distinguishing co-morbidities present on admission from complications during hospitalization.
- For purposes of estimating severity, electronically capturing laboratory results will require less time and fewer resources than incrementally improving coding practices, which may never achieve the accuracy and consistency of the laboratory results themselves.
- Credible risk adjustment based upon objective, physiologic data increases the likelihood of clinician acceptance and is critical to public reporting and pay-for-performance.

In the past, the cost to acquire physiologic data presented a barrier to their widespread use. Today, technological advances have made it possible to electronically capture laboratory results at a cost similar to that of capturing claims data alone. Michael O. Leavitt, Secretary of Health and Human Services, has repeatedly stressed the importance of electronic transmissibility of laboratory data.

The rapid growth of public reporting underscores the importance of ranking hospital performance accurately. Numerous publications have suggested that the use of claims data alone to determine severity can result in misclassification of hospital performance. Severity-adjusted mortality rates are a common measure of hospital performance. Analyses of our research database demonstrate that predicting severity rates using claims data alone could incorrectly rank up to 45% of top-performing hospitals.

The remainder of this document discusses these key issues related to the current CMS proposal and provides data analyses and an annotated review of the literature to support our positions and recommendations. An appendix contains supplemental tables, figures, and a detailed bibliography.

NEED FOR CHANGE

As detailed in the following sections, a growing body of evidence suggests the need for an objective, precise, and accurate approach to stratification of severity. This is especially true given the undesirable variability in documentation of patient records and in the coding process itself. Claims data are based on data from both accurate and inaccurate coding. These mixed-quality data form the basis of any system that relies solely on claims data, including the severity-adjusted-DRGs proposed by CMS.

It is also important to recognize that the proposed 861 consolidated severity-adjusted DRGs do not reflect the severity of illness of hospitalized patients on admission; rather, they reflect the burden of illness experienced by patients during the entire course of their hospital stay. This is a critical distinction. The ideal system to link hospital payment to severity of illness would estimate severity at the time of admission. On the other hand, using any severity-stratification system that is based on the total burden of illness during the entire course of the hospitalization, CMS could pay for complications that result from potentially sub-optimal care. Thus, severity adjustment based on the total burden of illness during hospitalization—as solely claims-based systems are—can undermine the very principles that pay-for-performance programs are designed to advance.

The ability of a severity-adjustment methodology to distinguish between co-morbidities and complications is crucial. Claims data cannot always separate secondary diagnoses that are present on admission from those that occur during hospitalization. For example, metabolic abnormalities in hospitalized patients are excellent predictors of increased severity, but current documentation and coding practices do not provide reliable information about the presence, absence, or degree of metabolic abnormalities. Such unreliability makes comparisons based on these codes suspect. This would be true even if a "present on admission" flag were added to the codes. If an abnormality is missed, it cannot be coded and cannot be flagged. Furthermore, even if the laboratory abnormality is coded, the degree of abnormality, which strongly predicts severity, would still not be available.

In contrast, the use of time-stamped physiologic data on admission provides the objective evidence that is the cornerstone to ensuring fair and accurate estimates of severity on admission. Physiologic data that are predictive of severity include laboratory results, vital signs, and other clinical indicators, such as neurological status at the time of admission. Laboratory results, which are widely available, provide the most immediate opportunity to include objective, physiologic evidence on admission for a cost-effective enhancement to claims-based severity estimates. Since data collection is already automated for both the claims data and the laboratory results, manual abstraction is unnecessary. In 2006 an estimated 95% of hospitals have the capability to capture laboratory results electronically.

The combination of time-stamped laboratory results with claims data provides an accurate measure of illness at the time of admission and enhances acceptance by clinicians. This approach ensures that events that occur following admission do not bias the estimate of the patient's severity at the time of admission. Unlike severity measures that are solely claims-based, such as those in the current CMS proposal, the use of objective, time-stamped, physiologic data on admission greatly reduces the potential for inaccurate quality assessment or improper payment due to imprecise documentation and coding.

Given the growing momentum of pay-for-performance and gainsharing initiatives, and given that the CMS plan is designed to be revenue neutral, it is imperative to ensure that the proper groups are being

rewarded. In the absence of an objective, admission-based, physiologic severity-adjustment approach, pay-for-performance and gainsharing programs could reward the wrong parties. This underscores the critical importance of which severity methodology CMS selects.

While it may be difficult or impossible for CMS to shoulder complete responsibility for maintaining any grouping and severity-adjustment system, the use of a single, non-public organization to provide both the resource-estimation grouping and the severity-adjustment system may eliminate important checks and balances. The use of a separate severity estimate based on objective, physiologic data—either to stratify severity or to serve as a cross-check of the proposed CMS system—would add substantial credibility. The use of an open methodology that utilizes objective, time-stamped, physiologic data on admission also adds a level of transparency that would facilitate hospital and clinician acceptance.

INTRODUCTION TO THE EVIDENCE

Pennsylvania holds the singular distinction of being the only state in the union to have a 20-year, uninterrupted history of reporting objective, admission-based, risk-adjusted outcomes across a wide variety of medical conditions. The reporting agency is the Pennsylvania Health Care Cost Containment Council (PHC4) located in Harrisburg, Pennsylvania. The Commonwealth of Pennsylvania has used us as the exclusive source for their risk-adjustment methodology since the inception of PHC4. For the past 20 years we have established the data definitions, performed the data collection, and developed the objective, admission-based, risk-adjustment methodology used for public reporting of hospital performance in the Commonwealth of Pennsylvania. Our extensive experience is based on having had access to this unique dataset.

From the outset, PHC4 has believed that clinical data beyond those which can be obtained from claims data are required to achieve the accuracy, consistency, and clinical acceptance required for public reporting. The Pennsylvania Medical Society endorsed this stance during the legislative reauthorization process for PHC4 in 2003, saying, *"The Pennsylvania Medical Society supports reporting as long as it is clinically based and risk-adjusted."* Through this long relationship with PHC4 we have extensive experience using claims data enhanced with objective, time-stamped laboratory results, vital signs, and other measures of physiologic status. Two decades of experience has shown us that an ounce of data improvement is worth a pound of changes in statistical methodology.

Michael Porter and Elizabeth Tiesberg, in "Fixing Competition in U.S. Health Care" (*Harvard Business Review Research Report,* 2004), list the use and analysis of *"the wrong information"* as one of the root causes for the failure of competition. In the section "Identifying Root Causes," the authors state, *"There have been isolated efforts to collect the right kind of information, among them Cleveland Quality Choice, the Pennsylvania Health Care Cost Containment Council, and New York State's CSRS."* It is important to note that all three of these organizations use objective, time-stamped, physiologic data on admission for severity adjustment. Porter and Tiesberg compliment both the organizations and the data.

A further compliment to these data has been their secondary uses by other medical investigators. One of the most important examples is the development of the Pneumonia Severity Index by Fine et al (*N Engl J Med* 1997). This index may well be the most widely used methodology for severity stratification of patients with community-acquired pneumonia. Another important secondary use of these data is Silber's Failure to Rescue metric (*JAMA 1995)*, which has been accepted as one of the Agency for Healthcare Research and Quality's (AHRQ) Patient Safety Indicators. Other predictive risk scores using these data have been published for various disease states, including pulmonary embolism and congestive heart failure.

AHRQ is just completing an independent study which bears on many of these issues. The study, "Adding Clinical Data Elements to Administrative Data for Hospital-level Reporting" [AHRQ Contract #233-02-0088], is under the direction of Anne Elixhauser, PhD. This study was commissioned by AHRQ to conduct a cost-benefit analysis of the incremental value of adding clinical data such as laboratory results, vital signs, and other clinical indicators to claims data for the purpose of hospital-level quality reporting. A formal report is expected to be available in July 2006. Evaluating the AHRQ report will provide important information to help guide CMS' selection of the optimal, cost-effective system.

RECOMMENDATIONS

Based on evidence and experience, we recommend that any changes to the current DRG system that include severity stratification include objective, time-stamped, electronically captured laboratory results.

Given the high complexity of this issue and the potentially large impact on hospital reimbursement and quality rankings, it would be prudent to conduct one or more demonstration projects studying claims data enhanced with objective, time-stamped, electronically captured laboratory results as an alternative approach for severity adjustment for payment and quality assessment purposes. This would allow time to garner more information to ensure that a severity component is successfully added to changes in the payment system.

We would welcome the opportunity to meet with CMS to discuss these issues as they pertain to pay-for-performance initiatives, public reporting, and the proposed changes to the DRG reimbursement system.

Respectfully yours,

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Headquartered in Cardinal Health, Inc. is a $75 billion, global company serving the health-care industry with a broad portfolio of products and services. Through its diverse offering, Cardinal Health delivers integrated health-care solutions that help customers reduce their costs, improve efficiency and deliver better care to patients. The company manufactures, packages and distributes pharmaceuticals and medical supplies, offers a range of clinical services and develops automation products that improve the management and delivery of supplies and medication for hospitals, physician offices and pharmacies. Ranked No.19 on the Fortune 500, Cardinal Health employs more than 55,000 people on six continents. More information about the company may be found at www.cardinalhealth.com.

Supporting Evidence for Cardinal Health Response to CMS-1488-P

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Table of Contents

	Page
I. Potential Misclassification of Hospital Performance	7
A. Review of Internal Research	7
B. Literature Review	9
C. Section Conclusion	11
II. Errors of Omission: Physiologic Data vs. Claims Data	12
A. Review of Internal Research	12
B. Literature Review	15
C. Section Conclusion	16
III. Risk Adjustment	17
A. Review of Internal Research	17
B. Literature Review	18
C. Section Conclusion	21
IV. Selected Literature	22
V. Appendix	27

I. Potential Misclassification of Hospital Performance Using Claims Data

Section Summary

Results of our analyses that compare risk-adjusted hospital mortality ranks using claims and physiologic models showed a misclassification of up to 45% for top-performing hospitals with models based on claims data. We believe that such misclassifications can impact public reporting of outcomes and payment-for-performance programs.

The medical literature and analyses of our data, which include electronically captured laboratory results, suggest that laboratory results provide the most immediate opportunity to include objective, physiologic evidence on admission for a cost-effective enhancement to claims-based severity estimates.

We suggest that it would be prudent to conduct one or more demonstration projects studying claims data enhanced with objective, time-stamped, electronically captured laboratory results as an alternative approach for severity adjustment for payment and quality assessment purposes.

A. Review of Internal Research

- To examine the potential for misclassification of hospital performance as a function of the risk-adjustment methodology used, our research database was evaluated for seven disease groups (congestive heart failure [CHF], pneumonia, sepsis, acute myocardial infarction [AMI], respiratory failure, diabetes mellitus [DM], and stroke) to determine the correlation between claims-based risk adjusted rankings and those based on physiologic data on admission. The physiologic risk-adjustment models used were those currently being used for public reporting in the Commonwealth of Pennsylvania.

- Claims-based risk-adjustment models were compared with two different physiologic-based models: (a) a physiologic laboratory model (PLM) that used laboratory results on admission plus claims data, and (b) a physiologic full model (PFM) that used laboratory results, vital signs, and clinical characteristics on admission, plus claims data. Each hospital's risk-adjusted mortality was computed as a standardized mortality ratio, and these were ranked from 1 to n. A perfect correlation (i.e. complete agreement) between the results achieved between any pair of models in a figure would appear as the complete agreement of plot points with no scatter, i.e. along a straight line.

- As can be seen from Figure 1 (a, b, and c) for heart failure, the agreement between PLM and PFM is greater (less scatter) than between claims data (more scatter) and either PLM or PFM.

Figure 1 (a, b, and c). Comparison of hospital level rank based on risk-adjusted mortality rate with claims, physiologic lab (PLM), or physiologic full model (PFM) for heart failure.

Figure 1a. Claims model vs. physiologic lab model

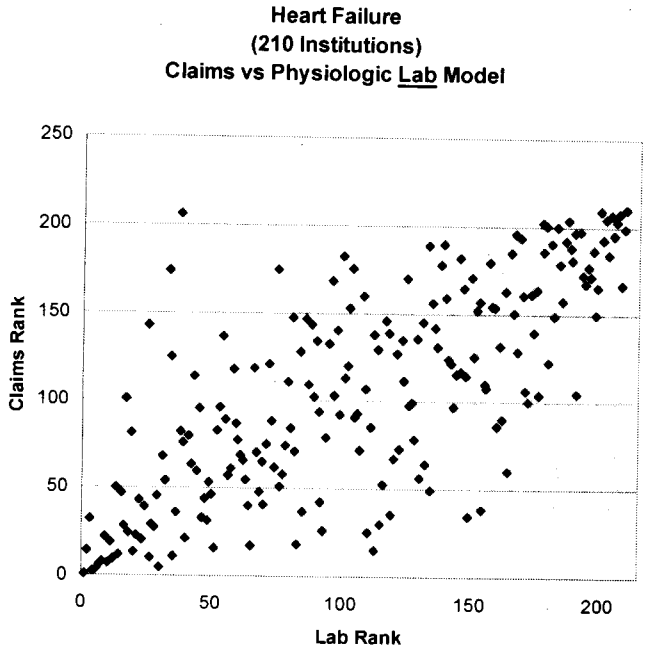


Figure 1b. Claims vs. physiologic full model

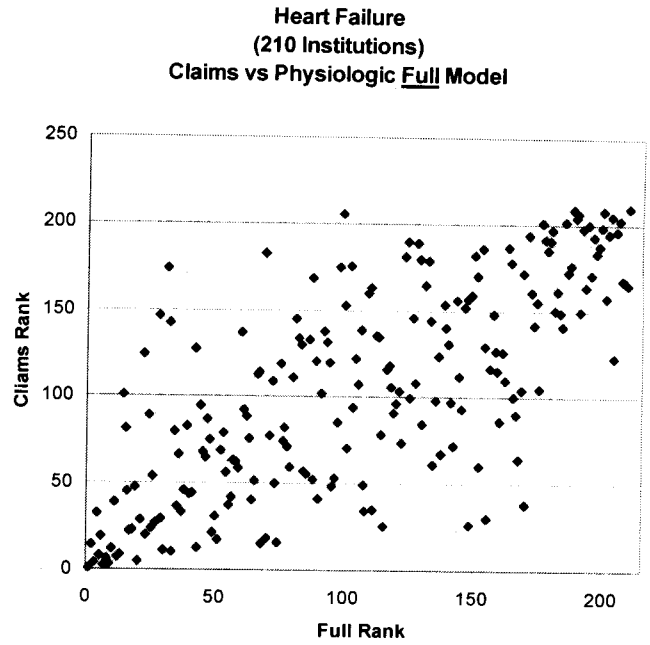
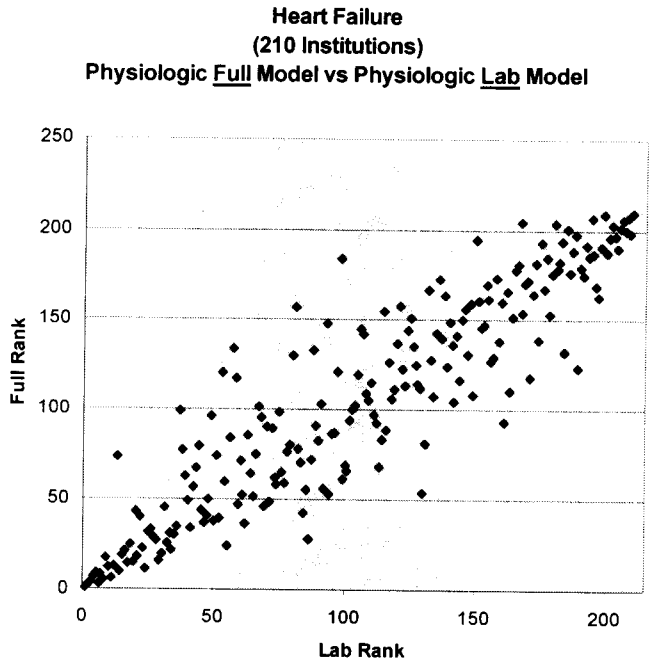


Figure 1c. Physiologic full model vs. physiologic lab model.



- A second analysis determined the degree of correlation between the claims models and the PLM and PFM models from the perspective of a pay-for-performance system that rewarded institutions that performed in the top two deciles (i.e. the top 20%). The top two deciles were chosen because this mirrors the cutoffs used in the Premier Pay-For-Performance Demonstration Project (http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1441). For each disease examined, the institutions that ranked in the top two deciles for risk-adjusted mortality using claims models were compared to those ranked in the top two deciles using either of the physiologic based models (PLM or PFM) to determine the extent of agreement between the models.

- Missed classification rates were calculated as follows: all hospitals whose performance exceeded the 80th percentile (i.e. the top 20%) using the claims-based adjustor formed the denominator. The numerator was the number of hospitals where both the claims based method and one of the physiologic-based models were in agreement. As shown in Table 1 the rates of misclassification between the claims-based ranking and either of the physiologic based rankings was substantial. The mean misclassification rate across the seven diseases was 28.8% (range of 7.7-45%). These findings provide further support for the usefulness of using models based on objective, time-stamped, physiologic data on admission, and specifically models based on laboratory results.

Table 1. Misclassification of high-performance hospitals based on hospital level risk-adjusted mortality rates in common diseases estimated using claims, physiologic lab, and physiologic full models.

Disease Group	Total Hospitals (n)	In-Hospital Mortality (%)	Misclassification* of Performance (%)	
			Claims vs. PLM	Claims vs. PFM
CHF	210	4.0	38.1	40.5
AMI	201	7.4	45.0	50.0
Pneumonia	210	5.6	19.1	21.4
Respiratory Failure	173	18.9	42.9	34.3
Sepsis	180	18.4	30.6	36.1
Stroke	188	6.1	18.4	31.6
DM	195	1.2	7.7	7.7

CHF = heart failure; AMI = acute myocardial infarction; COPD = chronic obstructive pulmonary disease; DM = diabetes mellitus; PLM = physiologic laboratory model; PFM = physiologic full model;
* Defined as: Hospitals that are in the top two deciles of risk-adjusted mortality using claims models but not in the top two deciles by the physiologic model in the comparison

B. Literature Review:

- Many researchers have commented that claims data do not adequately measure risk, especially risk on admission. This was highlighted in recent policy statements by the American Heart Association in "Payment for Quality: Guiding Principles and Recommendations (Buffalino, Circulation 2006 113: 1151 – 1154)" and "Standards for statistical modeling used for public reporting of health outcomes (Krumholtz, Circulation 2006;113)," which stated the following:

- *"Use rigorous methodological approaches to measure quality of care. Quality-of-care measures should be risk-adjusted, standardized, and evidence-based. Rigorous methods should be used to measure quality, and these methods should include defining data standards and providing for consistency of measures. Quality measures should be based on clinical data to the greatest extent possible."*

- *"If administrative data are used, then quality measures should be validated against higher-quality clinically derived data. Use of the highest-quality methodological approaches will minimize the likelihood of misrepresentation of quality."*

- *"Models that use patient risk variables that may represent events that occurred as a result of the care provided may inadvertently reward hospitals that poorly manage their patients by allowing them to 'adjust' for conditions that arose as a result of deficiencies in care. Consequently, codes that could represent complications should not be included in risk models. Moreover, continuous efforts should be made to improve the administrative claims data so that it would be possible to differentiate complications from co-morbidities."*

- Other researchers have provided similar comments:

  - MacLean et al (Medical Care 2006) noted that, "*Scores based on administrative data may be of little value to large numbers of older patients whose health conditions do not match limited administrative data performance measurement. Additionally, performance scores based on administrative data alone greatly overestimate health care quality because performance is much higher for the portion of health care that can be assessed with administrative data relative to the portion that requires data from medical records.*"

  - An editorial by David Mark (JAMA 2001) on a study that used claims data (Jha et al. JAMA 2001) notes that, "*...it is important to realize that the data on which these results are based are often extremely limited with respect to the assessment of the severity of the patients' illness and other characteristics that may be risk factors for mortality or the outcome of interest.*"

    - In other articles, Mark has also commented that, "*Much evidence exists that clinical variables add important predictive ability to administrative data, (Iezzoni et al. Medical Care 1992)" and that, "...this additional predictive ability makes a difference in assessing factors associated with patient outcomes" (Hannan et al. Health Serv Res 1997).*

  - Halm (N Engl J Med 2001) also discussed that the, "*Administrative data cannot account for differences in severity of illness with any degree of clinical subtlety.*"

  - The limitations of claims data have also been highlighted in other studies and editorials, such as those by Jenks (*JAMA*. 1992), Jollis et al (*Ann Intern Med.*1993), Birman-Deych et al (*Med Care*. 2005), and Lawthers et al (*Med Care*. 2000).

- The inability of the proposed CMS changes to differentiate complications that occur during hospitalization from complications present on admission can have significant implications for payment programs. Several studies have highlighted this issue.
    - In one of Lisa Iezzoni's many contributions to the literature, namely, "The Risks of Risk Adjustment (*JAMA* 1997)," she commented that, "*Additionally, to draw meaningful conclusions on quality based on severity adjusted death rates, one must adjust only for preexisting conditions but not those arising late in the hospital stay – possibly because of iatrogenic complications.*"
        - In this paper, published almost ten years ago, Iezonni warned that, "*Our preliminary analyses agree with others in suggesting that discharge-abstract-based measures rely on late events to boost their predictive ability.*"
    - A limited number of studies have attempted to corroborate coded diagnosis using explicitly defined *a priori* criteria. Using such a methodology McCarthey et al (*Med Care*. 2000) found that substantial numbers of discharge diagnoses in both surgical and medical cases lacked documented evidence to support the discharge diagnosis in the medical records.

C. Section Conclusion:

- For six of the seven disease groups evaluated, there was greater agreement between the two physiologic models than between the claims-based model and either physiologic model. Diabetes was the only disease group evaluated where there was good concordance with the claims and both physiologic models (PLM and PFM). This shows that:
    - Compared to claims-based models, either physiologic model—PLM or PFM—provides a more accurate estimate of severity in patients with common disease states evaluated.
    - PFM provides the most accurate estimates.
    - Severity estimates obtained using PLM methodology correlates well with those obtained using PFM.
- Severity-adjustment models based on full physiologic data are the "gold standard." However, until laboratory results, vital signs, and other clinical indicators are all available electronically, this is also a more costly approach.
- Severity-adjustment models based on objective, physiologic data in the form of laboratory results currently offer a cost-effective alternative that, compared with models based solely on claims data, provides significantly more accurate severity estimates.
- It is important to note that in 2006 laboratory results can be captured electronically from 95% of institutions in the US, and use of the LOINC terminology facilitates the standardization of laboratory results.

- Thus, the medical literature and analyses of our data, which include electronically captured laboratory results, suggest that physiologic lab models may provide the most immediate opportunity for a cost-effective enhancement to claims-based severity estimates.

- We would suggest that further research, including CMS-supported demonstration projects, be done to explore such alternatives prior to implementation of any major change in CMS policy.

II. Errors of Omission: Physiologic Data vs. Claims Data

Section Summary

- Abnormal laboratory results are one of the most important predictors of severity. Our results show that claims data are able to identify common laboratory abnormalities 9.1% to 18.6% of the time.

- Even when laboratory abnormalities are identified by claims data, they are not time-stamped and thus do not differentiate abnormalities present on admission (possible co-morbidities) from those that develop during hospitalization (possible complications).

- Unlike claims data, the use of time-stamped laboratory results provide the granularity to differentiate risk at patient-specific abnormal values that are important in estimating risk on admission.

- Given the low rates of detection of laboratory abnormalities using claims data and the importance of abnormal laboratory results in estimating severity on admission, we believe that electronically obtaining laboratory results would be significantly less costly than incrementally improving detection of laboratory abnormalities using claims data, which may never achieve the accuracy and consistency of the laboratory results themselves.

A. Review of Internal Research

- Since ICD-9-CM codes do exist for some laboratory data, these codes can be used to compare the performance of claims data against laboratory results in identifying abnormal laboratory results. Using data from our research database, we examined claims data for hypernatremia [high serum sodium], hyponatremia [low serum sodium], hyperkalemia [high serum potassium], hypokalemia [low serum potassium], and anemia [low serum hemoglobin]. The research database for these evaluations included data from 83 institutions all of whom provide laboratory results electronically for the entire hospitalization using the laboratory results as the "gold standard".

- Abnormal laboratory results were defined as any value outside the upper and lower boundaries as found in Harrison's Principles of Internal Medicine (McGraw-Hill Professional; 15^{nth} Edition, 2001). Using these definitions, the sensitivity and

specificity were calculated for claims data, using electronic laboratory results as the gold standard. Laboratory results at any time during hospitalization were examined, as well those during the admission period, defined as the first day of stay. Thus, we were able to evaluate the ability of claims data to identify laboratory abnormalities present during the admission period as well as those during the entire hospital stay. Furthermore, we were able to determine the ability of claims data to identify cases in which there was unequivocal evidence of laboratory abnormalities, i.e. cases in which laboratory abnormalities were identified more than 10 times during the hospitalization.

- The results showed that while cases with pertinent laboratory abnormalities identified from laboratory results during the hospital stay, claims data only identified such cases 9.1%-18.6% of the time (table 2 below and tables 3-5 in the appendix).

Table 2. Sensitivity and specificity of claims data to detect common laboratory abnormalities* identified from 83 institutions that provide electronically captured laboratory results during hospitalization [refer to Tables 3-5 in the appendix for the raw data for each analysis described].

Laboratory Abnormality*	Sensitivity (%)	Specificity (%)	Positive Predictive Value (%)	Negative Predictive Value (%)
Low Serum Sodium (≤ 135 mEq/L)	9.7	99.8	95.0	72.5
High Serum Sodium (> 145 mEq/L)	9.8	99.9	85.0	96.1
Low Serum Potassium (< 3.5 mEq/L)	18.6	99.3	85.9	83.7
High Serum Potassium (> 5.0 mEq/L)	15.0	99.7	87.4	90.7
Low Serum Hemoglobin (< 12 g/dl for females, < 14 for males g/dl)	9.1	99.3	96.1	35.8

* Using Harrison's Principles of Internal Medicine. McGraw-Hill Professional, 15th Edition, 2001.
ICD-9 Codes used: Low serum sodium (271.61), high serum sodium (276.0), low serum potassium (276.8), high serum potassium (276.7), low serum hemoglobin (285.9).

- A subsequent analysis was done to determine the ability of the claims codes to detect laboratory abnormalities in the admission period. As shown in table 3 below, claims data were able to identify these abnormalities 9.6%-22.8% of the time. For all 5 codes examined, the specificity was uniformly very good, exceeding 99% in all cases. In other words, when claims data identified an abnormality that identification was correct. This is not unexpected since false positive identification of laboratory abnormality is uncommon. This also accounts for the high positive predictive values.

- However, the story for sensitivity is quite different. The hypokalemia code, which showed the best sensitivity, still only identified fewer than one in five cases of laboratory-confirmed hypokalemia. Three of the five codes examined identified fewer than 1 case in 10 using ICD-9-CM codes. When the identification was constrained to the first day of stay, the sensitivity did improve, but only by 2%-4% (table 3 below).

Table 3. Sensitivity and improvement of claims data to detect common laboratory abnormalities* identified on admission from 83 institutions that provide electronically captured laboratory results.

Laboratory Abnormality	Sensitivity Admission Period	% Improvement from Full Hospital Stay
Low serum sodium (< 135 mEq/L)	11.8	2.1
High serum sodium (> 145 mEq/L)	12.3	2.5
Low serum potassium (< 3.5 mEq/L)	22.8	4.2
High serum potassium (> 5.0 mEq/L)	18.9	3.9
Low serum hemoglobin (< 12 g/dl (females), < 14 g/dl (males)	9.6	0.6

* Using Harrison's Principles of Internal Medicine. McGraw-Hill Professional, 15th Edition, 2001.
ICD9 Codes used: Low serum sodium (271.61), high serum sodium (276.0), low serum potassium (276.8), high serum potassium (276.7), low serum hemoglobin (285.9).

- Furthermore, we looked at the sensitivity of claims data as a function of the number of times the laboratory results were examined. Patients often have these laboratory values determined multiple times. Ignoring the important admission period sensitivity for the moment, we discovered that even in cases where laboratory studies were done more than 10 times, the claims data sensitivities never reached 50%. In other words, patients who had laboratory studies performed and documented more than 10 times were nevertheless identified less than half the time, and in the case of anemia, less than 10% of the time (see table 4).

Table 4. Sensitivity of claims data to detect common laboratory abnormalities* identified more than 10 times during the hospitalization from 83 institutions that provide electronically captured laboratory results.

Laboratory Abnormality	Sensitivity of Claims Data (%)
Low serum sodium recorded >10 times (≤ 135 meq/L)	30.0
High serum sodium recorded >10 times (>145 meq/L)	42.2
Low serum potassium recorded >10 times (< 3.5 meq/L)	19.5
High serum potassium recorded >10 times (> 5.0 meq/L)	20.4
Low serum hemoglobin Hgb recorded >10 times (<12 g/L for females or <14 g/L for males)	9.5

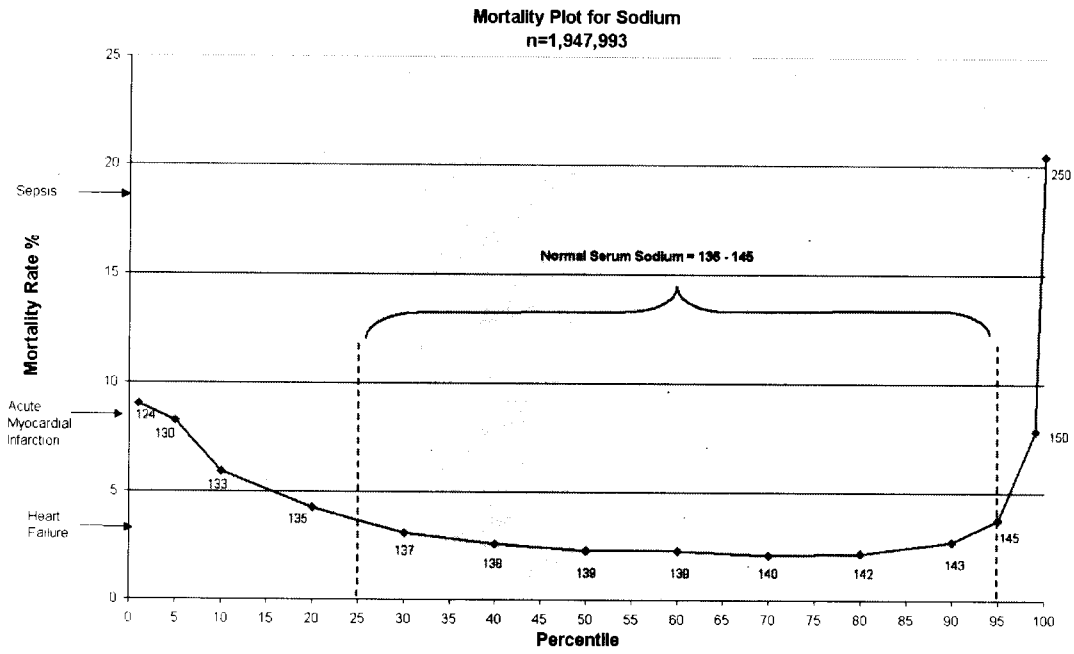
* Using Harrison's Principles of Internal Medicine. McGraw-Hill Professional, 15th Edition, 2001.
ICD-9 Codes used: Low serum sodium (271.61), high serum sodium (276.0), low serum potassium (276.8), high serum potassium (276.7), low serum hemoglobin (285.9).

- The poor sensitivity of the claims data suggests that if the goal is accuracy then the one-time cost of obtaining laboratory results might well be less than the cost of incrementally trying to improve coding practices.

- Even when claims data do identify laboratory abnormalities, they still do not provide the granularity required to appropriately estimate risk. The importance of using severity models based on objective laboratory results is highlighted by the

results that show the relationship between mortality rates and the differing degrees of laboratory abnormalities (see figure 2 following and figures 8-12 in the appendix). Mortality plots were developed by plotting unadjusted, all-cause mortality rates against laboratory results that had been categorized into deciles. For example, the 90th to 100th decile represented the 10% of cases with the highest value measured for that laboratory test. The mortality plot for serum sodium is shown in figure 2 below. As can be seen from the figure, the mortality increases when the laboratory value becomes very low or very high. Compared to the mortality rate associated with normal serum sodium values, the mortality rate doubles on the low end and increases by nearly four-fold on the high end. Even if claims data were able to detect the presence of abnormal serum sodium, they would not accurately estimate risk because the actual laboratory result would remain unknown. These data demonstrate that it is not only important to identify cases with laboratory abnormalities dichotomously (present or absent), but that the actual laboratory result has further discriminatory power in predicting a patient's mortality. Mortality graphs for other laboratory results are shown in figures 8-12 in the appendix.

Figure 2. In-hospital mortality by serum sodium result from institutions that provide electronically captured laboratory results during hospitalization.



Note: Each plot point provides mortality at the serum sodium result (normal as per Harrison's Principles of Internal Medicine. McGraw-Hill Professional, 15th Edition, 2001). As mortality rate varies by disease group, the arrows adjacent to the y-axis indicate the hospital mortality for sepsis, acute myocardial infarction, and heart failure.

B. Literature Review

- Omissive variability occurs in circumstances where the claims data do not have the ability to capture risk factors that are important in accurately estimating severity. Claims data have been found to be insensitive in capturing laboratory

abnormalities that are significant predictors of poor outcomes. The following points summarize key studies:

- Renal insufficiency is an example of a critical risk factor that can be reliably identified on admission by abnormal laboratory results (i.e. serum creatinine or blood urea nitrogen). Such identification is important in risk stratification, because renal insufficiency on admission has been found to be a significant predictor for poor outcomes (e.g., hospital or 30-day mortality) in various diseases. These include pneumonia (Fine, *N Engl J Med* 1997), pulmonary embolism (Aujesky, *Am J Respir Crit Care Med* 2005), congestive heart failure (Auble, *Academic Emergency Medicine* 2005; Fonarow, *JAMA 2005*), acute myocardial infarction (Sjauw, *Am J Cardiol* 2006), coronary artery bypass graft surgery (Hannan, *J Am Coll Cardiol* 2006), and percutaneous coronary intervention (Wu, *J Am Coll Cardiol* 2006).

    - A recent study by Kern et al (Health Services Research 2006) found that, *"Depending on the detail of the algorithm, only 20.2 to 42.4 percent of individuals with CKD* [chronic kidney disease] *received a renal-related diagnosis code in either VA or Medicare records over 1 year."* This study concluded, *"Diagnosis codes in administrative records from Medicare and VA systems are insensitive, but specific markers for patients with CKD."*

- Movig et al (*J Clin Epidem* 2003) studied the validity of claims data to identify patients with significant hyponatremia (low serum sodium). Results showed that of 2632 cases with significant hyponatremia identified by laboratory results, claims data were able to identify a maximum of 30% of these cases. They concluded, *"To assess the validity of case finding of patients with hyponatremia, the use of analytical techniques, such as certain laboratory measurements, is advisable."*

- Best et al (*J Am Coll Surg* 2002) studied whether data from the National Surgical Quality Improvement Program (NSQIP) could be provided from the less costly administrative dataset. They concluded that, *"Sensitivity and positive predictive value of administrative data in comparison to NSQIP data were poor."* Additionally they stated that, *"We cannot recommend substitution of administrative data for NSQIP data methods."*

C. Section Conclusion

- Results of our analyses and reports in the literature show that claims data are unreliable in detecting laboratory abnormalities. Even if claims data are able to detect such abnormalities they are unable to provide the granularity required to estimate severity.

- This has significant implications to CMS as well as to hospitals, since the current CMS proposal for hospital payment is based on an estimate of risk. Thus, errors of omission can lead to adverse consequences for the current CMS proposal, since for reimbursement purposes it may prove difficult to accurately estimate severity using claims data alone.

- The use of time-stamped, physiologic data captured electronically on admission—i.e., widely available laboratory results—can minimize the undesirable variability described above by providing a more accurate basis for severity adjustment compared with reliance on claims data.

III. Risk Adjustment

Section Summary

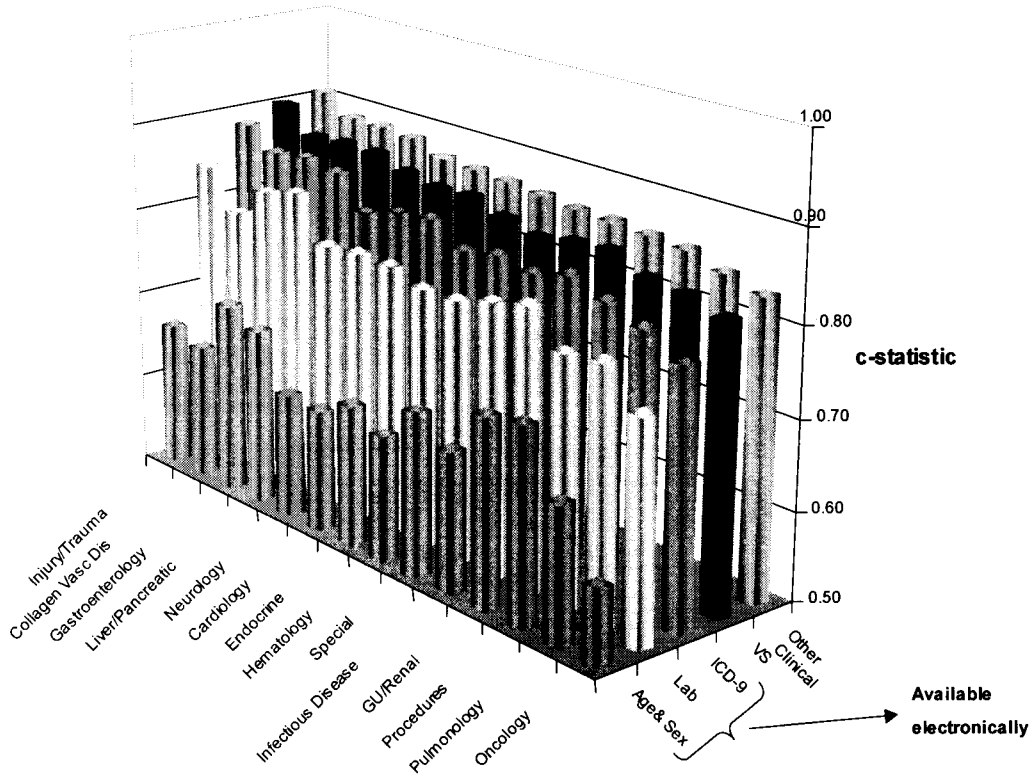
- In developing disease-specific severity-adjustment models, the largest increment in predictive power occurs with the addition of laboratory results.
- Disease-specific risk-adjustment models constructed with time-stamped objective physiologic data on admission consistently show c-statistic above 0.80, and thus demonstrate good predictive power.
- There are small differences between c-statistics (predictive power) found in our PLM and PFM models.
- C-statistics may not tell the entire story related to predictive power as inclusion of late hospital events that predict mortality can artificially inflate the c-statistic.

A. Review of Internal Research

- As PHC4 reports a wide variety of both medical and surgical conditions, a large number of disease-specific severity-adjustment models are required. Currently we divide the 114 disease-specific models into 17 large categories that correspond to the disease groupings found in the table of contents of any major medical textbook.
- We consider the parameters of risk to be five discrete, mutually exclusive groups of risk factors. These groups are demography (age and gender), laboratory results on admission, ICD-9-CM codes (claims), vital signs, and selected key clinical findings such as neurologic status at the time of admission. These models, which predict in-hospital mortality, were constructed using what are now quite standard logistic regression methods.
- Figure 3 following shows the increase in predictive power as estimated by the c-statistic that occurs as the various types of risk factors are included in the models (a c-statistic of 0.5 would indicate guesswork and a c-statistic of 1.0 would indicate perfect prediction). The mean and median c-statistics for the physiologic full models (PFM) across all categories are both 0.87 (range from 0.77 to 0.94). The mean and median c-statistics for the physiologic lab models (PLM) models across all categories are 0.84 (range from 0.60 to 0.93).
- The c-statistic does not tell the whole story since the use of claims data that confounds admission risk with complications can artificially inflate the c-statistic.

- Our sepsis, pneumonia, stroke, pediatrics, heart failure, and acute myocardial infarction models have been presented in major medical meetings (Tabak et al 2004-2005).

Figure 3. The relative contribution to the predictive power of the various parameters of risk across multiple disease categories.



B. Literature Review

- While there are published studies using claims data (Krumholtz et al; Circulation 2006; 113 and Circulation 2006; 113) showing that the predictive value of claims data approximates that of physiologic data, the studies are not based on the same data that would be used under the current CMS proposed changes. These studies used an all claims dataset across a 1-year period prior to index hospitalization to determine relevant risk factors for mortality.

    - The authors did use laboratory data within the first day of admission, however they chose to convert these data to simple dichotomous variables (present/not present) thereby limiting the predictive power of abnormal laboratory results as they become more extreme. For example, by making serum sodium dichotomous, the authors only evaluated hyponatremia, thereby both excluding hypernatremia as a risk factor and grouping patients with serum sodiums below 130 and those with serum sodiums between 135 and 145 into a single group. Our experience suggests that such grouping would limit the predictive power of serum sodium as a risk factor.

- Additionally, several important laboratory predictors of severity that we have consistently found to have predictive power were not included in their clinical model. These include serum albumin, arterial pH, serum total bilirubin, and cardiac enzymes.

- In addition to the use of 30-day mortality as the outcome variable, some of the factors listed above may explain why the c-statistic for their clinical model (0.78) appears somwhat low to us for a model comparable to our physiologic full model.

- Despite the limitations cited above, the c-statistic for their physiologic model was substantially better than any of the administrative models evaluated, all of which had a c-statistic of 0.70. We wonder whether improved efforts to optimize the predictive power of their clinical data might have improved the c-statistic even further. Our physiologic full and lab models for heart failure have a c-statistic of 0.83 and 0.79, respectively.

- While these studies compared the predictive power of using an expanded claims dataset to a clinical dataset, based on our experience we question whether the selection and utilization of clinical variables, including laboratory results, was optimized.

- We continue to believe that the use of electronically captured laboratory results to obviate the risk of undesirable variability due to imprecise documentation and coding (see Section III) is likely to be more cost-effective than enhancing the claims dataset through intensive education or by constructing new, expanded alternative claims datasets.

o There are several studies that have evaluated the importance of including laboratory abnormalities on admission in any severity-stratification system, in order to achieve the necessary accuracy in estimating severity of illness on admission.

- Pine et al (*Ann Int Med* 1997) and Iezzoni (*Ann Int Med* 1997) studied the risk-adjusted mortality using administrative data alone, administrative data plus laboratory results, and the combination of administrative data plus laboratory results plus clinical data.

  - Their results showed that, "*linking existing electronic data from laboratory reporting systems to administrative files could provide a cost-effective way to add valuable clinical information.*"

  - "*Additionally, even a few clinical variables can contribute substantially to predicting in-hospital deaths of general, acute care patients.*" Another study by Pine et al also resulted in similar findings (*International Journal for Quality in Health Care* 1998).

- Sjauw et al studied the "Value of Routine Admission Laboratory Tests to Predict Thirty-Day Mortality in Patients with Acute Myocardial Infarction" (*Am J Cardiol* 2006). Their results showed that, "*In multivariate*

analyses, higher white blood cell count, higher levels of serum creatinine, glucose, and lactate dehydrogenase, and lower platelet count were identified as independent risk factors for 30-day mortality. The model that incorporated these risk factors (added laboratory parameters model) had a 17% higher predictive power than did the model that contained only conventional risk factors (conventional risk factor model)."

- They found that, "*The added laboratory parameters model showed better discriminative ability than the conventional risk factor model according to the area under the curve (0.87 vs 0.80).*" They concluded that, "*routine admission laboratory tests hold significant prognostic information, with value in addition to conventional risk factors.*"

- Freire et al studied the risk factors for mortality on admission in patients admitted to the medical intensive care unit (*CHEST* 2005). Their results showed that, "*APACHE II score/per point (odds ratio, 1.06), mechanical ventilation (odds ratio, 3.06), severe hypoalbuminemia (< 2 g/dL) [odds ratio, 2.98], and severe lactic acidemia (> 8 mmol/L) [odds ratio, 7.3] to be associated with hospital mortality.*"

- Fonarow et al (*JAMA* 2005) studied the risk factors for hospital mortality on admission in acute heart failure using objective physiologic data from a large acute heart failure registry (263 institutions nationwide). Of 39 variables that predicted hospital mortality the three variables that were the greatest predictors of mortality were BUN > 43 mg/dL, SCr > 2.75 mg/dL and systolic blood pressure < 115.

- Khuri et al (*J Am Coll Surg* 1997) studied the preoperative predictors of postoperative mortality in a Veterans Affairs Surgical Risk Study. When they tried to determine the importance of predictive values for post-operative mortality across all operators, six of the top 20 predictors were laboratory results: normal albumin (odds ratio (OR) = 0.57), BUN > 40 (OR = 1.49), platelets < 115K (OR = 1.76), SGOT/ALT > 40 IU/L (OR = 1.31), white blood cell count > 11K (OR = 1.35), and serum sodium ≤ 135 (OR = 1.32).

- In one of the few reports on use of electronically captured laboratory data to predict hospital mortality, Froom (*Clin Chem* 2006) did a study to, "*explore whether electronically retrieved laboratory data can predict mortality in internal medicine departments in a regional hospital.*" They found that, "*Nearly all patients had a complete blood count and basic clinical chemistries on admission.*"

  - Their results showed that, "*Eight laboratory variables and age significantly and independently contributed to a logistic regression model (area under the ROC curve, 88.7%).*"

  - They concluded that, "*A logistic regression model including only age and electronically retrieved laboratory data highly predicted mortality in internal medicine departments in a regional hospital, suggesting*

that age and routine admission laboratory tests might be used to ensure a fair comparison when using mortality monitoring for hospital quality control."

C. Section Conclusion:

- Inclusion of objective time-stamped results consistently produces risk-adjustment models with strong predictive power (c-statistics above 0.80).
- There are numerous examples drawn from the literature to support the use of laboratory values on admission to estimate admission-based severity.
- The use of laboratory values can minimize issues associated with identification of co-morbidities. For example, knowing that serum blood urea nitrogen and creatinine obviates the need to use ICD-9-CM codes as a measure of renal insufficiency.

IV. Selected Literature

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V. Appendix

Table 1. Misclassification of high-performance hospitals based on hospital level risk-adjusted mortality rates in common diseases estimated using claims, physiologic lab and physiologic full models.

Disease Group	Total Hospitals (n)	In-Hospital Mortality (%)	Misclassification* of Performance (%)	
			Claims vs. PLM	Claims vs. PFM
CHF	210	4.0	38.1	40.5
AMI	201	7.4	45.0	50.0
Pneumonia	210	5.6	19.1	21.4
Respiratory Failure	173	18.9	42.9	34.3
Sepsis	180	18.4	30.6	36.1
Stroke	188	6.1	18.4	31.6
DM	195	1.2	7.7	7.7

CHF = heart failure; AMI = acute myocardial infarction; COPD = chronic obstructive pulmonary disease;
DM = diabetes mellitus; PLM = physiologic laboratory model; PFM = physiologic full model;
* Defined as: Hospitals that are in the top two deciles of risk-adjusted mortality using claims models but not in the top two deciles by the physiologic model in the comparison.

Table 2. Sensitivity and specificity of claims data to detect common laboratory abnormalities* identified from 83 institutions that provide electronically captured laboratory results during hospitalization [refer to Tables 3-5 for raw data for each analysis described].

Laboratory Abnormality*	Sensitivity (%)	Specificity (%)	Positive Predictive Value (%)	Negative Predictive Value (%)
Low Serum Sodium (≤ 135 mEq/L)	9.7	99.8	95.0	72.5
High Serum Sodium (> 145 mEq/L)	9.8	99.9	85.0	96.1
Low Serum Potassium (< 3.5 mEq/L)	18.6	99.3	85.9	83.7
High Serum Potassium (> 5.0 mEq/L)	15.0	99.7	87.4	90.7
Low Serum Hemoglobin (< 12 g/dl for females, < 14 for males g/dl)	9.1	99.3	96.1	35.8

* Using Harrison's Principles of Internal Medicine. McGraw-Hill Professional, 15th Edition, 2001.
ICD-9 Codes used: Low serum sodium (271.61), high serum sodium (276.0), low serum potassium (276.8), high serum potassium (276.7), low serum hemoglobin (285.9).

Figure 1 (a, b and c). Comparison of hospital-level rank based on risk-adjusted mortality rate with claims, physiologic lab (PLM), or physiologic full model (PFM) for heart failure.

Figure 1a. Claims model vs. physiologic lab model

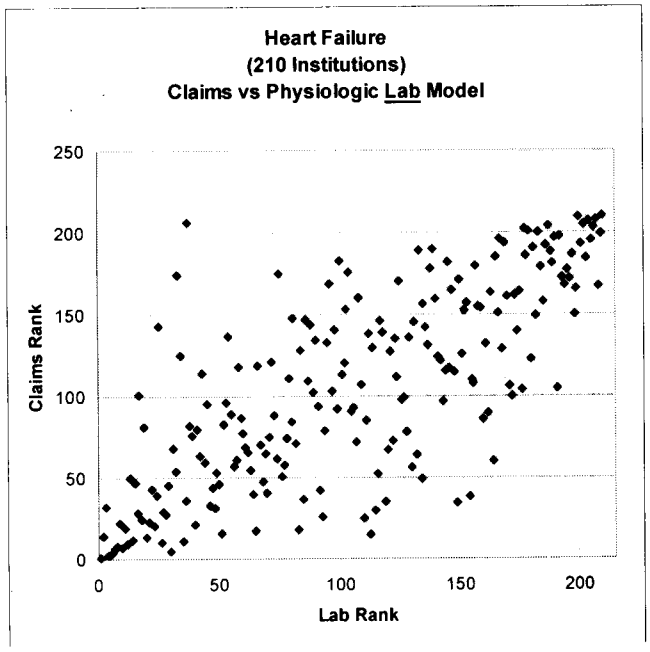


Figure 1b. Claims vs. physiologic full model

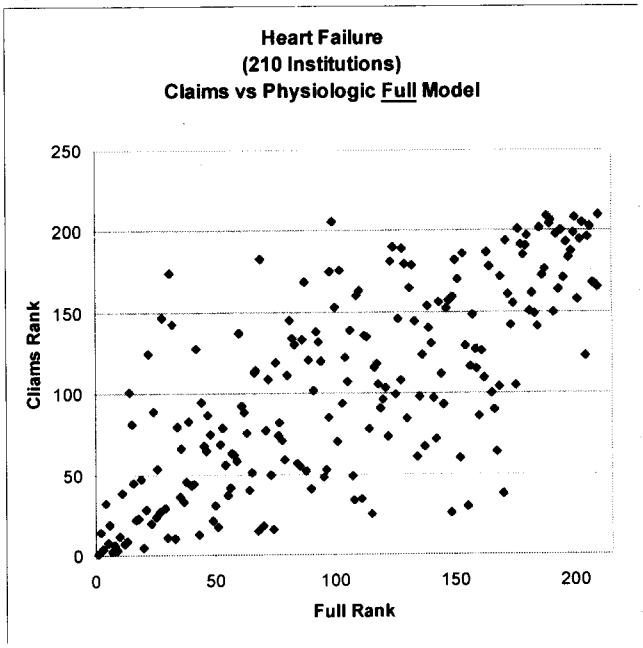
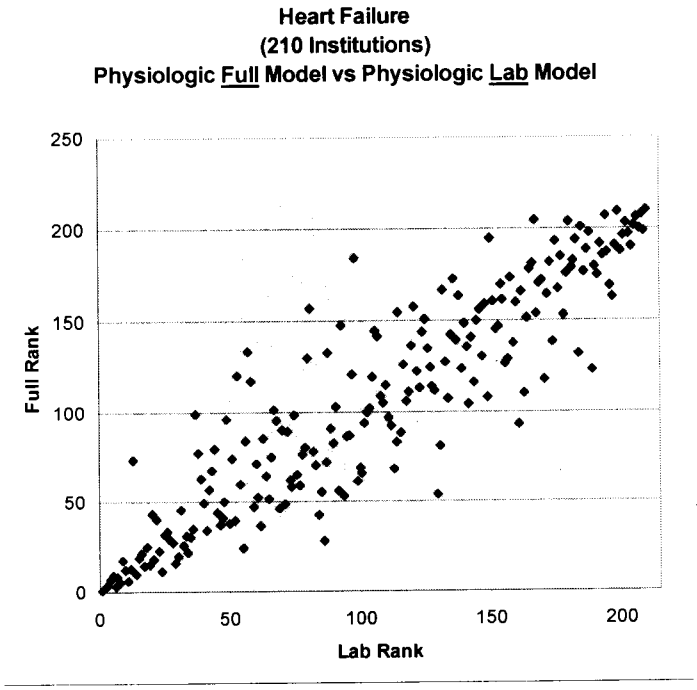


Figure 1c. Physiologic full model vs. physiologic lab model



Summary of Results: The agreement between PLM and PFM is much higher (less scattered) than that of claims model (more scattered) and either PLM or PFM models.

Figure 2 (a, b and c). Comparison of hospital-level rank based on risk-adjusted mortality rate with claims, physiologic lab (PLM), or physiologic full model (PFM) for acute myocardial infarction (AMI).

Figure 2a. Claims vs. physiologic lab model

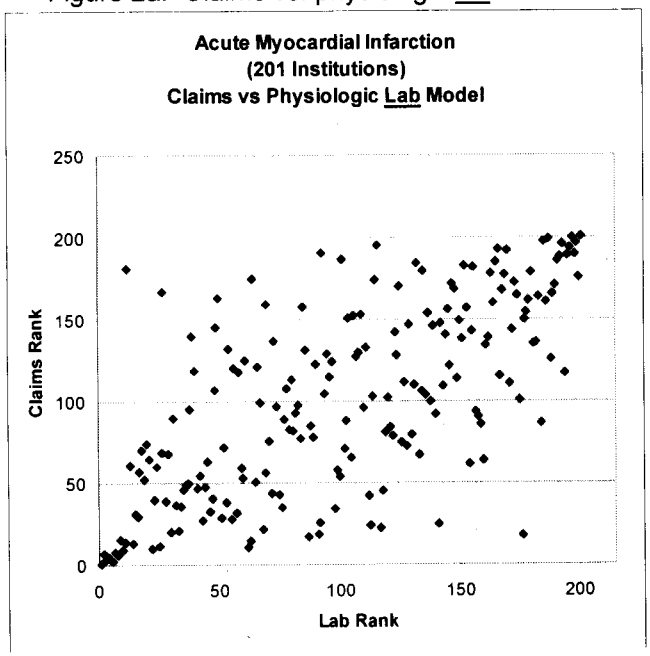


Figure 2b. Claims vs. physiologic full model

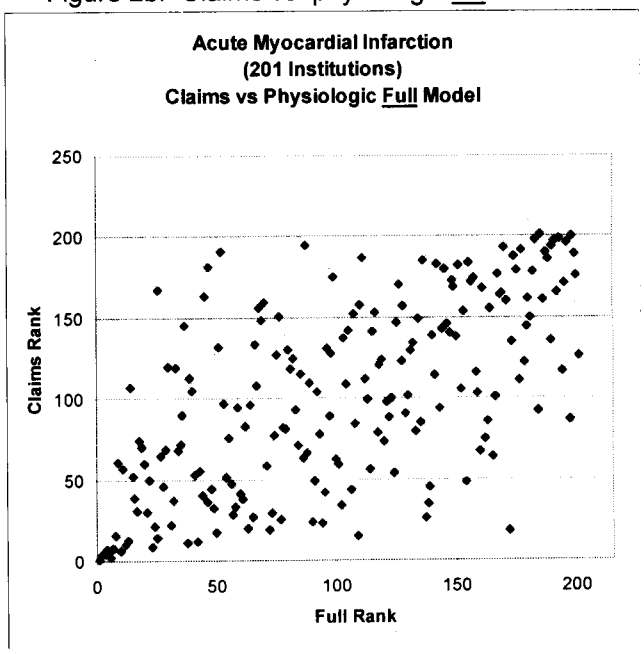
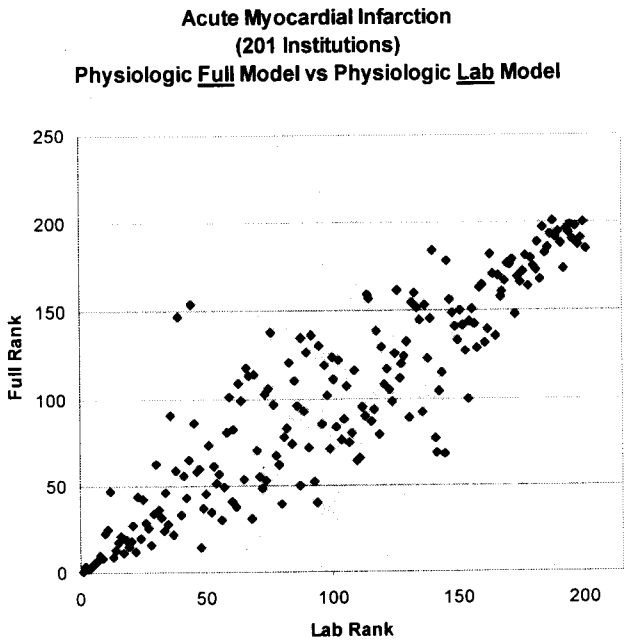


Figure 2c. Physiologic full model vs. physiologic lab model.



Summary of Results: The agreement between PLM and PFM is much higher (less scattered) than that of claims model (more scattered) and either PLM or PFM models.

Figure 3 (a, b and c). Comparison of hospital-level rank based on risk-adjusted mortality rate with claims, physiologic lab (PLM), or physiologic full model (PFM) for pneumonia.

Figure 3a. Claims vs. physiologic lab model

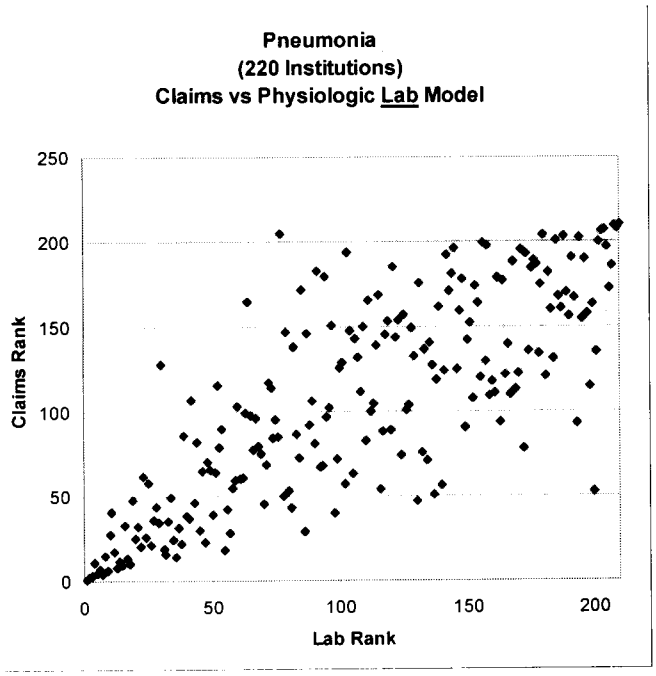


Figure 3b. Claims vs. physiologic full model

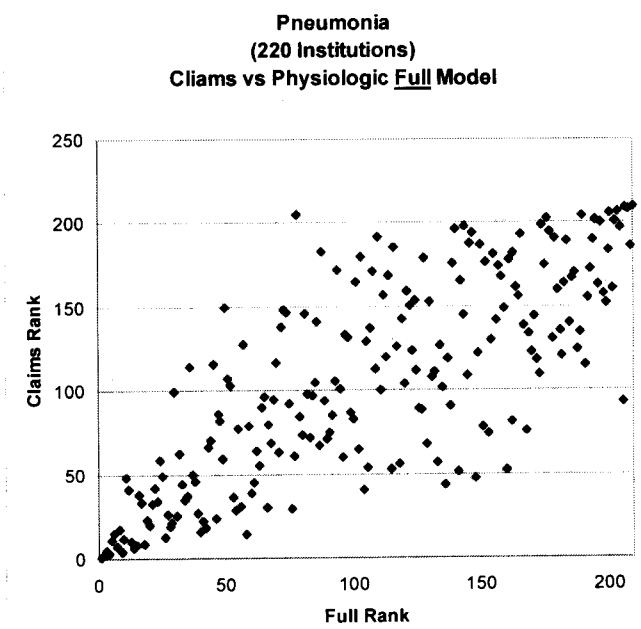
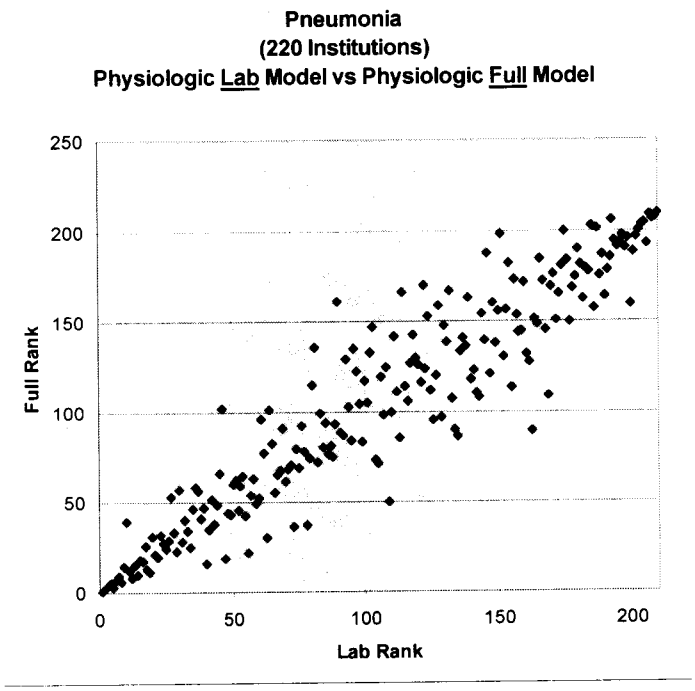


Figure 3c. Physiologic full model vs. physiologic lab model



Summary of Results: The agreement between PLM and PFM is much higher (less scattered) than that of claims model (more scattered) and either PLM or PFM models.

Figure 4 (a, b and c). Comparison of hospital-level rank based on risk-adjusted mortality rate with claims, physiologic lab (PLM), or physiologic full model (PFM) for respiraotry failure.

Figure 4a. Claims vs. physiologic lab model

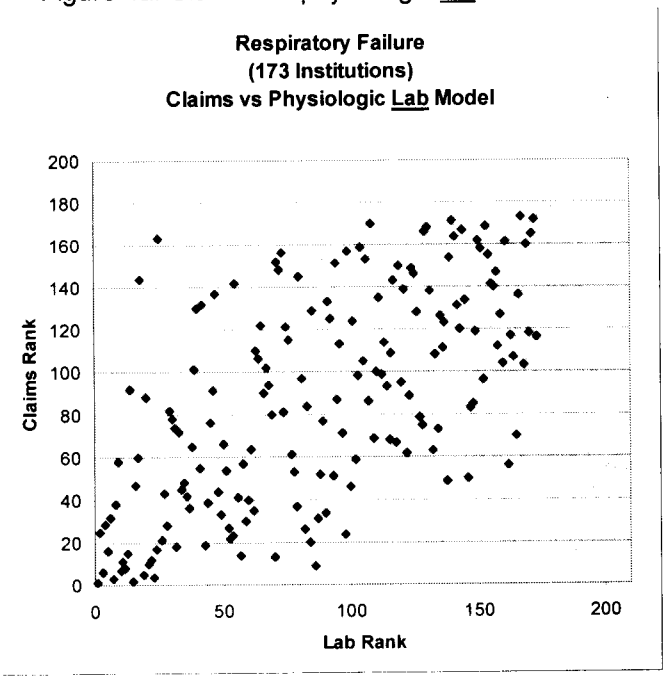


Figure 4b. Claims vs. physiologic full model

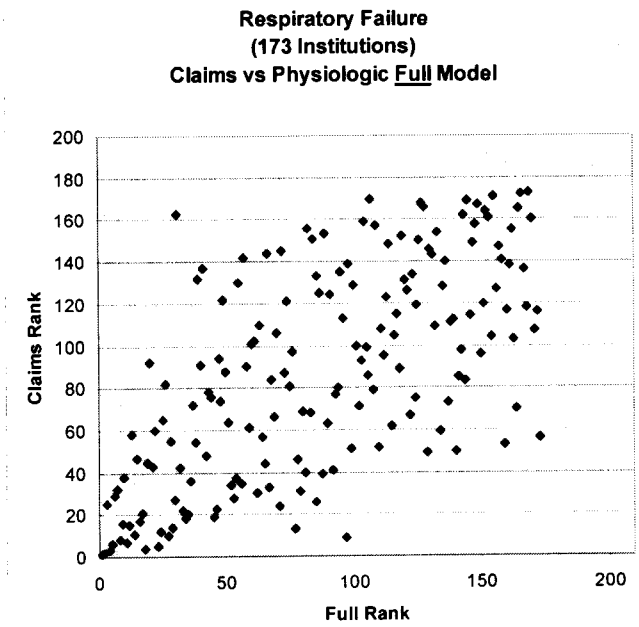
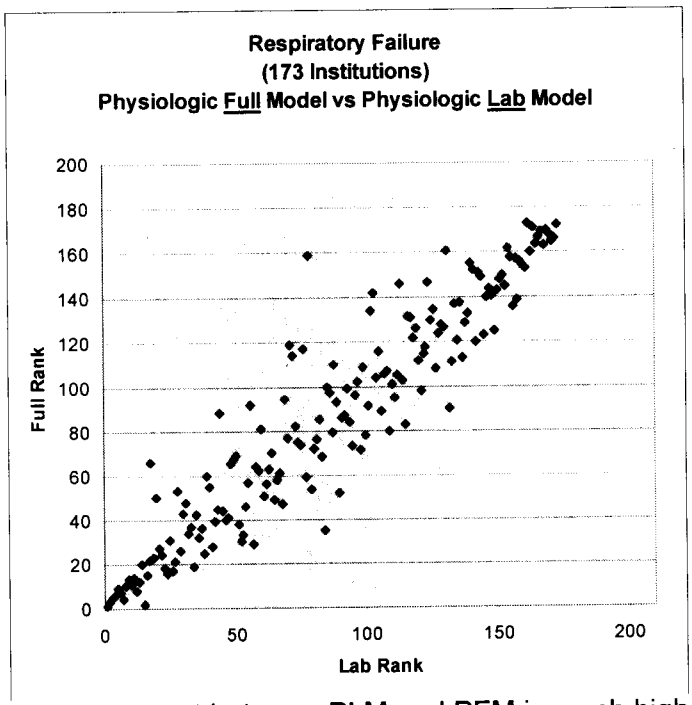


Figure 4c. Physiologic full model vs. physiologic lab model



Summary of Results: The agreement between PLM and PFM is much higher (less scattered) than that of claims model (more scattered) and either PLM or PFM models.

Figure 5 (a, b and c). Comparison of hospital-level rank based on risk-adjusted mortality rate with claims, physiologic lab (PLM), or physiologic full model (PFM) for sepsis.

Figure 5a. Claims vs. physiologic lab model

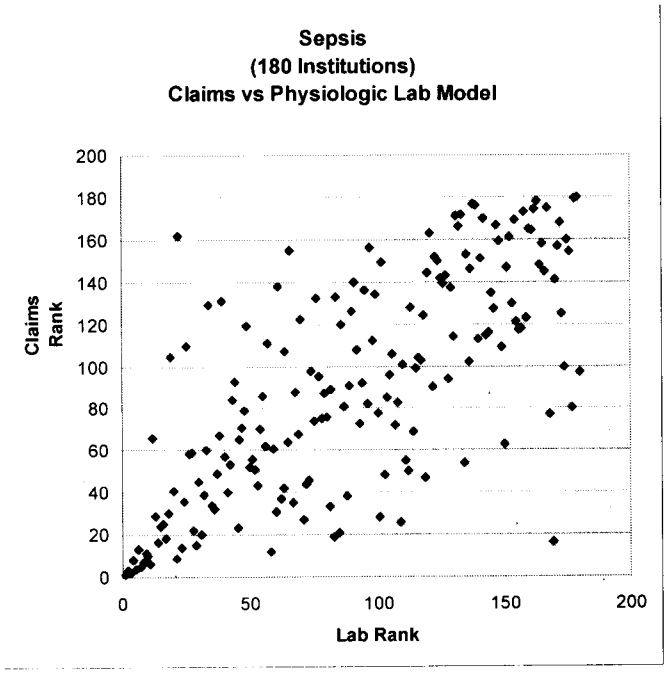


Figure 5b. Claims vs. physiologic full model

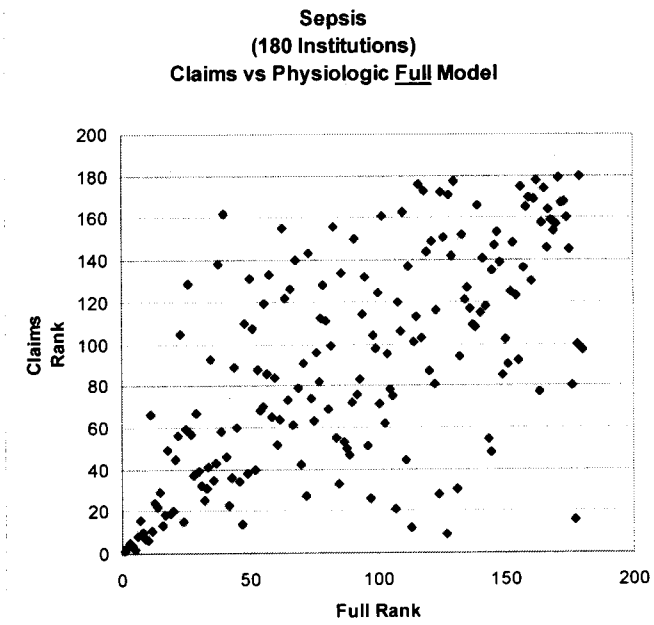
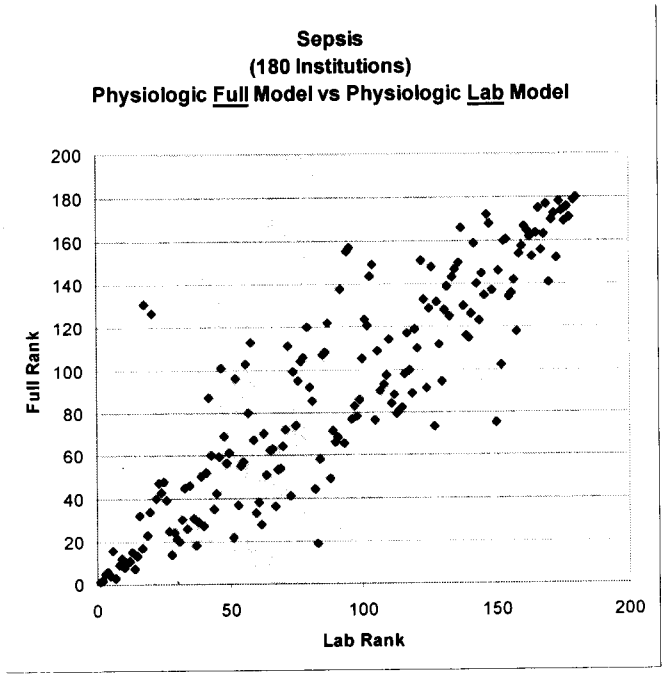


Figure 5c. Physiologic full model vs. physiologic lab model.



Summary of Results: The agreement between PLM and PFM is much higher (less scattered) than that of claims model (more scattered) and either PLM or PFM models.

Figure 6 (a, b and c). Comparison of hospital-level rank based on risk-adjusted mortality rate with claims, physiologic lab (PLM), or physiologic full model (PFM) for stroke.

Figure 6a. Claims vs. physiologic lab model

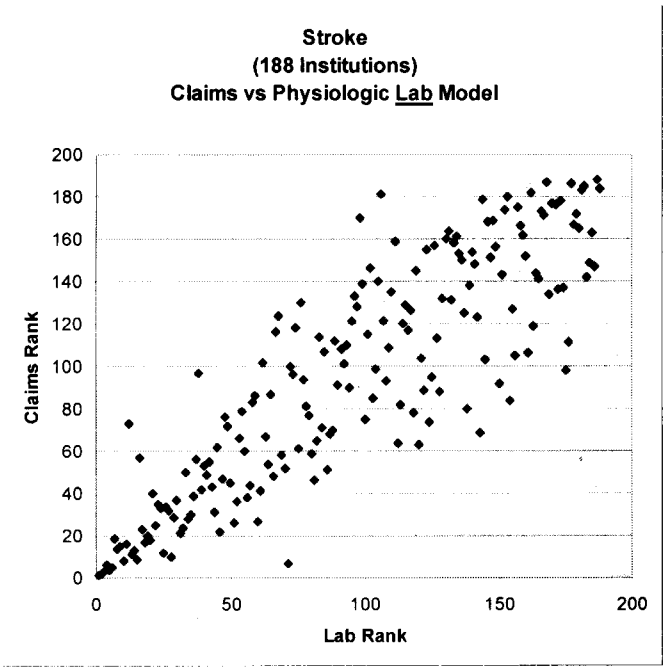


Figure 6b. Claims vs. physiologic full model

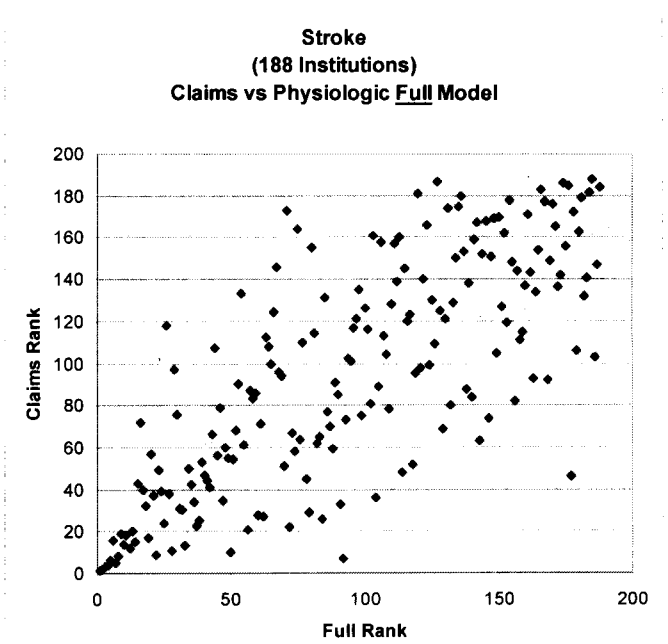
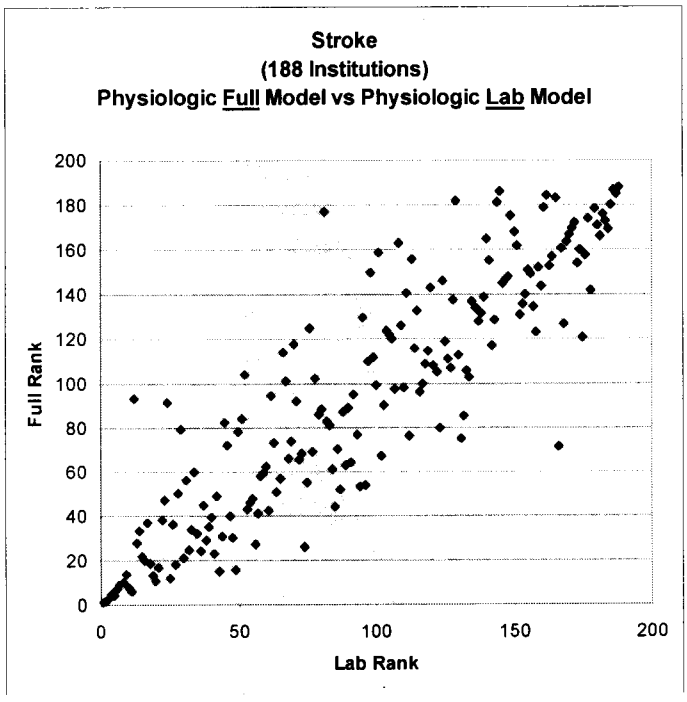


Figure 6c. Physiologic full model vs. physiologic lab model.



Summary of Results: The agreement between PLM and PFM is much higher (less scattered) than that of claims model (more scattered) and either PLM or PFM models.

Figure 7 (a, b and c). Comparison of hospital-level rank based on risk-adjusted mortality rate with claims, physiologic lab (PLM), or physiologic full model (PFM) for diabetes.

Figure 7a. Claims vs. physiologic lab model

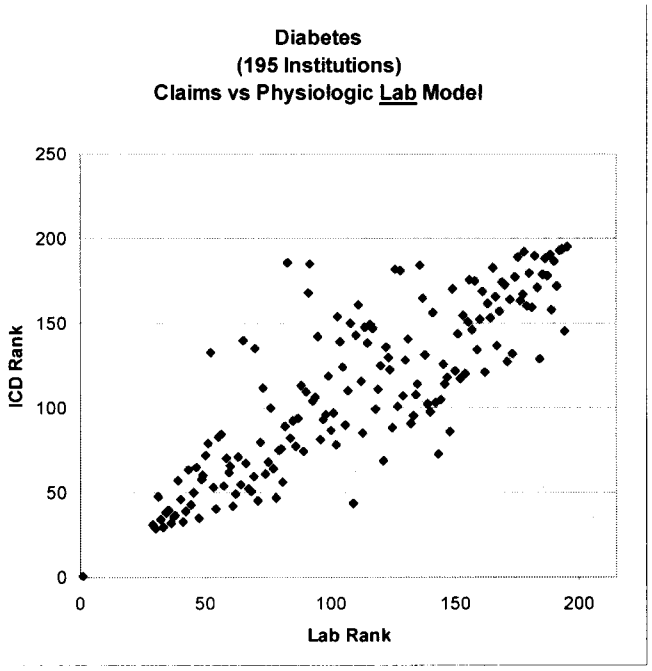


Figure 7b. Claims vs. physiologic full model

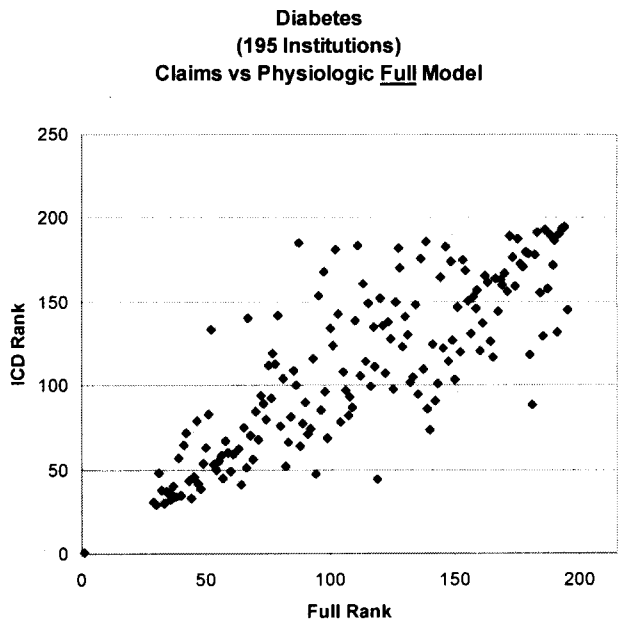
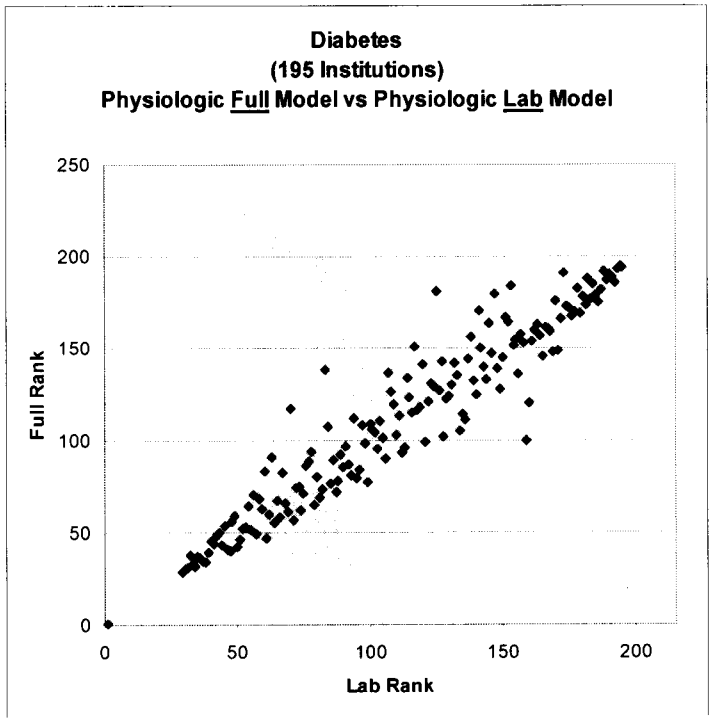


Figure 7c. Physiologic full model vs. physiologic lab model



Summary of Results: The agreement between PLM and PFM is much higher (less scattered) than that of claims model (more scattered) and either PLM or PFM models.

Table 3 (a and b). Two by two table of the ability of claims data to detect serum sodium abnormalities identified from 83 institutions that provide electronically captured laboratory results during hospitalization [see figure 8 for in-hospital mortality by serum sodium result].

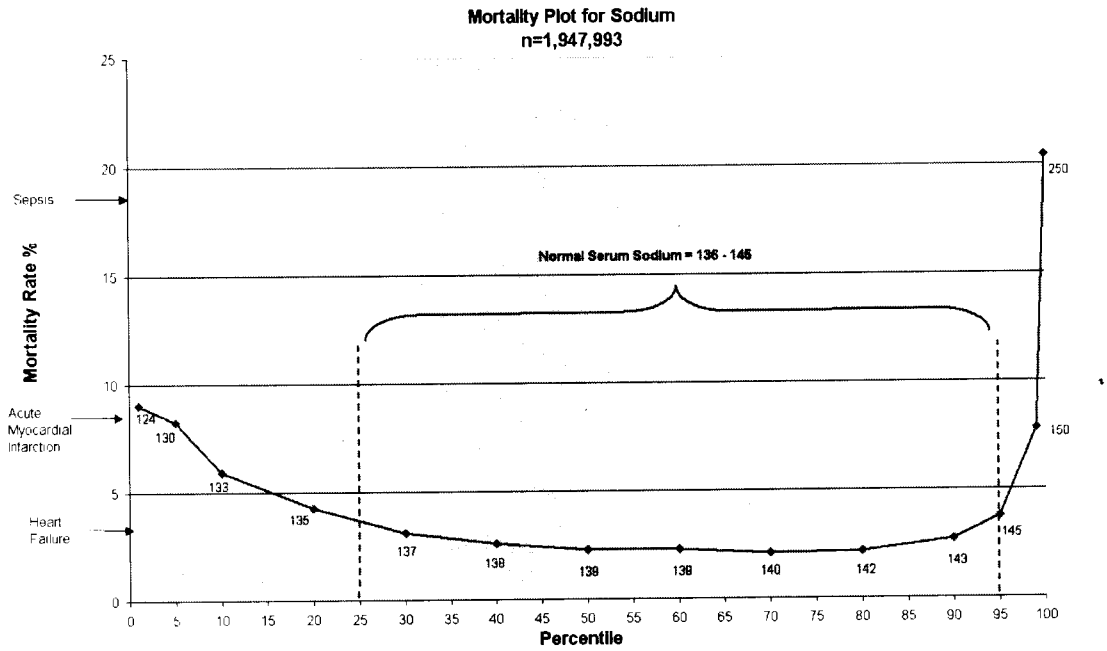
Table 3a. Low serum sodium.

ICD9 Code Present (276.1)	Low Serum Sodium (≤ 135 mEq/L) Yes	No		
Yes	16,612	880	95.0%	PPV
No	154,331	407,055	72.5%	NPV
	9.7% Sensitivity	99.8% Specificity		

Table 3b. High serum sodium.

ICD9 Code Present (276.0)	High Serum Sodium (> 145 mEq/L) Yes	No		
Yes	2,484	440	85.0%	PPV
No	22,763	553,191	96.0%	NPV
	9.8% Sensitivity	99.9% Specificity		

Figure 8. In-hospital mortality by serum sodium value from institutions that provide electronically captured laboratory results during hospitalization [corresponds to figure 2 in text].



Note: Each plot point provides mortality at the serum sodium result (normal as per Harrison's Principles of Internal Medicine. McGraw-Hill Professional, 15nth Edition, 2001). As mortality rate varies by disease group, the arrows adjacent to the y-axis indicate the hospital mortality for sepsis, acute myocardial infarction and heart failure.

Table 4 (a and b). Two by two table of the ability of claims data to detect serum potassium abnormalities identified from 83 institutions that provide electronically captured laboratory results during hospitalization [see Figure 9 for in-hospital by serum potassium result].

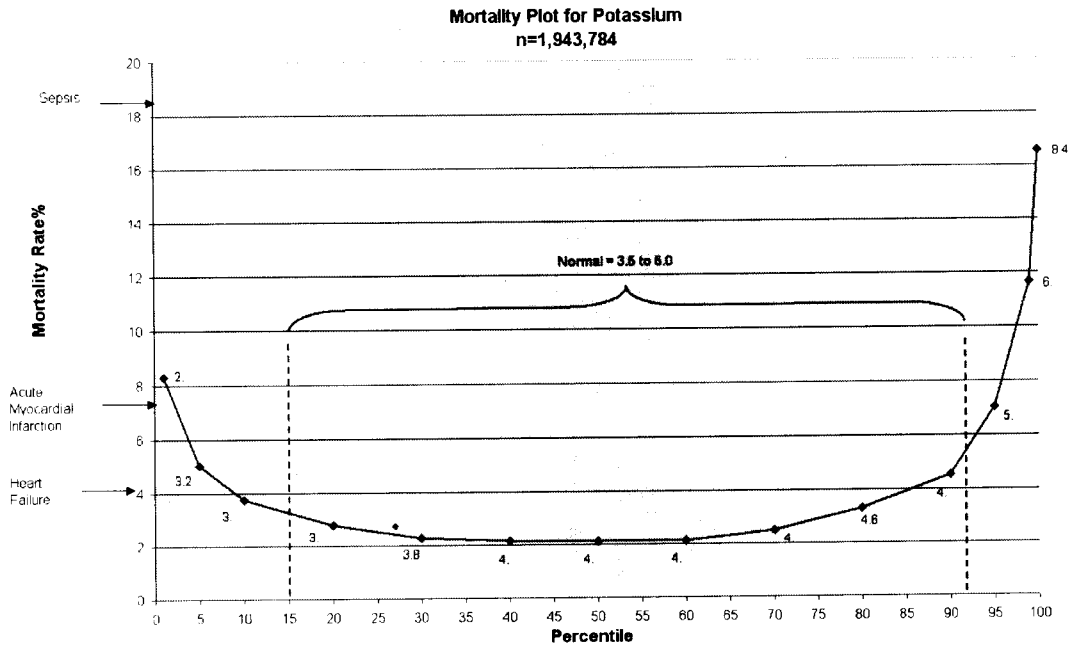
Table 4a. Low serum potassium.

ICD9 Code Present (276.8)	Low Serum Potassium (< 3.5)			
	Yes	No		
Yes	20,693	3,393	85.9%	PPV
No	90,699	464,093	83.7%	NPV
	18.6% Sensitivity	99.3% Specificity		

Table 4b. High serum potassium.

ICD Code Present (276.7)	High Serum Potassium (> 5.0)			
	Yes	No		
Yes	9344	1347	87.4%	PPV
No	53087	515100	90.7%	NPV
	15.0% Sensitivity	99.7% Specificity		

Figure 9. In-hospital mortality by serum potassium value from institutions that provide electronically captured laboratory results during hospitalization.

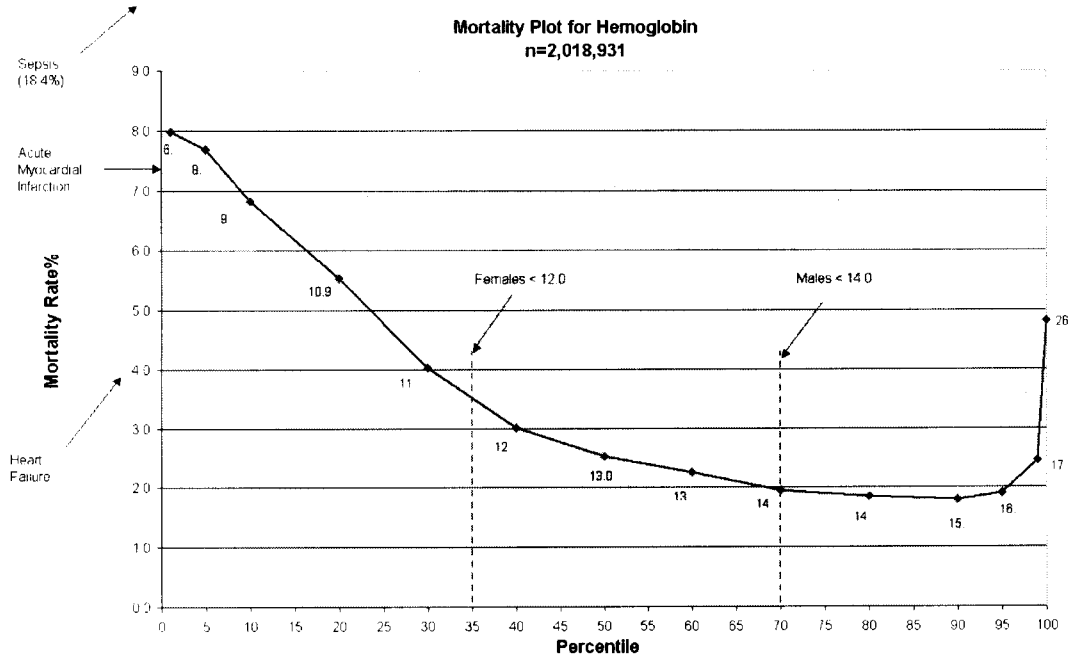


Note: Each plot point provides mortality at the serum potassium result (normal as per Harrison's Principles of Internal Medicine. McGraw-Hill Professional, 15nth Edition, 2001). As mortality rate varies by disease group, the arrows adjacent to the y-axis indicate the hospital mortality for sepsis, acute myocardial infarction, and heart failure.

Table 5. Two by two table of the ability of claims data to detect low serum hemoglobin abnormality (anemia) identified from 83 institutions that provide electronically captured laboratory results during hospitalization [see figure 10 for in-hospital by serum hemoglobin result].

ICD Code Present (285.9)	Low Serum Hemoglobin (anemia) **(< 12 mg/dl for females or < 14 for males**			
	Yes	No		
Yes	34693	1422	96.1%	PPV
No	348782	193981	35.7%	NPV
	9.0% Sensitivity	99.3% Specificity		

Figure 10. In-hospital mortality by serum hemoglobin value from institutions that provide electronically captured laboratory results during hospitalization.



Note: Each plot point provides mortality at the serum hemoglobin result. Cutoff for normal serum hemoglobin result is < 12 g/dl for females and < 14 g/dl for males (Harrison's Principles of Internal Medicine. McGraw-Hill Professional, 15nth Edition, 2001). As mortality rate varies by disease group, the arrows adjacent to the y-axis indicate the hospital mortality for sepsis, acute myocardial infarction, and heart failure.

Table 6. Sensitivity and improvement of claims data to detect common laboratory abnormalities* identified on admission from 83 institutions that provide electronically captured laboratory results [corresponds to table 3 in text].

Laboratory Abnormality	Sensitivity Admission Period	% Improvement from Full Hospital Stay
Low serum sodium (< 135 mEq/L)	11.8	2.1
High serum sodium (> 145 mEq/L)	12.3	2.5
Low serum potassium (< 3.5 mEq/L)	22.8	4.2
High serum potassium (> 5.0 mEq/L)	18.9	3.9
Low serum hemoglobin (< 12 g/dl for females, < 14 for males g/dl)	9.6	0.6

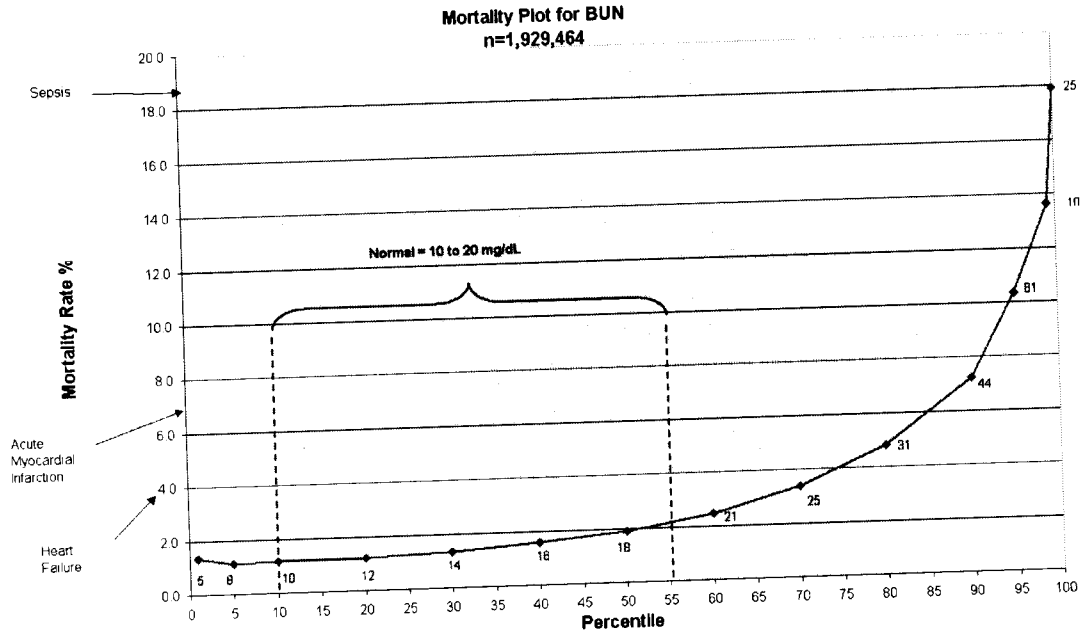
* Using Harrison's Principles of Internal Medicine. McGraw-Hill Professional; 15nth Edition, 2001.
ICD-9 Codes used: Low serum sodium (271.61), high serum sodium (276.0), low serum potassium (276.8), high serum potassium (276.7), low serum hemoglobin (285.9).

Table 7. Sensitivity of claims data to detect common laboratory abnormalities* identified more than 10 times during the hospitalization from 83 institutions that provide electronically captured laboratory results [corresponds to table 4 in text].

Laboratory Abnormality	Sensitivity of Claims Data (%)
Low serum sodium recorded >10 times (≤ 135 meq/L)	30.0
High serum sodium recorded >10 times (>145 meq/L)	42.2
Low serum potassium recorded >10 times (< 3.5 meq/L)	19.5
High serum potassium recorded >10 times (> 5.0 meq/L)	20.4
Low serum hemoglobin Hgb recorded >10 times (<12 g/L for females or <14 g/L for males)	9.5

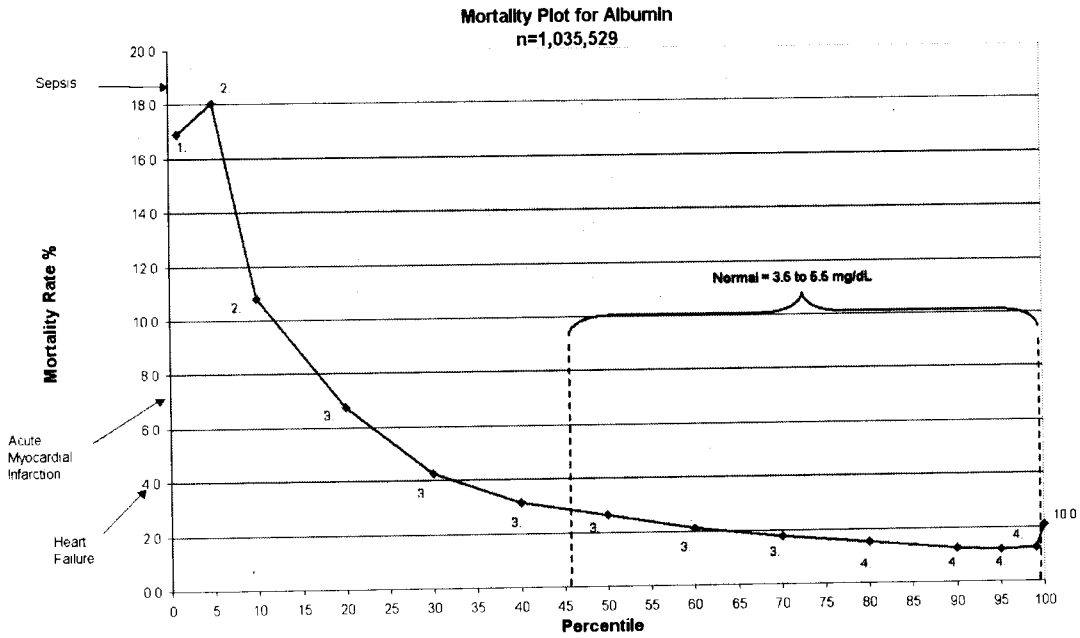
* Using Harrison's Principles of Internal Medicine. McGraw-Hill Professional, 15nth Edition, 2001.
ICD-9 Codes used: Low serum sodium (271.61), high serum sodium (276.0), low serum potassium (276.8), high serum potassium (276.7), low serum hemoglobin (285.9).

Figure 11. In-hospital mortality by serum blood urea nitrogen (BUN) value from institutions that provide electronically captured laboratory results during hospitalization.



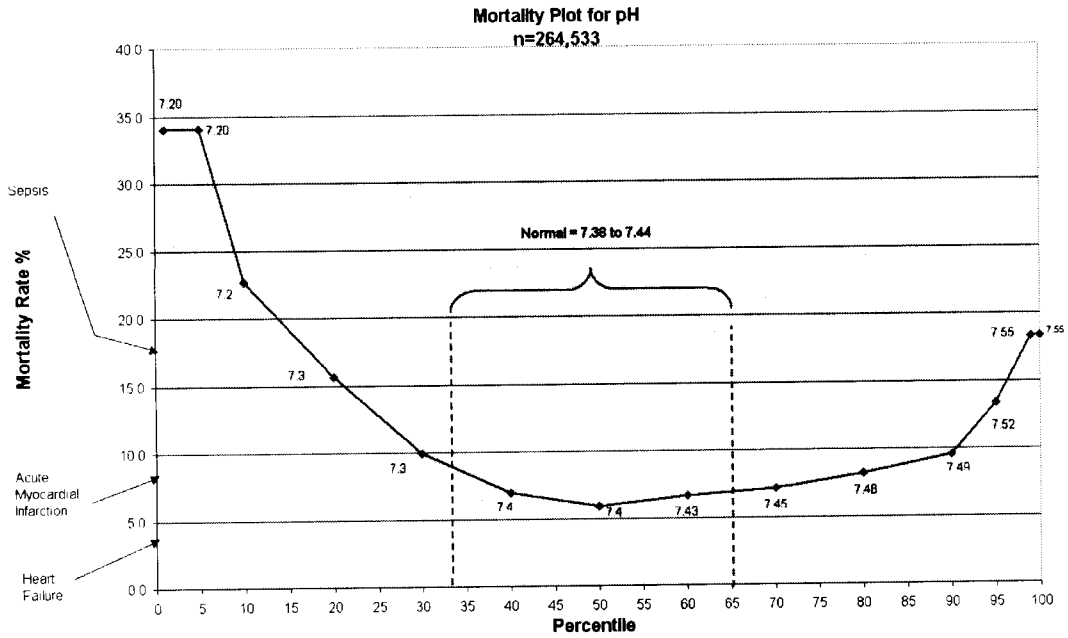
Note: Each plot point provides mortality at the serum blood urea nitrogen (BUN) result (normal as per Harrison's Principles of Internal Medicine. McGraw-Hill Professional, 15nth Edition, 2001). As mortality rate varies by disease group, the arrows adjacent to the y-axis indicate the hospital mortality for sepsis, acute myocardial infarction, and heart failure.

Figure 12. In-hospital mortality by serum albumin value from institutions that provide electronically captured laboratory results during hospitalization.



Note: Each plot point provides mortality at the serum albumin result (normal as per Harrison's Principles of Internal Medicine. McGraw-Hill Professional, 15nth Edition, 2001). As mortality rate varies by disease group, the arrows adjacent to the y-axis indicate the hospital mortality for sepsis, acute myocardial infarction, and heart failure.

Figure 12. In-hospital mortality by serum pH value from institutions that provide electronically captured laboratory results during hospitalization.



Note: Each plot point provides mortality at the serum pH result (normal as per Harrison's Principles of Internal Medicine. McGraw-Hill Professional, 15nth Edition, 2001). As mortality rate varies by disease group, the arrows adjacent to the y-axis indicate the hospital mortality for sepsis, acute myocardial infarction, and heart failure.

Submitter : **Dr. Nicole Talbot** **Date: 06/12/2006**

Organization : **Dr. Nicole Talbot**

Category : **Physician**

Issue Areas/Comments

GME Payments

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.

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. Nicole Talbot

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

Organization :

Category : **Physician**

Issue Areas/Comments

FTE Resident Count and Documentation

FTE Resident Count and Documentation

Dear Dr. McClellan:

I 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). I 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 .

The activities cited in the 1999 position 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.

The proposed inpatient rule alteration exclusion, for purpose of DGME and IME payment activities held in medical school or physician s office, and other non-hospital settings, reflects a lack of understanding of the interconnectivity of graduate medical education.

The geographic location of teaching activities is ubiquitous and is often held at bedside, in conference rooms, in physician office, and other locations. The evolving merger of all of these facilities into Academic Health Centers precludes parsing out geographic sites. Conferences, such as Journal Clubs, are directed at specific patients or groups of patients. Health problems are presented in a variety of techniques, but never disconnected from the healthcare of the patient. Conferences, such as those of Morbidity and Mortality, have been major teaching activities for a century and focus on specific patients. Moreover, these conferences are sequencing into the basis of error reduction, a quality forum emphasized by CMS.

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, Clark Denniston, MD. University of North Carolina, Chapel Hill

Submitter : **Dr. William Duerfeldt** **Date: 06/12/2006**

Organization : **Ohio University**

Category : **Individual**

Issue Areas/Comments

GME Payments

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.

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,
William F. Duerfeldt, D.O. FAAFP

Submitter : **Dr. Matthew Ewend** **Date: 06/12/2006**

Organization : **UNC Division of Neurosurgery**

Category : **Physician**

Issue Areas/Comments

FTE Resident Count and Documentation

FTE Resident Count and Documentation

June 12, 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 University of North Carolina Neurosurgery Residency Training Program 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.

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 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.

The ACGME requires us to demonstrate that our residents are trained using evidence based medicine. To paraphrase this, we need to make sure that our residents base their medical decision making upon published studies. At the same time, we are told that holding a journal club to review these published studies is no longer an acceptable activity in training the residents.

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,

Matthew G. Ewend, MD
Chief & Program Director
Division of Neurosurgery

CMS-1488-P-1505-Attach-1.TXT

71505

□□June

12, 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 University of North Carolina Neurosurgery Residency Training Program 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.

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 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. The ACGME requires us to demonstrate that our residents are trained using evidence based medicine. To paraphrase this, we need to make sure that our residents base their medical decision making upon published studies. At the same time, we are told that holding a journal club to review these published studies is no longer an acceptable activity in training the residents.

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, Matthew G. Ewend, MD Chief & Program Director Division of Neurosurgery Division of Neurosurgery Faculty Matthew G. Ewend, MD KM & VL Weatherspoon
Professorship in Neurosurgery Associate Professor
Chief & Program Director Elizabeth Bullitt, MD Professor Krystal A. Coffman, ACNP Clinical Instructor Eldad J. Hadar, MD Assistant Professor Sivakumar Jaikumar, MD
Assistant Professor

Robert Price, Jr., MDClinical Associate Professor Clinical Faculty Robert Allen, MD Stephen Boone, MD Adam Brown, MD Dennis Bullard, MD Bruce Kihlstrom, MD David Klein, MD Kimberly Livingston, MD Thomas Melin, MD Liang Soo, MD Joint Appointments Stephen R. Aylward, PhD Albert R. Hinn, MD Sten Y. Solander, MD Residents Ming Cheng, MD Chief Resident Samer Elbabaa, MD Michaux Kilpatrick, MD
Alim Ladha, MD Timothy Maryanov, MD Deanna Sasaki-Adams, MD Clinical Nurses Sharon S. Cush, RN Nurse Education Clinician Susan D. Fairholm, RN, BSN Nurse Education Clinicianl The University of North Carolina at Chapel Hill 3015 Burnett-Womack Building
Campus Box 7060 Chapel Hill, NC 27599-7060 Phone (919) 966-1374 Fax (919) 966-6627 The University of North Carolina at Chapel Hill 2160 Bioinformatics Building Campus Box 7060 Chapel Hill, NC 27599-7060 Phone (919) 966-1374 Fax (919) 966-6627

Submitter : **Mr. Jeffrey Heidt**

Date: 06/12/2006

Organization : **Ropes**

Category : **Attorney/Law Firm**

Issue Areas/Comments

Wage Data

Wage Data

See Attached Comments

CMS-1488-P-1506-Attach-1.PDF

#1506

ROPES & GRAY

ROPES & GRAY LLP
ONE INTERNATIONAL PLACE BOSTON, MA 02110-2624 617-951-7000 F 617-951-7050
BOSTON NEW YORK PALO ALTO SAN FRANCISCO WASHINGTON, DC www.ropesgray.com

June 12, 2006

Submitter: Deborah Kantar Gardner and Jeffrey L. Heidt

Organization: Ropes & Gray LLP

Category: Health Care Provider Representative

Issue Areas/Comments: General re: CMS-1488-P-Wage Data

VIA ELECTRONIC MAIL
http://www.cms.hhs.gov/eRulemaking

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1488-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Comments on Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates, Published at 71 F.R. 24,001 (April 25, 2006) CMS-1488-P- Wage Data

Dear Dr. McClellan:

We welcome the opportunity to submit these comments on proposed rules published on April 25, 2006 at 71 F.R. 24001 *et seq.* This firm provides legal services to numerous providers who may be adversely effected by implementation of that portion of the proposed rules that seeks to exclude the wage data of a critical access hospital (CAH) converting to rural hospital status from the computation of the wage index until the converting hospital is an IPPS hospital in both the year in which the survey data is collected (the "base year") and the current rate year (the "rate year"). This aspect of the proposed rule is contrary to the statutory mandate that requires inclusion of all subsection (d) hospitals (those hospitals subject to the prospective payment system) in the wage index calculation and frustrates the purpose of the wage index and the rural

floor. It also is inconsistent with the position the Secretary took in determining to remove the wage data of CAHs from the wage index calculation. It has no basis in law or in logic and is antagonistic to the interests of Massachusetts PPS hospitals, many of whom are suffering from a declining and non-representative wage index due to the exclusion of CAHs from the wage index and who would benefit from the immediate inclusion of any converting CAH in the wage index computation.

As you know, Congress mandated the creation of a wage index in 1983 by requiring the Secretary to adjust the proportion of hospitals' costs attributable to wages and wage-related costs of the DRG rates for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. Pub. L. No. 98-21, § 601 (1983) (codified at 42 U.S.C. § 1395ww(d)(3)(E)). In 1987, Congress amended the statute to require the Secretary to update this factor on the basis of an annual survey of the wages and wage-related costs of subsection (d) hospitals. Pub. L. No. 100-203, § 4004. Generally, a hospital's PPS reimbursement is based on the wage index for the geographic area in which it is located. However, Congress also mandated that an urban area's wage index cannot be lower than the wage index applicable to rural areas in that state (the "rural floor"). Pub. L. No. 105-33, § 4410. Congress intended that the rural wage floor benefit urban providers by preventing the wage indexes of urban hospitals from falling below the wage index applicable to rural areas and thereby correct the anomaly of some urban providers being paid less than the average rural hospital in their states.

Prior to October 1, 2003, the Secretary included the wage data of CAHs in the computation of the wage index and the rural floor for various states. It did so because it had no reason to believe that these hospitals did not provide an accurate reflection of the labor market during the relevant period. However, effective October 1, 2003, the Secretary decided to exclude the wage data of CAH from the wage index based on data showing that a substantial negative impact of CAHs on the wage indexes of areas where they were located. Therefore, beginning with the FY 2004 wage index, the Secretary excluded from the wage index the wage data of CAHs "even if the hospital was paid under the IPPS during the cost reporting period used in calculating the wage index." 68 F.R. 45,398, Aug. 1, 2003. The sole reason the Secretary gave for his exclusion of CAHs from the wage index was that he "believe[d] that this change would improve the overall equity of the wage index." Id.

Without regard to the propriety of excluding CAHs from the wage index, the proposed rule preventing the inclusion of the wage data of CAHs in the wage index is inconsistent with the statute and the Secretary's prior practices. Pursuant to the statutory mandate, a CAH that converts to a PPS hospital is a subsection (d) hospital that must be included in the wage index because its wage data reflects the actual wages paid by the hospital and the conditions occurring in the labor market area in which it is located. A CAH that converts to IPPS status is not tantamount to a new hospital that has not filed any wages and hours data on a Medicare cost report; rather, it is a provider that participated in the Medicare program (albeit with a different status) previously and has developed, and in many cases submitted, wages and hours data for the

wage index. Because this data is available to the Secretary for the wage index survey and presents an accurate and objective picture of wage conditions in the area that the provider is located, it should be included in the wage index calculation. Indeed, in prior years, the Secretary has recognized the importance of including all available wage data in the wage index calculation:

> We have always maintained, subject to limited expectations [sic], that any hospital that is in operation during the data collection period used to calculate the wage index should be included in the database, since the hospital's data reflects conditions occurring in that labor market area during the period surveyed.

67 F.R. 49,982, 50,023 (Aug. 1, 2002). By excluding the wage data of a CAH that converts to IPPS status for the reason that the hospital was not an IPPS hospital in the year in which the wage survey was conducted, the Secretary arbitrarily creates a wage index that does not "reflect[] the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level" in violation of the statutory mandate. See 42 U.S.C. § 1395ww(d)(3)(E).

This aspect of the proposed rule also violates the statutory purpose of the wage index and the rural floor. Congress required the wage index to reflect real wage levels and selected a survey format to ensure that a group of providers were included in the wage index calculation. CAHs that have converted to IPPS hospitals are subsection (d) hospitals that Congress intended to be included in the calculation of the wage index. Where actual wage data is available, it defies the statutory purpose of the wage index survey not to use that data. Moreover, to the extent that CAHs form the rural floor in a given state, their wage data is all the more important in carrying out Congressional desire to protect urban hospitals from declining wage indexes. This is particularly true in states subject to an imputed rural floor which, in accordance with Medicare's principles of fairness and accuracy, should be able to avail themselves of a wage index based on the more accurate and representative wage data of a true subsection (d) rural hospital rather than an imputed rural index.

Immediately including converting CAHs in the wage index computation would be consistent with the Secretary's past practice in excluding CAHs from the wage index. As noted above, the Secretary excluded CAHs from the wage index based on their Medicare status in the current rate year. Even hospitals that were IPPS hospitals in the base year (the year the wage data was collected), were excluded from the wage index calculation simply by virtue of their Medicare status in the rate year. In choosing to focus on a provider's Medicare status in the rate year, the Secretary acknowledged the importance of actual conditions in the labor market, despite the time lag in the computation of the wage index.

The Secretary's proposed changes will have a significant adverse impact in Massachusetts should its CAHs choose to convert to IPPS status. In Massachusetts, the imputed rural floor for FY 2006 (1.075) is lower than the actual rural floor that existed prior to the Secretary's exclusion of CAHs from the wage index and lower than the rural floor would be if converting CAHs were

included in the wage index in the year of conversion. Massachusetts PPS hospitals would continue to suffer severe reductions in their Medicare payments if they are compelled to wait four years after a CAH converts to PPS status before the Secretary includes the wage data of the converting CAH in the wage index calculation. The proposed changes would, therefore, have a drastic and unwarranted impact on Massachusetts PPS hospitals and would undoubtedly have an injurious impact on their ability to deliver quality care and services.

Thank you for the opportunity to comment on the proposed rules. For the reasons set forth above, these proposed changes to the wage index calculation are arbitrary and should not be implemented. If you or your staff needs further clarification of the views expressed in this submission, please contact either of the undersigned at 617-951-7000.

Respectfully submitted,

Deborah Kantar Gardner and Jeffrey L. Heidt
Ropes & Gray LLP
One International Place
Boston, MA 02110-2624
617-951-7000

Submitter : **Mr. Thomas Cockrell** **Date: 06/12/2006**

Organization : **South Carolina Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

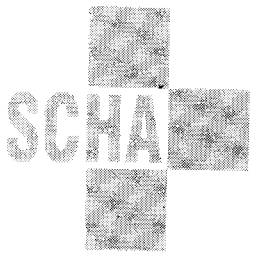
GENERAL

See Attachment

CMS-1488-P-1507-Attach-1.DOC

CMS-1488-P-1507-Attach-2.DOC

#1507.



June 9, 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 South Carolina Hospital Association's (SCHA) 90+ member hospitals, health care systems and other health care organizations, we 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.

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc). It also proposes refining the DRGs to account for patient severity, with implementation likely in FY 2008. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education, among other policies.

While the SCHA supports many of the proposed rule's provisions, we have serious concerns about the proposed changes to the DRG weights and classifications. The hospital field supports meaningful improvements to Medicare's inpatient PPS. Along with the American Hospital Association, we believe that the hospital industry and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. 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.

We have received hospital specific impacts from two different sources and the 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. Moving forward requires thoughtful change.

With this in mind, the South Carolina Hospital Association joins the American Hospital Association in supporting the following:

- **One-year Delay:** We support a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. SCHA, along with the AHA and the rest of the hospital industry, are committed to working with CMS over the next year to address these concerns.

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

- **A New Classification System Only if the Need Can Be Demonstrated:** At this point, SCHA does 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**: SCHA (through its partnership with AHA) commits to working with CMS to develop and evaluate alternatives for new weights and classifications.

We have enclosed detailed comments with respect to hospital quality data. We also support the detailed comments as outlined by the American Hospital Association on a variety of issues as outlined in the proposed rule.

The SCHA appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me at (803) 744-3510 or tcockrell@scha.org.

Sincerely,

Thomas D. Cockrell, FHFMA
Chief Operating Officer

SCHA Comments on CMS Proposed Rule

Hospital Quality Data

Time Frame Concerns - In reviewing the proposed rule, SCHA would like to submit the following comments for consideration.

- The proposed rule was published in the *Federal Register* on April 25, 2006 well after hospitals had finished or were finishing most of the abstraction for 1st quarter 2006 discharges and had already or were nearly ready to transmit that data to their respective performance measurement vendors.
- Comments on the proposed rule are not due until June 12, 2006, but hospitals would only have until August 15, 2006 in order to comply with the requirements since first quarter discharge data must be in the warehouse by that date in order to qualify for the update.
- In order to meet the deadlines proposed in this rule, hospitals have to enter into agreements with their performance measurement vendors in order institute a process that requires them to re-abstract medical records for the additional measures. The SIP measures are particularly problematic given that only a small number of South Carolina hospitals eligible for the annual payment update are presently collecting and reporting these measures to the data warehouse, although many are collecting and reviewing this data. With the proposed rule, the majority of these hospitals have put processes in place to collect the required data beginning with 2nd quarter 2006 hospital discharges, but these hospitals will need to go back and retrieve the necessary data from medical records for 1st quarter 2006 discharges. Hospitals will incur additional expenses that include costs associated with the work required by their respective performance measurement vendors and overtime costs that are required for staff needed to perform this work under an expedited time frame.
- Although data are not required to be in the data warehouse until August 15, 2006, hospitals must have their data submitted to their performance measurement vendors no later than sometime between June 15 and June 30 depending on the performance measurement vendor. Performance measurement vendors have had to move back their cutoff dates to allow hospitals sufficient time to abstract medical records. In essence, a large number of hospitals have only been given about six weeks to meet the timelines in this proposed rule.
- Given these tight timeframes to collect and report additional measures, South Carolina hospitals are concerned about the education and training of medical record abstractors. We do not believe that they have been given sufficient time to ensure appropriate training of their medical record staff to ensure a high degree of accuracy in the data abstraction, particularly with respect to the SIP measures.

Recommendations - In light of these identified problems with the retroactive nature of the proposed rule, SCHA requests that CMS require the submission of the additional measures, specifically the SIP measures, begin with 3rd quarter 2006 discharges and that the annual payment update be tied to successful transmission of the additional measures beginning with 3rd quarter discharges. This is congruent with the AHA's recommendations. We also recommend that the SIP measures **not** be included in the formal validation process for the annual payment update until after one full year of reporting of the additional measures. We do support a review of the records by the Clinical Data Abstraction Center (CDAC) for these additional measures,

especially the SIP measures to permit hospitals to obtain feedback about the data abstraction for learning purposes during the course of the year.

Since the DRA calls for further expansion of the measures reported to the data warehouse, SCHA recommends that CMS develop a process that affords organizations sufficient time prospectively to begin collection and reporting of any additional measures that will be considered in an annual payment update or part of a value-based purchasing program for hospitals. Any additional expansion should be done under the auspices of the Hospital Quality Alliance in order to streamline quality reporting requirements while providing the public with meaningful information.

Chart Validation – SCHA recognizes the importance of ensuring that the data reported by hospitals to the data warehouse is accurate and appreciates the volume of charts that must be reviewed by the CDAC in order to ascertain whether the reported data is reliable and valid. In the proposed rule, CMS has indicated that hospitals must pass validation of a minimum of 80 percent reliability based on the CMS chart-audit validation process for the first three quarters of data from calendar year 2005. CMS has combined the chart samples for the first three quarters of 2005 or a total of 15 charts into a single stratified sample to determine whether the 80 percent reliability is met.

Recommendations – SCHA strongly encourages CMS to allow hospitals to challenge any mismatches in the chart validation that they may have with CDAC in order to score as high as they possibly can in any quarter, learn from the process, and remedy any identified problems to prevent them from occurring in subsequent quarters. Additionally, SCHA recommends that CMS consider a validation process that would focus more resources on those hospitals that are having difficulty in passing the validation thresholds on a consistent basis. Finally, going forward, CMS should prospectively establish and communicate to the field which quarters will be used in the calculation of the validation threshold.

Reconsideration Process – CMS has indicated that hospitals that do not meet the APU requirements for the applicable fiscal year may appeal this determination to the Provider Reimbursement Review Board and that any such requests for FY 2007 must be made by no later than November 1, 2006. CMS has also proposed that the November 1, 2006 deadline apply to FY 2005 and FY 2006 APU decisions and that a November 1 deadline would apply in all future fiscal years. Further, CMS is seeking public comment on the need for a more structured reconsideration process to precede any Provider Reimbursement Review Board appeal for FY 2008 and subsequent years.

Recommendations – South Carolina hospitals are supportive of a process that could potentially consider the reasons why a hospital was not able to meet the APU requirements for the applicable fiscal year and allow the hospital to meet the requirements to qualify for the APU. We believe that Quality Improvement Organization staff could be extremely helpful to hospitals and to CMS in implementing any reconsideration process.

Future Measures – The DRA requires expansion to other quality measures.

Recommendations: SCHA would strongly suggest that Medicare work with the Hospital Quality Alliance partners to identify outcome measures that better reflect the quality of hospital care and to only use the HQA measures for public reporting in order to avoid confusing the public even more. Additionally, use of the 30-day risk-adjusted mortality for acute myocardial infarction is not congruent with the in-hospital mortality measure that is part of the JCAHO core measures for acute myocardial infarction and an outcome measure that was used in the Premier Hospital Quality Incentive Demonstration project.

CMS has clearly indicated that HCAHPS® results will be considered as part of a future measure expansion. We strongly recommend that CMS identify when hospitals will need to have HCAHPS® data reported to the Data Warehouse to meet possible time lines for the next fiscal year's APU and to offer another dry run period that will also hospitals to meet those time frames.

Value-Based Purchasing

Plan for Implementing Hospital Value-Based Purchasing in FY 2009 – In the proposed rule, CMS describes several of its efforts over the past several years to improve the quality and efficiency of care delivered to Medicare beneficiaries in America's hospitals, including CMS' participation in the Hospital Quality Alliance as a strategy to encourage hospital accountability by making comparative information about hospital performance publicly available and the testing of innovative approaches to improving quality through pilot project such as the Premier Hospital Quality Incentive Demonstration. South Carolina hospitals have actively participated in both projects.

Recommendations – SCHA believes that it is essential that CMS work with its Hospital Quality Alliance partners in developing quality incentive proposals that could be shared in the near future with the hospital community for comment given the short-time frame that has been mandated by Congress to begin a Medicare value-based hospital purchasing program.

Hospital-Acquired Infections

Plan for Reducing Hospital Payment for Preventable Complications –Congress has determined that hospitals should not receive higher amounts of reimbursement when post-admission complications, such as hospital-acquired infections, occur. Congress through the DRA of 2005 (1) directs CMS to identify at least two conditions that are high cost/high volume or both that result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis code that reasonably could have been prevented though the application of evidence-based guidelines by October 1, 2007; (2) requires hospitals submit the secondary diagnoses that are present at admission on inpatient claims for discharges on or after October 1, 2007; and (3) obligates CMS to lower reimbursement to hospitals for discharges on or after October 1, 2008 for cases in which one of the selected conditions was not present on admission.

Recommendations –
Due to the substantial work already being done by CMS and the hospital community, the Surgical Care Improvement Project (SCIP) should be the starting point for meeting this requirement.

SCHA recommends that CMS consider smaller-scale demonstration projects to test any methodology with hospitals before a national implementation for DRG specific payment reductions for complications, never events, or hospital-acquired infections.

Submitter : **Dr. Joseph Blonski** **Date: 06/12/2006**

Organization : **St. Cloud Hospital - Family Practice Residency**

Category : **Hospital**

Issue Areas/Comments

GME Payments

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.

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. Blonski
Program Director of St. Cloud Hospital Family Practice Residency Program

Submitter : **Mr. Kevin Higdon** **Date: 06/12/2006**

Organization : **Elkhart General Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

#1509

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 : **Date: 06/12/2006**

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1510-Attach-1.DOC

ATTACHMENT TO # 1510

Hamot Medical Center
201 State Street
Erie, PA 16550
814-877-6000

June 12, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
P.O. Box 8010
Baltimore, MD 21244-1850

Re: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates
Docket Number: CMS –1488-P

Dear Sir/Madame:

We are writing to comment on the proposed 2007 Centers for Medicare and Medicaid Services (CMS) Hospital Inpatient Prospective Payment System (IPPS), released on April 12, 2006 and published in the *Federal Register* on April 25, 2006.

We recognize the need to continually evolve the payment system to reflect the present environment in medical service delivery. We appreciate the considerable effort that has gone into the development and improvement of the inpatient prospective payment system (IPPS) to date. We further recognize the significant complexities associated with gathering reasonably accurate cost data, data that should serve as the foundation of payment systems such as the proposed IPPS.

The proposed changes appear to have their roots in the Medicare Payment Advisory Commission's (MedPAC) 2005 Report to Congress on Medicare payments for a certain subset of "specialty" hospitals. The MedPAC report raised concerns that these specialty hospitals were providing care for only the most profitable cases, and leaving less profitable services to be delivered by other acute care hospitals. Unfortunately, rather than addressing the specific issue of specialty hospitals, MedPAC recommended changing the payments for ALL acute care hospitals. This appears to be aimed at reducing the incentives present in the overall inpatient payment system that lead to the growth of these specialty hospitals.

We believe CMS should certainly address the issues and concerns raised in the MedPAC report when considering policy changes. However, the current changes to the inpatient payment system as proposed are the equivalent of throwing the baby out with the bath water. Efforts to address issues identified in the MedPAC report should be focused on the

specialty hospital subset and should not occur in conjunction with payment systems at large for all other hospital facilities.

Looking beyond the issue of specialty hospitals, we have two other major areas of concern with the proposed IPPS. First, the proposal incorporates an estimated "cost-based" system, rather than a charge-based system for determining the payment weights for each patient category in 2007. Second, the proposal endeavors to change the method of identifying the variation in patients' severity of illness that would be implemented in 2008, or potentially 2007. Each change is significant and in previous years would be considered a major modification to the payment system. Proposing both changes in a single regulation, with implementation in 2007, is unprecedented.

This proposal will base payments on "costs". This is consistent with how private insurers handle costs associated with health care technology. However, one very important difference between the proposed methodology and that of private insurers is the timing of the cost data. Private insurers utilize data in real-time and pay actual invoice costs for technology used in the care of patients. In CMS's proposal, the "cost" that will be used to determine payment is a rough approximation of costs, not an approximation of the actual price the hospital pays for the items and services required to appropriately treat patients.

The cost estimates for Fiscal Year 2007 payments will be made using hospital claims data from Fiscal Year 2005 and hospital cost reports from Fiscal Year 2003. The use of any data from Fiscal Year 2003 fails to account for current technology costs such as drug-eluting stents and bi-ventricular pacemakers/defibrillators. These devices are vital to the adequate care of the cardiac patient. Because of the use of 2003 data, the cost estimates under the proposed changes will absolutely be incorrect and will inadequately compensate hospitals for the care of Medicare patients.

Attempting to estimate cost data in this fashion is further complicated by the lack of a uniform approach to mark-up strategies for technology. Generally, higher cost technologies, such as those used listed above, are often marked up a lower rate than lower cost items. Therefore, costs are inappropriately reflected when attempting to apply derived averages. High-cost technology such as defibrillators and drug-eluting stents will be unfairly underestimated in the proposed reimbursement methodology, causing hospitals to lose substantially when using these technologies. Cost reports were never intended to be utilized for the sake of developing accurate procedure specific payment rates.

Staying with the cardiac example, this CMS proposal will result in a reduction of reimbursement for cardiac services to all hospitals by approximately 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%. Additionally, technology intensive DRGs will also be significantly reduced under this proposal. For example, 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%. These reductions will severely impact the delivery of these services.

These proposed reductions are severe and are not based on any type of realistic mechanism for cost assessment. While it is appropriate to pursue a better understanding of the actual costs of treating patients, all such efforts must be made with the intention of producing accurate information. This proposal simply cannot be implemented in its current form, as the impact for cardiac programs across the country will be grave. Such an impact may potentially limit patient access to the best available technology, as hospitals will not be able to adequately recover their acquisition costs for high cost devices. This type of technology is not in any way experimental. The well-informed American public knows about stents and defibrillators, and knows that this technology has been scientifically proven to be beneficial for its intended patient populations.

We would propose that is clearly not what CMS intends to achieve. We recommend delaying the implementation of any changes to cardiac services reimbursement until such time as accurate and appropriate information regarding costs to treat and manage patients can be compiled.

We appreciate the opportunity to provide our comments on the 2007 CMS IPPS proposal. We commend CMS for its ongoing efforts to ensure adequate reimbursement for cardiac and all clinical services, and we recognize the extremely complex issues involved in establishing appropriate reimbursement for procedures performed in the inpatient setting. We remain committed, with CMS, to ensure that Medicare beneficiaries, and all patients, have continued access to high quality, efficient, and effective services.

If you have any questions regarding the comments submitted by our organization, please contact either of us using the information below.

Sincerely,

Tom Williams
Operations Director,
Hamot Heart Institute
814-877-2960
tom.williams@hamot.org

Gary Maras
Senior Vice President,
Hamot Medical Center
814-877-5262
gary.maras@hamot.org

Submitter : **Mr. Lonnie Younger** **Date: 06/12/2006**

Organization : **Mission Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1511-Attach-1.DOC

MISSION
HEALTH & HOSPITALS

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:

I am writing on behalf of Mission Health and Hospitals, located in Asheville, North Carolina. We are a three-hospital system and serve an 18-county are of western North Carolina providing inpatient and outpatient services. We 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.

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc). It also proposes refining the DRGs to account for patient severity, with implementation likely in FY 2008. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education, among other policies.

Mission Hospitals supports many of the proposed rule's provisions; however we have serious concerns about the proposed changes to the DRG weights and classifications. We support the goal of refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions.

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. For Mission Hospitals, this change will result in an additional loss on Medicare of over $2.5 million dollars.

Last year, we lost over $23,000,000 treating Medicare patients due to inadequacy of payment. These losses are cost shifted to other payers and driving up the cost of insurance provided by area businesses.

Analysis shows the impact of the proposed changes to be highly unstable, with small changes in method leading to large changes in hospital payment. The validity of CMS' proposals versus potential alternatives to improve the DRG weights and classification system is uncertain. Moving forward requires thoughtful change.

Specifically, the **Mission Health and Hospitals supports the following**:

- **One-year Delay:** We support a one-year delay in the proposed DRG changes given 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:** Mission Health and Hospitals does not support a new classification system at this time, 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.

Mission Health and Hospitals appreciates the opportunity to submit these comments

Sincerely,

Lonnie Younger, Senior Vice President and Chief Financial Officer
Mission Health and Hospitals
509 Biltmore Ave.
Asheville, NC 28801
828 213-1137

Submitter : **Ms. Wanda Marvel** **Date: 06/12/2006**

Organization : **Missouri Hospital Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

#1512

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. Tamara Babb** **Date: 06/12/2006**

Organization : **American Academy of Family Physicians**

Category : **Physician**

Issue Areas/Comments

GME Payments

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 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.

Knowledge of medicine is extremely complex. Medical students, residents and practicing physicians must spend a significant amount of time to maintain and build upon their knowlege.

Physicians learn the SCIENCE of medicine in didactic training. We learn the ART of medicine in direct patient care. The two cannot be separated as the very lives of those in our charge depend on our competency in both areas. Do not deprive future physicians of comprehensive, ongoing trainig in the science of medicine.

To put this into perspective, would YOU fly in a 747 with a pilot who never cracked a book, never attended ground school, never flew a simulator, never studied emergency procedures, never solo'ed- just learned all he/she knew by transporting folkslike YOU? I didn't think so.

Submitter : **Joanne Donsky** **Date: 06/12/2006**

Organization : **UCSF Dept of Family and Community Medicine**

Category : **Academic**

Issue Areas/Comments

GME Payments

GME Payments

As a faculty member of a department of family medicine, 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.

In addition, 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.

Joanne Donsky
Associate Clinical Professor
UCSF-Deptartment of Family and Community Medicine

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

Organization : **Marquette General Health System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1515-Attach-1.DOC

#1515

Marquette General Health System
580 W. College Avenue
Marquette, Michigan 49855

June 9, 2006

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, DC 20201

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

Dear Dr. McClellan:

Marquette General Health System (MGHS) appreciates the opportunity to comment to the Centers of Medicare and Medicaid Services regarding the proposed rule updating the Medicare Inpatient Prospective Payment System for Federal Year 2007, as published in the April 25, 2006, Federal Register.

DRG CHANGES

As a regional provider of health care services in the large rural area of Michigan's Upper Peninsula, one of our primary concerns is providing adequate access to care for the patients we serve. As a regional hospital, MGHS provides a wide array of specialized services not available at smaller community hospitals. These intensive specialized services are those being dramatically impacted by this proposed rule and its changes to DRG w eights. We believe that the significant changes of the proposed rule may negatively impact access to care in our region. We, along with the hospital field, support meaningful changes to Medicare's inpatient PPS. However, we feel that more time is needed to understand the proposed policy changes, which redistribute significant funds within the inpatient system.

Analysis performed by the American Hospital Association shows the impact of the proposed changes to be highly unstable, with small changes in method leading to large changes in hospital payment. In addition, the validity of CMS' proposals versus potential alternatives to improve the DRG weights and classification system is uncertain. For example, the overall cost to charge ratio being used to forecast medical supply

costs fail to recognize the variations in many facilities' mark-up policies for high cost devices. The mark-up formulas often implement lower increases for the highest cost items, such as stents, defibrillators, and other cardiac devices. The end result is an understatement of the actual costs of these DRGs, and subsequently a lower weight assignment.

Specifically, we have the following suggestions regarding the proposed DRG changes:

- Delay in the implementation of the proposed DRG changes to allow adequate time further study and validate the methodologies involved.

- Re-evaluate the proposed cost based weights, as we believe the proposed methodology is flawed.

- Implement a new classification system only if the need can be demonstrated.

- Adopt any changes to weights and classification simultaneously. If it is demonstrated that the these two changes are appropriate, they should be implemented simultaneously to provide better predictability and smooth the volatility created by these two changes.

- Utilize a three year transition for any changes. Given the magnitude of the potential change in hospital payments, this time will be necessary for hospitals to make the adjustment.

SCH/MDH CHANGES IN QUALIFICATION STATUS

MGHS would also like to comment on the new sole community hospital self-attestation requirements. We believe that our intermediary has much better data in order to make determinations on whether significant changes occurred which could potentially impact an SCH's designation. . Instances of "like hospital" changes, or criteria for determining inpatient case numbers in specific geographic areas are more readily available to our intermediaries. Further, we ask that when adjustments to a SCH's designation become apparent, that the affects of this change be made on a prospectively basis and no penalties be applied on a retroactive approach.

TRANSPARENCY OF HEALTHCARE INFORMATION

Lastly, we feel that the retroactive application of validation criteria for all 21 quality measures with the potential for the loss of 2 percentage points of the market basket update is unreasonable. Retroactive alterations of the data files are difficult and costly. We suggest 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.

We appreciate the opportunity to submit these comments. If you have any questions about our comments, please feel free to contact me at (906) 225-4774.

Sincerely,

William R. Nemacheck
Chief Executive Officer

Submitter : **Ms. Lynn Waters** **Date: 06/12/2006**

Organization : **Greenville Hospital System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1516-Attach-1.DOC

#1516

GREENVILLE HOSPITAL SYSTEM
UNIVERSITY MEDICAL CENTER

June 12, 2006

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

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

Dear Dr. McClellan:

Thank you for allowing hospitals the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) on the Inpatient Prospective Payment System (IPPS) proposed rule for fiscal year 2007. I am the Director of Managed Care and Reimbursement for Greenville Hospital System, located in Greenville, South Carolina. Our main hospital, Greenville Hospital Center, is a teaching hospital with over 700 beds.

The fiscal year 2007 proposed rule contains significant changes to the IPPS and we believe it is imperative that CMS carefully consider the input from the hospitals that will be affected by these changes. This letter comments on only two aspects of the proposed rule: 1) the changes to the DRG table (including both the proposed FY07 changes in

weights as well as the severity adjusted DRGs), and 2) CMS's purported clarification of its policy relating to didactic time for interns and residents.

1) Proposed Changes to the DRG Table

The proposed changes to the DRG weights to a cost based rather than a charge based system is supposed to be a budget neutral proposition. However, while it is overall budget neutral, many hospitals will be either significant winners or significant losers as a result of the reweighting. Furthermore, indications are that in many cases, the change to the severity adjusted DRG's (currently slated to take place in 2008) will have an offsetting effect to the reweighting.

We have read the comment letter submitted by the American Hospital Association (AHA) and in general, we concur with the AHA position that CMS should at a minimum delay implementation of these changes for a year. The AHA has provided useful analysis and explanation to CMS of the reasons why such a delay is warranted. Furthermore, given the fact that in many cases the two changes offset each other, we do not believe that one change should be implemented without the other. Rather, both the reweighting and the severity adjusted DRGs should be implemented in the same year. We furthermore believe that there should be a transition period of not less than three years for such major sweeping changes.

2) Clarification of Didactic Time Policy

In its proposed rule, CMS has stated that didactic or classroom time spent by interns and residents is not allowable for purposes of counting full time equivalents (FTEs), with the one exception to this policy being that for the direct graduate medical education (DGME) FTE count, classroom time in the hospital setting is allowable for the FTE count. In other words, in the hospital setting, time spent in classroom time is allowable for the DGME FTE count but not allowable for the indirect medical education (IME) FTE count. CMS cites 42 U.S.C. § 1395ww(h)(4)(E) which provides that only patient care time should be counted in the FTE count. CMS has taken the position that didactic activities do not qualify as activities relating to patient care and therefore they should not be included in the IME FTE count.

We take exception to CMS including this "clarification" in its proposed rule because we believe that a) the law does not contain a patient care related requirement for training in a hospital setting b) CMS's policy denies reimbursement for activity which CMS mandates through its designated accrediting body and, c) classroom time is in fact related to patient care.

a) No Patient Care Related Requirement in Hospital Setting

The IME provisions at 42 U.S.C. § 1395 ww(d)(5)(B) impose no requirement that time spent in didactic activities *at the hospital* be related to patient care. Instead, the patient care related requirement relates solely to training in a *non-hospital* setting (42 U.S.C. §

1395ww(d)(5)(B)(iv)). Congress has clearly elected to use different language in different sections of the statute to apply to two different situations. When Congress elects to use different language in different sections of the statute, we must assume that they have done so intentionally. Russello v. United States, 464 U.S. 16, 23 (1983); S.E.C. v. McCcarthy, 322 F.3d 650, 656 (9th Cir. 2003). Therefore, Congress apparently intended to impose a "related to patient care" requirement for nonhospital training and intended for there not to be such a requirement for training that takes place in a hospital setting.

b) Policy Would Deny Reimbursement For Mandated Activities

In order to be accredited by the American Council for Graduate Medical Education (ACGME), residency programs must include didactic activities. Medicare regulations require that, in order for FTEs to be counted for DGME and IME, residents must be enrolled in a program approved by the ACGME or another accrediting organization. 42 C.F.R. §§ 413.75, 413.78(a), (c), 412.105(f), 415.152. Therefore, by requiring ACGME accreditation, CMS has essentially mandated that the residents participate in classroom time activities. The following language appears in Section II of the Graduate Medical Education Directory 2005-2006 (pp. 9-10):

> The education of resident physicians relies on an integration of didactic activity in a structured curriculum with diagnosis and management of patients under appropriate levels of supervision and scholarly activity aimed at developing and maintaining life-long learning skills. The quality of this experience is directly related to the quality of patient care, which is always the highest priority. Educational quality and patient care quality are interdependent and must be pursued in such a manner that they enhance one another.

c) Classroom Time is Related To Patient Care

Even if you were to accept CMS's position that a relationship to patient care is required for classroom time to be allowable, the time spent in classroom activities satisfies this requirement. As noted in the above quote from the Graduate Medical Education Directory of 2005-2006, there is an integration of didactic activity and patient care activity and the integration of these two activities is "...directly related to the quality of patient care, which is always the highest priority." The ACGME recognizes that the hands on training and the classroom training are integrally linked.

For the residency programs conducted at our hospital, the classroom time involves the discussion of the care of specific patients in our hospital. Frequently, specific cases are set forth in the classroom and there is a discussion about how best to approach the care of the patients. Furthermore, often the residents involved in the conference discussions of particular patients have either treated the patient or will be treating the patient. The physician faculty at our hospital do not consider the didactic components of the curricula

to be mere formalities to satisfy ACGME requirements. Rather, the teaching conferences and rounds afford our hospital the opportunity to further involve the residents in direct patient care.

Again, thank you for the opportunity to provide input regarding the Fiscal Year 2007 IPPS proposed rule. We trust that CMS will carefully consider the comments made by us and other hospitals and hospital associations.

Sincerely,

Lynn J. Waters
Director of Reimbursement

Submitter : **Dr. Samuel Matheny** **Date: 06/12/2006**

Organization : **University of Kentucky**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

Please see attachment

CMS-1488-P-1517-Attach-1.RTF

#1517

As a faculty member of a department of family medicine, 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.

In addition, 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.

Submitter : Mr. Cecil Terry **Date:** 06/12/2006

Organization : BJC HealthCare

Category : Hospital

Issue Areas/Comments

DRG Reclassifications

DRG Reclassifications

We support the move to cost-based DRG weights but believe the proposed method is flawed. We suggest that if CMS must implement the change to the cost based weights, as proposed, effective October 1, 2006, that CMS should continue efforts to correct the flaws and errors in the proposed cost based weights and implement such corrections prospectively for federal fiscal year 2008 or for 2009. The imperative implementation of a flawed methodology should not bar efforts to correct the weights to be used for payment in future periods.

In their June 8, 2006 comment letter on the subject proposed rule, the American Hospital Association (AHA) outlined in detail a number of flaws and errors in the proposed method of converting to cost-based DRGs, which we believe that CMS will acknowledge as valid findings. In addition to those identified by the AHA, we note an additional flaw in achieving optimum accuracy in the new cost-based rates; a failure to attempt to make any correction for distortion in cost-to-charge ratios (CCRs) of most hospitals caused by so-called charge compression. Charge compression is the distortion in CCRs caused by the fact the most hospitals apply lower mark-up percentages to high cost devices, drugs, and biologicals than are applied to other goods and services billed by hospitals. This mark-up differential problem makes CCRs, as developed from CMS existing data, invalid for making refinements and changes in Medicare prospective payment systems.

This problem was first discussed at length in conjunction with the proposed rule to update the Outpatient Prospective Payment System (OPPS) for calendar year 2003, when CMS was packaging the cost of devices (which had been paid on a pass through basis), into the APC device-related procedure payments. Then CMS agreed that the cost compression distortion was probably valid and, subsequently, supported a study of this cost compression problem by the Government Accountability Office (GAO). While the GAO ultimately concluded that this was valid problem, we are unaware that CMS ever attempted to make actual correction of the CCRs used for adjusting Medicare payments. While the distortion caused by charge compression had a more material impact on the packaging of device costs for payment under OPPS, this distortion does add additional error to an already flawed cost-based DRG methodology.

For those DRGs known to include a prevailing number of claims that include charges for very high cost devices, drugs, and biologicals, we believe that CMS can and should obtain the actual direct cost of high cost devices, drugs, and biologicals by surveying hospitals for specific devices costs, using statistically valid sampling methods, then add indirect allocated costs from the surveyed hospitals Medicare cost reports to arrive at the total actual cost of these items and incorporate this information into the correction of the overall CCRs used to calculated the weights of the proposed cost-based DRGs. Since CMS will not have time to accomplish this for the 2007 changes, we suggest that CMS should attempt to make these corrections for 2008 or even 2009. Again, the implementation of flawed payment methods now, should not bar corrections to payments used for future periods.

GME Payments

GME Payments

FTE Resident Count and Documentation, - Resident Time in Spent in Nonpatient Care Related 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.

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 .

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.

As a part of the whole, didactic activities are a relatively minor, but important, part of the resident physicians educational experience. Lectures and conferences enhance the patient care provided by the residents by emphasizing and communicating improvements in diagnostic procedures and best practices for increasing the quality and effectiveness of patient care (e.g., selection of alternative, effective drugs and biologicals, prevention and/or reduction of treatment side-effects, infection control, etc.). The information communicated in such lectures and conferences is not significantly different than the information conveyed to the residents by the supervising physicians in the immediate presence of patients. By making oral and written presentations to fellow residents, students, and faculty, the residents submit their knowledge and ideas on the diagnosis and treatment of their current patients to peer review for instant criticism and consultation. These presentations not only promote the general educational experience, but also function as a form of quality control on the current, active treatment of specific patients.

Significant and Unnecessary Additional Administrative Burden
While many of these didactic activities are interspersed throughout the day and week with general hands-on patient care, some are scheduled for brief after hours presentation. Also, since many physical locations throughout the system s teaching hospitals campuses are immediately adjacent to those of the affiliated medical school, it will be a matter of great difficulty in tracking the specific location of the didactic activities to determine, under CMS more rigorous rules, which activities may or may not be counted for graduate medical education reimbursement purposes. The incremental, and, as yet, unspecified documentation process that will be required to capture the uncountable didactic activities will result in significant increases in the administrative burden to teaching hospitals to create such

#1518

documentation and to their Medicare fiscal intermediaries to audit this documentation.

If, for budgetary constraint purposes, CMS must limit GME and IME payments, it is suggested that this is best accomplished through the fine-tuning of payment formulas rather attempting to redefine and micromanage patient care in the educational environment, a process which we believe is more appropriately within the purview of the Accreditation Council for Graduate Medical Education (ACGME).

Submitter : **Dwight Fine** **Date: 06/12/2006**

Organization : **Missouri Hospital Association**

Category : **Health Plan or Association**

Issue Areas/Comments

GENERAL

GENERAL

See attached inpatient PPS comment letter

CMS-1488-P-1519-Attach-1.DOC

#1519

MISSOURI HOSPITAL ASSOCIATION

Marc D. Smith, Ph.D., President

June 12, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P and P2
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-1488-P and P2 — Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; FR Vol. 71, No. 79, Tuesday, April 25, 2006, Proposed Rule

Dear Dr. McClellan:

On behalf of the Missouri Hospital Association's member hospitals, health care systems and other health care organizations and individual members, we appreciate the opportunity to submit comments on the fiscal year 2007 inpatient prospective payment system (PPS) and occupational mix adjustment proposed rules.

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values (HSRV) cost center methodology. It also proposes refining DRGs to account for patient severity, with implementation likely in FY 2008. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education, among other policies.

MHA supports many of the proposed rule's provisions, but has serious concerns about the proposed changes to the DRG weights and classifications.

DRG CHANGES

The Centers for Medicare & Medicaid Services (CMS) is proposing the biggest changes to the calculation of DRG relative weights since the creation of the PPS. These changes would significantly redistribute payments among the DRGs and hospitals. Specifically, CMS proposes the use of HSRVs and a modified version of cost-based weights rather than charge-based weights in FY 2007. The CMS also proposes an alternative patient classification system called consolidated severity adjusted DRGs (CS-DRGs), with implementation likely in FY 2008.

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The hospital field supports meaningful improvements to Medicare's inpatient PPS. Hospitals and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. We believe the system should be simple, predictable and stable over time. One of the fundamental values of a **prospective** payment system is the ability of providers to reasonably estimate payments in advance of their budgeting, marketing, staffing and other key management decisions. Another core feature of the PPS is 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, inpatient PPS should foster innovation and best practice in care delivery. These are essential characteristics of a well-functioning PPS and it is within these policy goals that we evaluate CMS' proposal.

We would like to emphasize here that payment changes alone will not remove the inappropriate incentives created by physician self-referral to limited-service hospitals. Physicians still will have the ability and incentive to steer financially attractive patients to facilities they own, avoid serving low-income patients, practice similar forms of selection for outpatient services and drive up utilization for services. We strongly urge the CMS to rigorously examine the investment structures of physician-owned, limited-service hospitals. It is imperative that CMS continue the suspension of issuing new provider numbers to physician-owned, limited-service hospitals until the strategic plan developed has been fully implemented and Congress has had an opportunity to consider CMS' final report.

The CMS proposes an alternative to the Medicare Payment Advisory Commission's (MedPAC) approach to HSRVs and cost-based weights that could be characterized as a short cut. The CMS asserts that this combined methodology, known as the HSRV cost center methodology, achieves similar results in a more administratively feasible manner. But that is not the case.

The MHA supports a move to cost-based weights, but believes CMS' proposed method is flawed. More work is needed to determine the best way to create cost-based weights. Hospitals are willing to work with CMS in a process to develop consensus around the right way to make this change. More time is needed to develop a sound methodological approach to create cost-based weights and to understand their potential impact.

SEVERITY OF ILLNESS

The CMS also proposes moving to an entirely new patient classification system beginning FY 2008 **or earlier**. Currently, Medicare uses 526 DRGs to classify all Medicare patients. The CMS considered use of 3M's all-patient refined DRGs (APR-DRGs) as an alternative to its current DRGs, which would increase the number of categories to 1,258. However, CMS ultimately proposed refining the APR-DRG system by consolidating APR-DRGs into fewer categories. This would result in a new DRG system with 861 consolidated severity-adjusted DRGs, or CS-DRGs.

The need for and best approach to changing the patient classification system has not been concretely and objectively demonstrated. More careful analysis is needed, along with greater access to the specifics of CMS's methodology and the new GROUPER.

DRG CHANGE RECOMMENDATIONS

More time is needed to understand the significant proposed policy changes, which redistribute from $1.4 to $1.7 billion within the inpatient system. Proposed changes appear 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. Moving forward requires thoughtful change. MHA makes the following recommendations.

- **One-year delay** — Delay proposed DRG changes for one year, given serious concerns with the HSRV cost center and CS-DRG methodology. Hospitals are committed to working with CMS over the next year to address these concerns.

- **Valid cost-based weights** — Pursue moving to a DRG-weighting methodology based on hospital costs rather than charges; but CMS' proposed HSRV cost center method is flawed!

- **New classification system only if the need can be demonstrated** — The need for a new classification system at this time 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.

- **Transition period** — Any changes should be implemented with a transition period, given the magnitude of payment redistribution across DRGs and hospitals. We recommend that CMS provide a three-year transition using a blend of the old DRG weights and the new DRG weights. In the first year, hospitals would be paid based on an average of DRG weights: 75 percent of the old weights; 25 percent of the new weights. The second year would be 50 percent of each, and the third year would be 25 percent of the old weights and 75 percent of the new weights. Another method of transition is dampening the reduction for DRGs with significant decrease in relative weights similar to the dampening of ambulatory payment classification weights in the outpatient PPS. Dampening could be more feasible — especially if a significant change to the classification system is made — because it does not require CMS to calculate payments using two different systems.

  A stop loss should be instituted as part of this transition. This would be similar to the approach currently used under the inpatient psychiatric PPS whereby no hospital can receive less than 70 percent of what they would otherwise have been paid under the old system. In combination with the DRG blend or dampening, this would result in less significant losses in the first year than in the last year of the transition. To avoid having to run all claims under both DRG weights, CMS could establish a payment-to-cost ratio for each hospital in FY 2006 and use that as a base against which to compare payments under the new system.

- **Move forward with collaborative approach** — Hospitals are committed to working with CMS to develop and evaluate alternatives for new weights and classifications.

LTCH DRGs

The MHA is very concerned about the proposed reweighting of long-term care hospital (LTCH) DRGs for FY 2007. The projected 1.4 percent payment cut resulting from reweighting in combination with the 7.1 percent payment cut resulting from the recent LTCH PPS final rule for 2007 will cause substantial volatility for LTCH providers, and ultimately restrict access for patients needing long-term acute care services. It would be extremely difficult for any provider group to withstand an 8.5 percent cut in one year. By pursuing these changes, CMS is misinterpreting MedPAC's estimate of 2006 Medicare margins for LTCHs and creating an extremely unstable regulatory environment for LTCHs. The MedPAC projected a 7.8 percent Medicare margin for LTCHs in 2006 and recommended no marketbasket update for FY 2007. However, this MedPAC projection does not include two major policy changes that also decrease Medicare margins for LTCHs: the projection excludes the impact of the "25 Percent Rule" limiting payments to co-located LTCHs and the new reductions associated with the LTCH short-stay outlier policy. Therefore, CMS goes too far with this proposal to reduce Medicare payments even further.

Given these considerations, we urge the CMS to forgo the proposed 1.4 percent cut and implement the reweighting in a budget-neutral manner.

This would appropriately redistribute allocated funds among the payment categories to reflect current costs and omit the inappropriate modification of total payments due to unrelated considerations. **It is irrational to treat the LTCH PPS differently than other Medicare payment systems by failing to reweight the LTCH PPS in a budget-neutral manner.**

At this time, CMS should focus on developing further patient and facility criteria for LTCHs to ensure that patients who are clinically suitable continue to have access to the LTCH setting. We strongly support CMS' pursuit of a scientific foundation for these expanded criteria and are eager to review the recommendations currently under development by CMS' contractor — the Research Triangle Institute.

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 remain very concerned that the threshold is too high. 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. The CMS only spent 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.

The 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 only will result in an inappropriately high outlier threshold and a real payment cut to hospitals. The MHA strongly opposes using this methodology to estimate the outlier threshold.** We believe CMS under spent the funds set aside for outliers by an estimated $3 billion over FYs 2004, 2005 and 2006. **This is a cut in payments to hospitals that cannot be recouped. If CMS leaves the threshold at $25,530 rather than dropping it to $24,000, we believe that CMS will again significantly under spend by over $300 million.**

CORE-BASED STATISTICAL AREAS

In adopting the core-based statistical areas in FY 2005, a small number of hospitals that were classified as urban in FY 2004 became classified as rural in FY 2005. Because moving from a metropolitan statistical area to the rural statewide average would have resulted in a significant decline in these hospitals' wage indexes, CMS implemented a three-year transition period (FYs 2005-2007). The MHA supports the continued transition for these hospitals to give them the opportunity and time to reclassify.

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 versus licensed practical nurses or certified nurse aides — rather than geographic differences in the costs of labor.

Initially, CMS stated in the proposed rule that it again would 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*, on May 12, CMS 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. Initially, data were 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.

Definitions and Covered Employees. In filling out the interim-survey, placement of certain employees caused confusion. Examples include surgical technicians, paramedics who are employed by the hospital and usually work in the emergency department, and unit secretaries who also are known as ward clerks. The CMS clarified after the proposed rule was released that these employees should be placed in the "all other" category for the interim-collection. Moving forward, CMS should re-evaluate where these employees belong. **However, such changes should not be made to the ongoing collection, as it would necessitate the resubmission of the first calendar quarter's data to ensure that both quarters could be used for FYs 2008 and 2009.** If CMS believes that such changes are warranted, then the hospitals will need notification prior to the release of the final inpatient PPS rule in order to meet the August 31 deadline for submissions.

Cost Centers. We agree with CMS' "bright line" clarification for this collection that only nursing personnel within the cost centers listed should be included in that category for the purposes of consistency. It is significantly less work for hospitals to focus on certain cost centers and we continue to support this methodology.

The CMS should consider refining the list for future collections. Every hospital has a different method for attributing costs to the cost centers, thus there probably are a few cost centers that contain a significant number of nursing personnel for certain hospitals that were not captured for this collection. Given the shortened comment period in combination with the magnitude of the other changes proposed by CMS in the inpatient PPS rule this year, we were unable to extensively research which cost centers CMS should add. We suggest that CMS accept comments on any potential changes to the cost center list before making such changes. **In addition, we believe that additional cost centers should not be added to the ongoing collection as it would necessitate the resubmission on the first calendar quarter's data to ensure that both quarters could be used for FYs 2008 and 2009.** If CMS believes that such changes are necessary for the current collection, then hospitals would need notification prior to the release of the final inpatient PPS rule in order to meet the August 31 deadline for submissions.

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 not participating 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 plenty of notice and time to submit data for the second calendar quarter in August. Thus, moving forward CMS should consider a methodology penalizing 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 not turning 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. **MHA 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 previously were 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 CMS is under severe time pressure due to timing of the court's decision, the 30-day comment period was **not** 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 registered nurses who are management versus registered nurses 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. **MHA urges CMS to publish the occupational mix adjustment changes as an interim-final rule in August with an associated comment period.**

WAGE INDEX BUDGET NEUTRALITY

The CMS eliminates critical access hospital (CAH) data from the wage index file it uses to compute the national average hourly wage (NAHW). For FY 2007, 1,191 CAHs representing approximately 24 percent of all inpatient PPS hospitals (as of FY 2000) — 55 percent of all rural hospitals in FY 2000 — have been eliminated from the file. Because CAHs have lower average hourly wages than the average PPS hospital, the elimination of this data results in an overstated NAHW. While the NAHW has been increasing, the systematic withdrawal of low-wage hospitals has artificially inflated the NAHW to some extent. This artificial increase is included in the negative budget neutrality adjustment that consequently reduces payment, resulting in the national inpatient PPS operating payments being understated by an estimated $1.52 billion over five years (2003-2007). **The CMS should therefore apply a positive budget neutrality adjustment in FY 2007 to compensate for underpayments.** The understatement increases each year as more hospitals become CAHs and more data are eliminated from the wage index data. This could be a one-time adjustment as we expect very few hospitals to convert to CAH status now that the necessary provider designation is no longer an option.

LOW-VOLUME HOSPITAL PAYMENT ADJUSTMENT

Section 406 of The Medicare Modernization Act of 2003 created an inpatient PPS payment adjustment to account for the higher costs per case of low-volume hospitals. The law defined

eligible hospitals as those located more than 25 miles from another facility with fewer than 800 total discharges annually. The rule proposes to maintain a 25 percent increase, the maximum allowable, in payments to hospitals with fewer than 200 discharges. For those hospitals that have between 200 and 800 discharges, CMS proposes to maintain its current policy, applying no payment increase. Only two hospitals will receive this adjustment in FY 2007 according to CMS estimates. **The CMS is ignoring congressional intent and denying a group of hospitals — those with more than 200 discharges but fewer than 800 discharges — access to this necessary payment increase.**

SCH/MDH QUALIFICATION STATUS CHANGES

The proposed rule would require approved sole community hospitals (SCH) or Medicare dependent hospitals (MDH) to notify the appropriate CMS regional office of any change affecting its classification as such. To date, it has been the FIs responsibility to evaluate hospitals' continuing qualification status as a SCH or MDH. CMS expects the hospital to now self-disclose any material changes in circumstances or potentially face a retroactive cancellation of their designation once the FI discovers its ineligibility.

This constitutes an inappropriate shift of the burden from fiscal intermediaries to hospitals. Hospitals are neither involved in, nor have any control over, the building of new roads or new hospitals and thus should not be accountable to report such changes. It would be very difficult for hospitals to know when and for how long there were prolonged severe weather conditions that closed area roads, or to note changes to posted speed limits and traffic patterns. Qualifying criteria such as inpatient admissions at other regional hospitals would be onerous to monitor as hospitals do not have this sort of data on their competitors. Requiring hospitals to constantly monitor whether they continue to meet these requirements would impose a tremendous and unreasonable administrative burden on hospitals. **This function should remain a responsibility of the fiscal intermediaries, who are in a better position to monitor these circumstances. If CMS requires hospitals to report changes in circumstances, then the specific types of situations must be noted and should only include aspects of their operation that are within their ready knowledge (e.g., number of beds).**

CMS' proposal to retroactively withdraw SCH or MDH status if a hospital does not appropriately self-report a change in circumstances could be financially devastating. At minimum CMS should give consideration to whether the hospital had knowledge of the disqualifying circumstance. Hospitals should not have to repay CMS based on the difference between the inpatient PPS or outpatient PPS payment and the SCH or MDH payment when they did not know that they no longer qualified for the program. Instead, CMS should develop a prospective process for withdrawing the hospitals' SCH or MDH status. A 30-day timetable for losing SCH/MDH status is unrealistic given the financial implications of such a change and the inability for a hospital to plan for this outcome. **The CMS should re-evaluate the proposed timetable for canceling SCH/MDH status when a hospital is found to be disqualified or self-reports disqualification, and consider revoking the hospitals' status as of the following cost-reporting period.**

SCH/MDH VOLUME DECREASE ADJUSTMENT

A SCH or MDH may apply for special payments if it experiences a decrease of 5 percent or more in its total number of inpatient discharges that was out of its control from one cost-reporting period to another. If the hospital qualifies, it must demonstrate that it took measures to scale back its nursing force commensurately. The adjustment is intended to cover the fixed costs that the hospital is unable to reduce in the year following the volume decrease. The CMS believes that only "core staff and services" should be covered by these special payments. To date, CMS has used the American Hospital Association's HAS/Monitrend Data Book to compare the hospital's staffing to other similar hospitals in the area to determine if the hospital is staffing its routine and intensive care units appropriately. However, the data book has not been updated since 1993. The CMS has been using the 1989 publication. Thus, CMS proposes using the occupational mix adjustment data currently being collected for wage index purposes to calculate nursing hours per inpatient day for a hospital in question and local peer hospitals.

The occupational mix adjustment was partially implemented in its first three years, primarily due to the questionable data and results. The current collection, which is occurring a gain under rushed circumstances, also may result in questionable data. **It is not wise to assume that the occupational mix adjustment data will be appropriate for this use. The data within the American Hospital Association's annual survey should be sufficient for CMS to determine the nursing levels per patient day.**

CAHs

The CMS issued interpretive guidelines November 14, 2005, on the relocation of CAHs as a follow-up to the FY 2006 inpatient PPS final rule that established the "75 percent test" — serving 75 percent of the same population, providing 75 percent of the same services and employing 75 percent of the same staff — for necessary provider CAHs. The guidelines not only extended the 75 percent test to **all** CAHs, but it also altered the definitions of "mountainous terrain" and "secondary road."

These guidelines go well beyond the regulations included in the FY 2006 rule that provoked numerous critical responses from individual CAHs, associations and congressional representatives. The "mountainous terrain" and "secondary road" definitions are overly prescriptive and the 75 percent test does not provide reasonable flexibility based on natural variation in demographics, patient needs distribution patterns, normal employee and board attrition, and necessary changes in services to meet community needs. **Rural hospitals that move a few miles clearly are the same providers serving the same communities.**

Many CAHs are planning to rebuild in the near future to improve site safety and quality of care by adding fire and smoke barriers, upgrading infrastructure to support utilities and air handling, modernizing telecommunications to support health information technology, or making other essential upgrades. Facilities expect to relocate when they rebuild for a multitude of reasons — to be closer to a highway, to connect to municipal water and sewer, to correct seismic safety concerns, or other similar concerns.

Undoubtedly, such improvements will result in higher quality care, better patient outcomes and more efficient service, yet CMS' guidelines discourage these improvements.

The CMS' guidelines will not only impose an unnecessary burden on CAHs, but will preclude many of them from securing financing for needed capital improvements. The hospitals themselves, their hospital districts and their lenders cannot risk investing in a hospital that will be unsure of its status until a year after moving. **The CMS should create a preliminary approval process to give assurances to those involved in the project that the CAH relocation will be approved if it meets the assertions made in the attestation submitted to CMS.**

Again this year, nearly 60 congressional representatives signed a letter to CMS supporting their CAHs and urging changes to these guidelines. We agree with their recommendations and reiterate our suggestion from last year that a safe harbor be established for hospitals relocating within five miles of their existing locations. These providers are not only clearly serving the same communities, but trying to improve the quality of and access to needed health care services. A safe harbor will reduce the administrative burden not only on the hospitals, but CMS and the state survey agencies as well. **We urge CMS to create a safe harbor for CAHs moving a short distance and make significant changes to these guidelines based on feedback from CAHs around the nation.**

GME PAYMENTS

Exclusion of Didactic Training. The proposed rule states that resident training occurring at non-hospital sites must be related to patient care if a hospital wishes to count that time for direct graduate medical education (GME) and IME payment purposes. Resident time spent in didactic activities that often occur in associated medical schools — such as educational conferences, journal clubs and seminars — specifically would be excluded. The CMS noted that its statement in a previous letter on this topic "implying that didactic time spent in non-hospital settings could be counted for direct GME and IME ... was inaccurate." The CMS also noted that time spent in these activities could be counted for direct GME purposes if they occur in a hospital; however, the counting prohibition applies for IME payments regardless of where the educational activity occurs.

The CMS should rescind its purported "clarification" in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare direct GME and IME payments. The stated rationale for the exclusion of this time not "related to patient care" is a direct contradiction to CMS' September 24, 1999, correspondence to Vinson & Elkins — that patient care activities should be broadly interpreted to include "scholarly activities, such as educational seminars, classroom lectures ... and presentation of papers and research results to fellow residents, medical students and faculty" — and should be rescinded.

The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. It would be very difficult to separate out time spent at these activities.

The CMS should withdraw this change in the proposed rule relating to the counting of didactic time for purposes of direct GME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

FUTURE CONCEPTS

HEALTH CARE INFORMATION TRANSPARENCY

The proposed rule includes the introduction of a proposed initiative to expand the public availability of consumer information on health care quality and pricing. The Department of Health and Human Services (HHS) intends to identify several regions in the United States with high health care costs where there is significant interest in reducing those costs and improving health care quality.

The work of the Hospital Quality Alliance (HQA) has led to voluntary reporting and sharing with the public of 21 quality measures on the Hospital Compare Web site, and more measures of hospital quality and patient satisfaction are planned for the future. This effort has been tremendously successful, with nearly all inpatient PPS hospitals voluntarily reporting quality information. **Efforts to further expand public availability of hospital quality information must continue to be pursued through the HQA.**

The CMS details four options for providing pricing information to health care consumers.

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

2. 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.

3. 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.

4. 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).

Hospitals are committed to sharing information that will help people make important decisions about their health care. Sharing pricing information, however, is more challenging because hospital care is unique. Hospital prices can vary based on patient needs and the services they use; prices reflect the added costs of hospitals' public service role — like fire houses and police stations — serving the essential health care needs of a community 24 hours a day, seven days a week; and most hospitals cannot yet provide prices that reflect important information from other

key players like the price of physician care while in the hospital or how much of the bill a patient's insurance company may cover.

Providing **meaningful** information to consumers about the price of their hospital care is the most significant challenge hospitals and CMS face in increasing transparency of hospital pricing information. The following represents one possible roadmap for pricing transparency.

- **Work with state hospital associations to expand existing efforts to make hospital charge information available to consumers.** Missouri makes pricing information on frequent hospital services available to the public, as do several other states (e.g., Florida, Nevada, North Carolina). Thirty-two states have statutes requiring hospitals to report pricing information that is made available to the public either by posting to a hospital, hospital association or government Web site, issued in a government or hospital association report, or made available to consumers upon request; additional states do so voluntarily.

- **Work with insurers to make available in advance of medical visits, information about an enrollee's expected out-of-pocket costs.** This "explanation of benefits," or EOB especially is important to the majority of consumers who already have some type of health insurance coverage. However, EOBs are given **after** the care is provided. To help inform consumers in advance of their out-of-pocket obligations, insurers could provide an "advance EOB." This information could be shared with an insured individual by phone or electronically through an insurer's Web site. Aetna currently is piloting a project like this for physician services in Cincinnati.

- **Research what type of pricing information consumers want and would use in their health care decision-making.** Research shows what kind of information consumers want about the **quality** of their health care. But what do consumers want to know about pricing information? Consumers need different types of price information, depending on whether and how they are insured (traditional insurance, health maintenance organization, health savings account, etc.).

- **Create consumer-friendly pricing "language" — terms, definitions and explanations that enable consumers to better understand the information provided.** Hospitals will lead an effort to create common terms, definitions and explanations of complex pricing information. This will include sharing innovative and understandable ways for displaying pricing information for use by consumers.

The HHS should provide incentives to the states to improve transparency at the state and local level. The HHS' Agency for Healthcare Research and Quality is in the best position to complete research on what consumers want and would use in purchasing health care services.

HEALTH INFORMATION TECHNOLOGY

The proposed rule states that it supports the adoption of health information technology (IT) as a normal cost of doing business to ensure patients receive high quality care. It also notes that the

quality and efficiency benefits of health IT may provide a policy rationale for promoting the use of IT through the Medicare program.

Health IT is a very important tool for improving the safety and quality of health care, and our members are committed to adopting IT as part of their quality improvement strategies. Also, IT is a public good that requires a shared investment between the providers and purchasers of care, however, a very costly tool, requiring both upfront and ongoing spending. The upfront and ongoing costs of IT are the greatest barriers to further adoption. Hospitals with negative margins and those with lower revenues use less IT.

The proposed rule highlights the anticipated benefits of health IT as laid out by the RAND Corporation. However, it overlooks another of the study's major findings — that the financial benefits of IT investments accrue more to the payers and purchasers of care than the hospitals and health systems that pay for them.

Hospitals have not seen financial returns greater than the costs of implementing clinical IT systems, particularly in the short term. They adopt clinical IT because it is the right thing to do for improving patient safety and quality of care, not because it saves them money. Thus, while IT may be a "normal cost of doing business," it systematically raises those costs. **Given that they reap many of the financial benefits of health IT, payers and purchasers of care should share in the costs of IT.**

Finally, hospitals learned through the Health Insurance Portability and Accountability Act process that efficient health information exchange requires all parties to upgrade their systems and work from a common set of standards. As we moved toward implementation of health IT in hospitals, payers — including the federal government — must modify their own systems to accept electronic data.

Statutory Authority. The broad question of whether CMS has statutory authority to encourage adoption and use of health IT will depend on the specific mechanisms it selects. For example, CMS has some authority to pursue demonstration projects. However, more systematic approaches, such as value-based purchasing or payment adjustments, would require legislative action.

Value-based Purchasing. Any value-based purchasing program should not be punitive. **With regard to health IT, only programs that add funds to the inpatient PPS should be pursued because IT is costly, requiring both upfront and ongoing expenditures.** Decreasing payments to those that have not been able to afford IT further limits their ability to invest. A budget-neutral approach also ignores the reality that health IT systematically increases hospitals' costs.

Value-based purchasing programs should build off consensus measures endorsed by the broad spectrum of organizations — including CMS — that participate in HQA. In general, HQA favors measures that address quality outcomes, rather than the tools used to get there.

Health IT can play a role in reducing the burden of quality reporting. Presently, electronic health records (EHR) and other clinical IT systems do not automatically generate quality measures. Most hospitals still require special calculations — including expensive manual chart abstraction and use of third-party contractors — to submit quality data. The CMS could advance the quality agenda by investing in the development of algorithms for the calculation of the quality measures it wants reported from EHRs and encouraging vendors to include them in their products.

Rather than including health IT in a value-based purchasing program, **CMS could support adoption of health IT through a payment adjustment funded with new money.** For example, it could increase payments to hospitals using health IT that improves the safety and quality of care by 1 percent. This kind of payment adjustment represents Medicare's share of the necessary investment to achieve this goal and would recognize the greater costs of a "wired" health care system. Hospitals will pursue legislation authorizing such a payment adjustment. Other mechanisms, such as loan guarantees and grant funds, are needed to help hospitals finance the upfront costs of implementing health IT.

Conditions of Participation. **The CMS should not include health IT in the Medicare conditions of participation for hospitals.** M edicare conditions o f p articipation a ddress t he basic, essential infrastructure needed to ensure patient safety and must be clearly understood. Successful implementation of quality-enhancing IT requires careful planning and changes to work processes. The hospital industry is still developing its understanding of how to implement these systems correctly. In addition, available commercial health IT applications do not always meet hospitals' needs. The evidence on health IT does not yet support this level of requirement and would amount to an unfunded mandate. A recent report supported by HHS' Agency for Healthcare Research and Quality found that the existing research on the quality benefits of health IT is limited to a handful of leadership institutions that generally developed their own systems. And, while promising, the results are not yet generalizable to the average community hospital using the vendor systems currently on the market.

Efforts of the Certification Commission on Health Information Technology (CCHIT) to provide the market with better confidence in vendor product are only at the beginning stages of looking into certification of hospital inpatient products. The CCHIT's work on ambulatory products is more advanced but, while it shows promise, has not yet proven itself in the marketplace.

The MHA appreciates the opportunity to submit these comments on the proposed rule. If you have questions regarding our comments, please contact me at 573/893-3700, ext. 1347 or *dfine@mail.mhanet.com*, or Gary Toliver, MHA vice president of federal relations, at ext. 1336 or *gtoliver@mail.mhanet.com*.

Sincerely,

Dwight L. Fine
Senior Vice President of Governmental Relations

dlf/cs

Submitter : **Dr. Barry Skrobot** **Date: 06/12/2006**

Organization : **Wright State University**

Category : **Physician**

Issue Areas/Comments

GME Payments

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.

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,

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

Organization : **Withrow, McQuade & Olsen, LLP**

Category : **Attorney/Law Firm**

Issue Areas/Comments

DRG Reclassifications

DRG Reclassifications

See Attachment

GENERAL

GENERAL

See Attachment

CMS-1488-P-1521-Attach-1.DOC

ATTACHMENT TO #1521

June 12, 2006

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

Submitted electronically at http://www.cms.hhs.gov/eRulemaking

Re: CMS-1488-P, DRG Reclassifications

Ladies and Gentlemen:

The law firm of Withrow, McQuade & Olsen, LLP is pleased to submit comments to the Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates published on April 25, 2006 at 71 Fed. Reg. 23996.

DRG Reclassifications

1. DRG Architecture Should Remain in the Public Domain.

We strongly oppose the proprietary rights being reserved by 3M Health Information Systems ("3M") to APR-DRGs. DRG architecture has been in the public domain for the past 23 years, enhancing the creation of innovative coding and billing solutions that benefit the Medicare program.

In evaluating risk adjustment systems which are proprietary vs. systems in the public domain, the Agency for Healthcare Research and Quality (AHRQ) stated its preference for using 'open' systems where the risk adjustment logic was published and available for scrutiny by interested parties, as opposed to "black box" or proprietary systems.[1]

2. APR-DRGs are in fact a "black box" system.

The inherent complexity of both the APR-DRG system and the consolidated severity-adjusted DRG system, which is essentially APR-DRG in nature, renders the process of DRG assignment practical only via utilization of software available solely from one source—the government-contracted entity, 3M Health Information Systems.

The documentation provided by 3M of the APR-DRG fails to describe the risk adjustment logic in sufficient detail for scrutiny or use by interested parties. The Definitions Manual sets forth only a high-level, convoluted and poorly explained sequence of 18 steps that cannot be tested or

[1] Davies S, Geppert J, McClellan M, et al. *Refinement of the HCUP Quality Indicators*. Technical Review 4. (Prepared by the UCSF-Stanford Evidence-based Practice Center). AHRQ Publication No. 01-0035. Rockville (MD): Agency for Healthcare Research and Quality. May 2001, p. 58.

evaluated without much more detailed information about how the software works. The maze of tables and lists also lack the critical information detailing each step of clinical logic embedded in the software. The result is an essentially obfuscated process without any practical application: a black box.

3. **3M's proprietary rights prohibit use of the risk adjustment logic by third parties.**

3M retains ownership of APR-DRGs under the terms of its Software Licenses with the General Services Administration.[2] In its licensing agreements, 3M requires its customers not to disassemble, reverse-engineer or create derivative works based upon APR-DRGs.[3] The proprietary rights retained by 3M prohibit the use of the risk adjustment logic embedded in APR-DRG software by third parties. This proprietary system is contrary to the goal of an open system where the risk adjustment logic is fully disclosed and made available for use by interested parties, and contrary to the current DRG system which is in the public domain.

4. **CMS should explicitly comply with HIPAA constraints on the modification of code sets (including DRGs).**

The Health Insurance Portability and Accountability Act (HIPAA) places constraints on the process of modifying code sets, including DRGs. "The Secretary shall establish efficient and low-cost procedures for distribution (including electronic distribution) of code sets and modifications made to such code sets under section 1320d-3(b) of this title."[4] "Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption and cost of complying with such modification." [5]

The proposed change from a DRG code set in the public domain to a proprietary APR-DRG black box fails to comply with these HIPAA requirements. The proposed proprietary black box establishes new licensing fees necessary to use federally mandated code sets that are currently in the public domain. The change to APR-DRGs will cause significant disruption because the clinical logic imbedded in the software is concealed. Any DRG reclassification must include efficient and low-cost procedures for distribution of the code sets and modifications, and must be implemented in a manner that minimizes the disruption and cost of complying with such modification. The proposed rule should specifically reference these HIPAA provisions and explain how the proposal complies with the HIPAA provisions.

We would be happy to discuss our comments further if that would be helpful. If you have any questions about our comments, please contact Scott Withrow at (404) 814-0200 or by email at swithrow@wmolaw.com.

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[2] General Services Administration Contract Number: GS-35F-4002G, Section 1, Part B, Section 2.1.
[3] General Services Administration Contract Number: GS-35F-4002G, Section 1, Part B, Section 2.4(v).
[4] 42 U.S.C.A. Section 1320d-2(c)(2)(West 2006).
[5] 42 U.S.C.A. Section 1320d-3(b)(2)(B)(ii)(West 2006).

Respectfully submitted,

Withrow, McQuade & Olsen, LLP

By:_____
Scott C. Withrow, Partner

Submitter : **Carol Walker** **Date: 06/12/2006**

Organization : **Oklahoma Heart Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1522-Attach-1.DOC

ATTACHMENT TO #1522

Oklahoma Heart Hospital

4050 WEST MEMORIAL ROAD

OKLAHOMA CITY, OK 73120

405-608-3200

FAX: 405-608-1585

June 12, 2006

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

Ladies and Gentlemen:

We are submitting comments to the Proposed Changes to Hospital Inpatient Payment Systems and Fiscal Year 2007 Rates for the Medicare Program [CMS-1488-P].

Oklahoma Heart Hospital is a 78-bed hospital that was established in August 2002 and is jointly owned by an affiliate of the Sisters of Mercy Health System and physicians. It is located adjacent to Mercy Hospital, which is a 392-bed charitable community hospital located in Oklahoma City. The Oklahoma Heart Hospital is dedicated exclusively to preventing and treating cardiovascular disease and has the only dedicated heart emergency department in Oklahoma City. Patients presenting to Mercy Hospital emergency room primarily suffering from cardiovascular disease are transferred to the Oklahoma Heart Hospital after stabilization. Mercy Hospital patients requiring scheduled procedures or other cardiac inpatient services are admitted to the Oklahoma Heart Hospital as the provider for their cardiac care. Because of its affiliation with Mercy Hospital, the Oklahoma Heart Hospital treats a mix of heart patients that is similar to a community hospital's, both with respect to payor mix and severity of illness. In particular, Oklahoma Heart Hospital performs a significant number of cardiac procedures in the inpatient setting and relies heavily on Medicare as a major payor, greater than 60%, for those services. We have reviewed the proposed rule and have comments to the following provisions.

HSRV Weights. CMS is proposing to implement hospital-specific cost relative weights in fiscal year 2007 as a more accurate reflection of the costs of providing services than has been provided by a charge-based mechanism. However, the proposed calculation of HSRV weights inaccurately reflects the actual costs of operation of a hospital's cardiology department for two reasons.

First, the use of hospital claims data from fiscal year 2004 and cost report data from fiscal year 2003 to establish the hospital specific relative values for 2007 fails to take into account the significant technological changes that have occurred in cardiology care in the past two or three years primarily in the stent, pacemaker, and defibrillator areas. The data is clearly too old.

Second, sorting costs for each of the ten costs centers by cost report line item, as CMS has proposed, fails to accurately include all relevant costs. For example, the "Medical Supplies" cost center utilized in the Cost Center Charge Group fails to accurately reflect the cost of medical supplies. Many hospitals include their medical supplies in each applicable line of the cost report (*i.e.,* medical supplies specific to the Emergency Room are included in line 61 of the cost report). We do not believe that CMS has appropriately considered the potential impact this may have on the revised/proposed DRG weights. As we move to a cost-based system, there should be mechanisms in place to ensure accuracy of this new system. We believe CMS could identify which provider reports were filed using this approach in order for all facilities to properly include Medical Supply costs in the appropriate cost center grouping(s) to ensure consistency and impartiality.

In particular, we are concerned that the calculation of costs of Cardiology in the Cost Center Charge Group fails to include all relevant costs. CMS indicated that it used data from our cost report line item 53 to analyze the cardiology costs, but many complex hospitals (primarily facilities with significant cardiac cases) may utilize other cost center lines (for example, line 59) of the cost report. However, cost center lines 58 and 59 were grouped in the "other services and charges" category. For example, line 53 in the Oklahoma Heart Hospital cost report represents the EP Lab and line 59 encompasses our Cath Labs. We believe these issues have resulted in an unjustifiable negative impact on the cardiology DRG weights.

We believe additional time and resources will be required to make necessary recommendations on best approaches for moving forward and suggest that CMS transition the implementation of cost-based weights over time, to coincide with the implementation of the APR DRG classification system, over a period of several years in order to have sufficient time to evaluate accurate and timely data.

DRGs: Severity of Illness. The APR DRG classification system does not accommodate distinctions based on complexity. As CMS indicated in the Federal Register (71 Fed.Reg. 24014), in the CMS DRGs there are separate DRGs for differences in technology, such as DRGs 555 through 558, non-drug eluting and drug eluting stents, but the APR DRGs do not make such a distinction. Current CMS DRG 515 and 535 through 536 for cardiac defibrillator implants will no longer differentiate between with or without cardiac cath under the new CMS APR DRGs.

The severity of a patient's condition is not a sole indicator of the amount of resources necessary to adequately and successfully treat all patients. There are certain procedures that require very costly devices that will not be adequately reimbursed based on the proposed system. Some examples for Oklahoma Heart Hospital:

- An ICD device cost averages $22,500 per procedure at the Oklahoma Heart Hospital Under the current DRG payment system, DRG 515 would pay our facility approximately $29,300 for the entire encounter (which would include the inpatient procedures and the implanted device). Under the proposed cost based DRG system, our Medicare payment would fall to less than $23,000, which would barely, if at all, cover the cost of the device.

- **Cardiac Valve procedures, whether aorta or mitral, averages a direct cost per case of $19,500. Under the CMS APR DRG structure, APR DRG 214 will reimburse slightly above, however will not cover essential indirect costs.**

- **A Drug-eluting Stent procedure averages an implant cost per procedure of $6,200, covering multiple stent placement, however the projected reimbursement only provides 8% of that payment to cover remaining direct costs. The reimbursement projected will not address any associated indirect costs.**

As a result, implementation of the APR DRG classification system, together with the HSRVcc weights, will result in reimbursement to the Oklahoma Heart Hospital for some patients receiving high cost implants to be below the actual cost of the device. There are other examples of reimbursement that will be below the cost of the applicable technology. CMS has acknowledged that a method of recognizing technologies that represent increased complexity, but not necessarily increased severity of illness, should be included in the system and proposes to implement such adjustments at an unspecified date in the future. CMS has requested comments for developing criteria to determine when it is appropriate to recognize increased complexity in the structure of the DRG system and how these criteria interact with existing statutory provisions for new technology add-on payments. We suggest utilizing the APR DRGs above the base rate be weight adjusted based on the implants employed, such as non-drug-eluting and drug-eluting stents or tissue versus gortex for endograph procedures.

Also, CMS has solicited comments regarding the phased-in implementation of the APR DRG classification system. Implementation of the HSRVcc weighting methodology coupled with the simultaneous implementation of the APR DRG classifications system will provide a better match of cost and severity. Due to Medicare being a critical source of revenue to our Hospital and these changes resulting in significant payment reductions, not only for the Oklahoma Heart Hospital but for all cardiac programs, these reductions need to be phased in over a reasonable period to minimize significant and abrupt disruptions to operations. We recommend that both be implemented over a transitional period that provides CMS sufficient time to evaluate the data.

We estimate that the implementation of the FY 2007-2008 changes will result in a net decrease of 10.5% in Medicare reimbursement to the Hospital. Unfortunately, we cannot calculate the full effect of the proposed rule until CMS releases the proposed occupational mix adjustment in September. Because of the increased difficulty in evaluating the effect of the proposed changes to the rules, we strongly suggest that CMS delay implementation of any rules until it has the benefit of all proposed modifications and the comments thereto.

Jim Best-Co President

John Harvey – Co President

Submitter : **Ms. Jill Berger** **Date: 06/12/2006**

Organization : **Marriott**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1523-Attach-1.DOC

CMS-1488-P-1523-Attach-2.DOC

#1523

Thank you for the opportunity to comment of the proposed changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 Rates. We applaud your efforts to promote and foster increased transparency and we believe that Medicare should lead the way to promoting a market that recognizes and rewards high-quality, efficient, and patient-centered care. First, let us offer some overarching comments for your consideration before providing more granular feedback on three sections of the proposed rules that address hospital quality data, value-based purchasing, and the health care information transparency initiative.

OVERARCHING COMMENTS

Assess provider performance using robust measures: Medicare should evaluate the performance of each health care provider that bills Medicare, using nationally-endorsed, scientifically-valid, risk-adjusted, and regularly-updated measures that address:

- Clinical quality (safe, timely, and effective care);
- Efficiency (prices and resource use over time);
- Equity (gender, race, ethnicity);
- Patient experience; and
- Structure or systems (e.g., use of quality-enhancing information technology).

Recommended Actions

- Provide substantial funding to support development of consumer-relevant measures that fill existing gaps (especially efficiency and equity). Developing measures is a public good that requires significant financing from the public sector. Because of the lack of well-specified and endorsed measures that meet consumers and purchasers' needs, measure developers and their funders should be guided by the following considerations:
    - Reasonably scientifically acceptable. Consumers and purchasers want measures to be scientifically sound, but do not want the pursuit of perfection to delay the availability of good and useful information.
    - Feasible to implement. Rapid reporting necessitates measures are constructed and specified so that the data needed is currently available or can be collected with limited reporting burden.
    - Relevant to consumers and purchasers. The needs of consumers and purchasers for important and actionable information must drive the development of measures.
    - Reflect the continuum of care/care coordination from a patient's perspective. Measures should address the extent to which comprehensive, patient-centered care is delivered, often by multiple providers.
- Provide core operating support for the National Quality Forum (NQF) to ensure ongoing, independent consensus process for the review, endorsement, and updating of measures so as to enable the availability comparative information and the reduction of provider reporting burden.

Collect and report information that will enable informed decision making and provider selection. Medicare should provide the public with the information on the

aspects of provider performance described above. Doing so, will allow: 1) consumers to make informed decisions about their health care; 2) insurers and purchasers to make value-based contracting decisions and use differential payments as incentives; and 3) providers' improvement efforts to be supported with better information.

Recommended Actions

- Release physician-identifiable Medicare claims data (fully protecting patient privacy), to allow for better quality and efficiency performance reporting.
- Continue to allow private-sector organizations to download granular provider performance information from the Compare websites.
- Augment hospital claims data with additional clinical data elements to better understand patient acuity.

Implement financial incentives that are sensitive to the provision of high-quality, efficient, patient-centered care: Medicare should phase in a system that differentially pays providers based on nationally standardized measures.

Recommended Actions

- Continue to rapidly expand the number and type of measures that hospitals must report to obtain annual payment update.
- Medicare payments must be sensitive to provider performance and create financial incentives to provide quality care.
- Incentives should take into account performance on quality, efficiency, and patient experience.
- Provider incentives should be budget-neutral and based on a combination of improvement and meeting thresholds.

Now let us offer specific comments on the proposed changes to the three sections that address hospital quality data, value-based purchasing, and the health care information transparency initiative.

SECTION: HOSPITAL QUALITY DATA

Reporting of Hospital Quality Data for Annual Hospital Payment Update
Fiscal Year 2007: We support CMS' recommendation to reduce the FY 2007 annual hospital payment update by 2% for any hospital that does not submit data on 21 measures (8 heart attack, 4 heart failure, 7 pneumonia, 2 surgical infection prevention) for patients discharged starting January 1, 2006 through December 31, 2006.

Fiscal Year 2008: CMS must do far more than merely "exploring the feasibility of adopting additional measures for FY 2008 update, including HCAHPS." There should be a **substantial** expansion of measures for hospitals to obtain the FY 2008 annual update. We strong urge that CMS adopt the measures identified in the Institute of Medicine's *Performance Measurement: Accelerating Improvement*, i.e., Hospital-CAHPS and three structural measures (computerized provide order entry, intensive care staffing with intensivists, and evidence-based hospital referral) as well as consider and adopt a number of other NQF-endorsed measures, for example:

Outcomes
- 30-day heart failure mortality
- 30-day heart attack mortality
- Failure to rescue

Complications
- Urinary catheter-associated infection rate
- Central line-associated blood stream infection rate
- Ventilator associated pneumonia rate

Clinical
- Surgery patients with recommended venous thromboembolism prophylaxis ordered
- Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hour prior to surgery to 24 hours after surgery.

Electronic Medical Records (p. 343-344)
Health information technology (HIT) – which includes software applications for care management (EMR, EHR, practice management systems, registries) – has the potential to dramatically improve the quality and efficiency of health care, however implementation has been slow. The Secretary should ensure that the data necessary for quality measurement are captured by using conditions of participation that require hospitals to implement HIT/software applications that:

- Comply with interoperability standards;
- Enable standardized quality, performance, and efficiency measurement are a routine by-product of their use. [NOTE: Adapted from AQA Data Sharing and Aggregation Subgroup on HIT: www.ambulatoryqualityalliance.org/files/PrinciplesforHITandMeasAgg-May06.doc]
- Are designed to enable the merger of their data with others for the purpose of facilitating the production of standardized quality, performance, and efficiency

information. [NOTE: Adapted from AQA Data Sharing and Aggregation Subgroup on HIT]

Further, the Secretary should tie the annually hospital payment update to the reporting of hospitals' progress toward CPOE implementation (see previous comments under Hospital Quality Data for Annual Payment Update).

Until HIT becomes wide-spread the Secretary can enable much more robust hospital performance reporting by requiring hospitals to report the following data elements on both paper and electronic claims:

- A unique physician identifier for each coded procedure;
- Capture the referring/ordering physician for each coded procedure;
- Vital signs (heart rate, blood pressure, temperature, and respiratory rate) recorded at presentation;
- Key lab values (BUN, hematocrit, platelets, WBC, sodium, potassium, and creatinine) if obtained at the time of admission, excluding hospitalizations for psychiatric, obstetrical and newborn services;
- Do Not Resuscitate order present (including date and time), if recorded during first 24 hours of patient presenting; and
- Time of day of admission, discharge, and each procedure.

SECTION: VALUE-BASED PURCHASING (p. 344 – 367)

Plan for Implement Hospital Value-Based Purchasing Beginning with FY 2009

As CMS works to develop a plan to implement hospital value-based purchasing beginning in FY 2009, the following issues must be addressed: (a) the ongoing development, selection, and modification process for hospital quality and efficiency measures; (b) the reporting, collection, and validation of data; (c) the structure of payment adjustments; and (d) the disclosure of hospital performance information.

Measure development and refinement (p.350-353)

- As noted in our overarching comments, the development of consumer relevant measures is critical and the Secretary should provide substantial funding to support development of consumer-relevant measures that fill existing gaps (especially efficiency and equity). Developing measures is a public good that requires significant financing from the public sector. Because of the lack of well-specified and endorsed measures that meet consumers and purchasers' needs, measure developers and their funders should be guided by the following considerations:
    - Reasonably scientifically acceptable. Consumers and purchasers want measures to be scientifically sound, but do not want the pursuit of perfection to delay the availability of good and useful information.
    - Feasible to implement. Rapid reporting necessitates measures are constructed and specified so that the data needed is currently available or can be collected with limited reporting burden.
    - Relevant to consumers and purchasers. The needs of consumers and purchasers for important and actionable information must drive the development of measures.
    - Reflect the continuum of care/care coordination from a patient's perspective. Measures should address the extent to which

comprehensive, patient-centered care is delivered, often by multiple providers.

- Provide core operating support for the NQF to ensure ongoing, independent consensus process for the review, endorsement, and updating of measures so as to enable the availability comparative information and the reduction of provider reporting burden.

Incentive Methodology (p. 357-367)

- *Incentive Structure*: Incentives should be based on a combination of improvement and meeting quality thresholds based on standard measures adhering to the consumer-purchaser disclosure project guidelines. Our experience with incentives programs indicates that basing the incentives on attaining specific quality-based thresholds allows hospitals (including those serving disenfranchised populations or unique communities) to focus their efforts on the highest-yield improvements. Because of the evidence that performance dramatically varies within hospitals, incentives should be available and calculated at both the service-line level (for clinical areas) and hospital-wide (e.g. for HCHAPS). In the private sector, The Leapfrog Group designed the Leapfrog Hospital Rewards Program to reward both *top performers* and *performance improvers*. The goal is to provide incentives for hospitals to improve continuously and to sustain that improvement once it is achieved. Because the LHRP measures a hospital's performance relative to the performance of other hospitals, even top performers will need to improve continually in order to maintain their status. This use of relative performance to determine which hospitals earn rewards and the level of those rewards was advanced by the current CMS-Premier Hospital Quality Incentive Demonstration. As reported, this Demonstration has experienced quality improvement among participating hospitals on care processes that help ensure better outcomes. As Medicare moves to a permanent use of incentives for quality, setting both baseline thresholds of performance and a relative ranking system will help all hospitals make improvements appropriate to their current level of performance.
- *Level of Incentive*: The share of payment tied to performance should be substantial, though what constitutes "substantial" will differ from one provider to another, i.e., the same percentage may not be appropriate for both hospitals and physicians. The overall proportion of CMS payments dependent on incentives should grow significantly and could eventually reach a level so that 10% or more of total Medicare payments is sensitive to performance. CMS should set and revise the appropriate level using the information that continues to develop from its demonstration projects and private-sector efforts. Initially, we believe that the performance incentive for hospitals should be on the same order of magnitude as the 2% incentive for the FY07 annual market basket update. In addition to financial rewards, there are two other types of incentives CMS can employ: the potential for increased market share and public recognition. For example, The Leapfrog Group designed the Leapfrog Hospital Rewards Program to increase the patient volume at better hospitals through consumer education and benefit design that encourages patients to seek out the best hospitals. This patient shift creates savings for the purchaser, better care for patients, and incentives in the marketplace for hospital improvement. This phenomenon can be supported by ongoing consumer testing of Hospital Compare and making sure that it displays

hospital performance information that is as current as possible. We strongly support the current CMS efforts to increase quality and cost transparency. The Leapfrog Group employer members agree that **public** awareness of hospital quality is a powerful motivator for performance improvement. A powerful example was the significant improvement in nursing home quality that was demonstrated in AHRQ's National Healthcare Quality Report between 2003 and 2004, following when CMS began publicly releasing nursing home quality data.

- *Source of Incentive*: Providing additional funding to finance performance incentives is an unrealistic option given the current economic pressures faced by CMS. As a result, value based purchasing initiatives should be budget neutral. The Leapfrog Hospital Rewards Program is an example of how to accomplish budget neutral incentives. Rewards paid out are based on a share of the savings which accrue in the market due to hospital improvement. If there are no savings, no rewards are paid. This design helps ensure implementers' ability to fund bonus payments is sustainable over time. The dollar amount of hospital rewards is not set in advance, though the methodology by which rewards will be calculated is known by hospitals in advance. As rewards are based on the savings generated by hospital performance, the amount of rewards will vary from one period to the next. While this "shared savings" model is more easily implemented when hospitals earn per-diem reimbursement, The Leapfrog Group, with assistance from private sector stakeholders and CMS, is currently devising a similar methodology for DRG-based reimbursement. Leapfrog's incentive structure design for DRGs adheres to the principles of using measured quality and efficiency performance to create budget neutral incentives for hospital performance. The Leapfrog Group would be eager to continue to share its ideas in this area with CMS as appropriate.

Public Reporting (p. 362)

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SECTION: HEALTH CARE INFORMATION TRANSPARENCY INITIATIVE (p. 447)

As the Department builds upon its current transparency efforts, we would encourage the Secretary to increase both the scope and breadth of consumer-friendly cost and quality information by employing the following strategies:

Support the development, endorsement, and updating of performance measures

- Provide substantial funding to support development of consumer-relevant measures that fill existing gaps (especially efficiency and equity). Developing measures is a public good that requires significant financing from the public sector. Currently, because of the lack of well-specified and endorsed measures that meet consumers and purchasers' needs, measure developers must be encouraged to create measures that are:
    - Reasonably scientifically acceptable. Consumers and purchasers want measures to be scientifically sound, but do not want the pursuit of perfection to delay the availability of good and useful information.
    - Feasible to implement. Rapid reporting necessitates measures are constructed and specified so that the data needed is currently available or can be collected with limited reporting burden.
    - Relevant to consumers and purchasers. The needs of consumers and purchasers for important and actionable information must drive the development of measures.
    - Reflect the continuum of care/care coordination from a patient's perspective. Measures should address the comprehensive, patient-centered care that may be delivered by multiple providers.
- Provide core operating support for the National Quality Forum to ensure ongoing, independent consensus process for the review, endorsement, and updating of measures so as to enable the availability comparative information and the reduction of provider reporting burden.

Increase the breadth and scope of performance information available to the public

- Release physician-identifiable Medicare claims data (fully protecting patient privacy), to allow for better quality and efficiency performance reporting.
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- Develop BOTH total costs of episodes AND total estimated beneficiary out-of-pocket for episodes of care (with estimates for beneficiaries with and without Medigap supplemental coverage). This release should include contextual and background information.
- Present price information in a manner that reflects the following principles:
    - **Linked directly to Quality measures** (outcomes, patient experience, compliance with evidence-based medicine). Whenever possible price information should be directly linked to quality information to facilitate total value consideration by the consumer. When it cannot be, there should be context and background (including that "more expensive" does not mean better)
    - **Understandable**: Information should be "transmissible", that is, it can be communicated from one consumer to another and must recognize that different consumer audiences will have different information seeking and comprehension skills.

- **Actionable**: Information should include relevant comparisons of providers based on quality and cost; link to a consumer being able to select a particular option; and should provide context and background on how to not just compare price of providers/treatments selected, but information on potentially relevant alternatives.
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- **Relevant to consumers' circumstances** (health and coverage status): Information should be as specific as possible to an individual or family's health coverage and health status (including potentially a discrete condition OR considering a combination of conditions).
- **Predictive (accurate)**: Information should predict likely expense accurately and/or have clear explanation of the reason for range of cost variation.

CMS/HHS should consider using either voluntary or regulatory/contracting mechanisms to further enhance transparency of quality and cost information by:

- Releasing physician-identifiable Medicare claims data (fully protecting patient privacy), to allow for better quality and efficiency performance reporting.
- Establishing conditions of participation for hospitals that require posting of prices and/or policies regarding discounts and other payment options for uninsured patients. For insured individuals, health plans will be the primary vehicle for this information but disclosure is an important issue for equity reason, though true transparency and informed consumer decision-making will require actionable tools.
- The Administration through its various contracting mechanisms with health plans (via OPM or Medicare), should ensure they are providing tools for enrollees to make informed choices, considering both quality and costs.
- Requiring hospitals to augment claims form with additional clinical data elements. Accurately assessing provider performance would be greatly enhanced if the severity of the patient could be captured off of administrative claims data. The public reporting of quality and cost information would benefit greatly from claims data richer detail. Adding the following data elements to the inpatient paper and electronic claim form would enable much more robust hospital outcomes reporting:
  - A unique physician identifier for each coded procedure;
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  - Vital signs (heart rate, blood pressure, temperature, and respiratory rate) recorded at presentation;
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  - Do Not Resuscitate order present (including date and time), if recorded during first 24 hours of patient presenting; and
  - Time of day of admission, discharge, and each procedure.

Again, thank you for the opportunity to comment.

#1523

Thank you for the opportunity to comment of the proposed changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 Rates. We applaud your efforts to promote and foster increased transparency and we believe that Medicare should lead the way to promoting a market that recognizes and rewards high-quality, efficient, and patient-centered care. First, let us offer some overarching comments for your consideration before providing more granular feedback on three sections of the proposed rules that address hospital quality data, value-based purchasing, and the health care information transparency initiative.

OVERARCHING COMMENTS

Assess provider performance using robust measures: Medicare should evaluate the performance of each health care provider that bills Medicare, using nationally-endorsed, scientifically-valid, risk-adjusted, and regularly-updated measures that address:

- Clinical quality (safe, timely, and effective care);
- Efficiency (prices and resource use over time);
- Equity (gender, race, ethnicity);
- Patient experience; and
- Structure or systems (e.g., use of quality-enhancing information technology).

Recommended Actions

- Provide substantial funding to support development of consumer-relevant measures that fill existing gaps (especially efficiency and equity). Developing measures is a public good that requires significant financing from the public sector. Because of the lack of well-specified and endorsed measures that meet consumers and purchasers' needs, measure developers and their funders should be guided by the following considerations:
  - Reasonably scientifically acceptable. Consumers and purchasers want measures to be scientifically sound, but do not want the pursuit of perfection to delay the availability of good and useful information.
  - Feasible to implement. Rapid reporting necessitates measures are constructed and specified so that the data needed is currently available or can be collected with limited reporting burden.
  - Relevant to consumers and purchasers. The needs of consumers and purchasers for important and actionable information must drive the development of measures.
  - Reflect the continuum of care/care coordination from a patient's perspective. Measures should address the extent to which comprehensive, patient-centered care is delivered, often by multiple providers.
- Provide core operating support for the National Quality Forum (NQF) to ensure ongoing, independent consensus process for the review, endorsement, and updating of measures so as to enable the availability comparative information and the reduction of provider reporting burden.

Collect and report information that will enable informed decision making and provider selection. Medicare should provide the public with the information on the

aspects of provider performance described above. Doing so, will allow: 1) consumers to make informed decisions about their health care; 2) insurers and purchasers to make value-based contracting decisions and use differential payments as incentives; and 3) providers' improvement efforts to be supported with better information.

Recommended Actions

- Release physician-identifiable Medicare claims data (fully protecting patient privacy), to allow for better quality and efficiency performance reporting.
- Continue to allow private-sector organizations to download granular provider performance information from the Compare websites.
- Augment hospital claims data with additional clinical data elements to better understand patient acuity.

Implement financial incentives that are sensitive to the provision of high-quality, efficient, patient-centered care: Medicare should phase in a system that differentially pays providers based on nationally standardized measures.

Recommended Actions

- Continue to rapidly expand the number and type of measures that hospitals must report to obtain annual payment update.
- Medicare payments must be sensitive to provider performance and create financial incentives to provide quality care.
- Incentives should take into account performance on quality, efficiency, and patient experience.
- Provider incentives should be budget-neutral and based on a combination of improvement and meeting thresholds.

Now let us offer specific comments on the proposed changes to the three sections that address hospital quality data, value-based purchasing, and the health care information transparency initiative.

SECTION: HOSPITAL QUALITY DATA

Reporting of Hospital Quality Data for Annual Hospital Payment Update
Fiscal Year 2007: We support CMS' recommendation to reduce the FY 2007 annual hospital payment update by 2% for any hospital that does not submit data on 21 measures (8 heart attack, 4 heart failure, 7 pneumonia, 2 surgical infection prevention) for patients discharged starting January 1, 2006 through December 31, 2006.

Fiscal Year 2008: CMS must do far more than merely "exploring the feasibility of adopting additional measures for FY 2008 update, including HCAHPS." There should be a **substantial** expansion of measures for hospitals to obtain the FY 2008 annual update. We strong urge that CMS adopt the measures identified in the Institute of Medicine's *Performance Measurement: Accelerating Improvement*, i.e., Hospital-CAHPS and three structural measures (computerized provide order entry, intensive care staffing with intensivists, and evidence-based hospital referral) as well as consider and adopt a number of other NQF-endorsed measures, for example:

Outcomes
- 30-day heart failure mortality
- 30-day heart attack mortality
- Failure to rescue

Complications
- Urinary catheter-associated infection rate
- Central line-associated blood stream infection rate
- Ventilator associated pneumonia rate

Clinical
- Surgery patients with recommended venous thromboembolism prophylaxis ordered
- Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hour prior to surgery to 24 hours after surgery.

Electronic Medical Records (p. 343-344)
Health information technology (HIT) – which includes software applications for care management (EMR, EHR, practice management systems, registries) – has the potential to dramatically improve the quality and efficiency of health care, however implementation has been slow. The Secretary should ensure that the data necessary for quality measurement are captured by using conditions of participation that require hospitals to implement HIT/software applications that:

- Comply with interoperability standards;
- Enable standardized quality, performance, and efficiency measurement are a routine by-product of their use. [NOTE: Adapted from AQA Data Sharing and Aggregation Subgroup on HIT: www.ambulatoryqualityalliance.org/files/PrinciplesforHITandMeasAgg-May06.doc]
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Until HIT becomes wide-spread the Secretary can enable much more robust hospital performance reporting by requiring hospitals to report the following data elements on both paper and electronic claims:

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SECTION: VALUE-BASED PURCHASING (p. 344 – 367)

Plan for Implement Hospital Value-Based Purchasing Beginning with FY 2009

As CMS works to develop a plan to implement hospital value-based purchasing beginning in FY 2009, the following issues must be addressed: (a) the ongoing development, selection, and modification process for hospital quality and efficiency measures; (b) the reporting, collection, and validation of data; (c) the structure of payment adjustments; and (d) the disclosure of hospital performance information.

Measure development and refinement (p.350-353)

- As noted in our overarching comments, the development of consumer relevant measures is critical and the Secretary should provide substantial funding to support development of consumer-relevant measures that fill existing gaps (especially efficiency and equity). Developing measures is a public good that requires significant financing from the public sector. Because of the lack of well-specified and endorsed measures that meet consumers and purchasers' needs, measure developers and their funders should be guided by the following considerations:
    - Reasonably scientifically acceptable. Consumers and purchasers want measures to be scientifically sound, but do not want the pursuit of perfection to delay the availability of good and useful information.
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comprehensive, patient-centered care is delivered, often by multiple providers.

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Incentive Methodology (p. 357-367)

- *Incentive Structure*: Incentives should be based on a combination of improvement and meeting quality thresholds based on standard measures adhering to the consumer-purchaser disclosure project guidelines. Our experience with incentives programs indicates that basing the incentives on attaining specific quality-based thresholds allows hospitals (including those serving disenfranchised populations or unique communities) to focus their efforts on the highest-yield improvements. Because of the evidence that performance dramatically varies within hospitals, incentives should be available and calculated at both the service-line level (for clinical areas) and hospital-wide (e.g. for HCHAPS). In the private sector, The Leapfrog Group designed the Leapfrog Hospital Rewards Program to reward both *top performers* and *performance improvers*. The goal is to provide incentives for hospitals to improve continuously and to sustain that improvement once it is achieved. Because the LHRP measures a hospital's performance relative to the performance of other hospitals, even top performers will need to improve continually in order to maintain their status. This use of relative performance to determine which hospitals earn rewards and the level of those rewards was advanced by the current CMS-Premier Hospital Quality Incentive Demonstration. As reported, this Demonstration has experienced quality improvement among participating hospitals on care processes that help ensure better outcomes. As Medicare moves to a permanent use of incentives for quality, setting both baseline thresholds of performance and a relative ranking system will help all hospitals make improvements appropriate to their current level of performance.
- *Level of Incentive*: The share of payment tied to performance should be substantial, though what constitutes "substantial" will differ from one provider to another, i.e., the same percentage may not be appropriate for both hospitals and physicians. The overall proportion of CMS payments dependent on incentives should grow significantly and could eventually reach a level so that 10% or more of total Medicare payments is sensitive to performance. CMS should set and revise the appropriate level using the information that continues to develop from its demonstration projects and private-sector efforts. Initially, we believe that the performance incentive for hospitals should be on the same order of magnitude as the 2% incentive for the FY07 annual market basket update. In addition to financial rewards, there are two other types of incentives CMS can employ: the potential for increased market share and public recognition. For example, The Leapfrog Group designed the Leapfrog Hospital Rewards Program to increase the patient volume at better hospitals through consumer education and benefit design that encourages patients to seek out the best hospitals. This patient shift creates savings for the purchaser, better care for patients, and incentives in the marketplace for hospital improvement. This phenomenon can be supported by ongoing consumer testing of Hospital Compare and making sure that it displays

hospital performance information that is as current as possible. We strongly support the current CMS efforts to increase quality and cost transparency. The Leapfrog Group employer members agree that **public** awareness of hospital quality is a powerful motivator for performance improvement. A powerful example was the significant improvement in nursing home quality that was demonstrated in AHRQ's National Healthcare Quality Report between 2003 and 2004, following when CMS began publicly releasing nursing home quality data.

- *Source of Incentive*: Providing additional funding to finance performance incentives is an unrealistic option given the current economic pressures faced by CMS. As a result, value based purchasing initiatives should be budget neutral. The Leapfrog Hospital Rewards Program is an example of how to accomplish budget neutral incentives. Rewards paid out are based on a share of the savings which accrue in the market due to hospital improvement. If there are no savings, no rewards are paid. This design helps ensure implementers' ability to fund bonus payments is sustainable over time. The dollar amount of hospital rewards is not set in advance, though the methodology by which rewards will be calculated is known by hospitals in advance. As rewards are based on the savings generated by hospital performance, the amount of rewards will vary from one period to the next. While this "shared savings" model is more easily implemented when hospitals earn per-diem reimbursement, The Leapfrog Group, with assistance from private sector stakeholders and CMS, is currently devising a similar methodology for DRG-based reimbursement. Leapfrog's incentive structure design for DRGs adheres to the principles of using measured quality and efficiency performance to create budget neutral incentives for hospital performance. The Leapfrog Group would be eager to continue to share its ideas in this area with CMS as appropriate.

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Again, thank you for the opportunity to comment.

Submitter : **Jaymie Billbrough** **Date: 06/12/2006**

Organization : **Aetna**

Category : **Health Care Industry**

Issue Areas/Comments

GENERAL

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see attachment

CMS-1488-P-1524-Attach-1.DOC

#1524

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June 7, 2006

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

RE: CMS Issues Proposed Rule for FY 2007 Rates under Hospital Inpatient PPS

In response to the CMS Proposed Rule, file code CMS-1488-P, announcing a change to the Inpatient Prospective Payment System, Aetna Inc. is submitting the following comments:

In general, Aetna supports the implementation of the cost based recalibration of relative weights and the implementation of a severity-adjusted DRG system. Providing a more accurate cost structure for inpatient services and a more detailed system for coding complex cases will result in a higher degree of accuracy in determining the actual resources expended during an inpatient confinement.

However, the proposed timing of the implementation is of great concern. Operational impacts to facilities and payors will be substantial. The retraining of coding, billing and claim management staff, thorough evaluation of information technology changes related to inpatient claim pricing and provider network communication and education activities will take a minimum of twenty-four months to ensure a transition that is seemless for Medicare beneficiaries. Anything less than 24 months will put Medicare members, including Aetna's Medicare Advantage members, at risk for issues resulting from a lack of operational preparedness.

Aetna's second and final comment is regarding the degree of access hospitals and payors will have to all details of the APR DRG Classification system. Currently this system is a proprietary system and in order for CMS to be successful in its implementation all aspects of the system must be transparent to allow hospitals and payors to:

- **Manage Regulated Reimbursement Levels** - as required by the statutes governing Medicare Advantage Plans we must know the details to be able to price claims for our Medicare Advantage members and ensure compliance with paying no less than what Medicare FFS plans pay. Hospitals will require the same transparency to validate they have received the required level of

reimbursement.

- **Manage Transition Costs** – Medicare Advantage payors must have an automated solution to keep claim administration expenses low. Allowing existing vendor relationships to access and distribute the new APR DRG system will reduce the transition cost and ensure a higher degree of claim pricing accuracy for current Medicare Advantage payors. This requires full disclosure and transparency of the new reimbursement system including:
    - Fully functional grouper software, including those return values which highlight which diagnoses and procedures were critical to group assignment,
    - Source code for the grouper, which is comparable to what CMS provides for the current DRG grouper,
    - Access to all underlying tables that drive the grouper with documentation,
    - A complete set of test cases to validate the functioning of the software,
    - System and user documentation comparable to what is currently available for the CMS DRG grouper,
    - Contact people who can and will respond to questions in a timely fashion,
    - The right for re-distribute the methodology to business partners and consultants,
    - The right to translate the source code to other technology environments and to integrate it into other systems
    - In addition, given the complexity of the methodology the industry needs pre-releases of the software and documentation well in advance of planned implementation.

- **Ensure Financial Integrity** – to ensure accurate modeling and forecasting of Medicare Advantage plan medical costs the drivers for determining inpatient reimbursement levels must be a publicly available.

- **Support Industry Reimbursement Standards** – most major payors have adopted the CMS reimbursement systems as a basis for contracting with providers across all business segments. In order to accurately adjust those systems and ensure adequate reimbursement levels, consideration must be given to make the case mix grouping, severity adjustment rules and other APR data elements publicly available. It is also essential that any system adopted by CMS be subject to the same standards of annual public review and discussion currently available under the Acute Care IPPS system.

Sincerely,

Jaymie Billbrough

Jaymie Billbrough
Director National Regulatory and Compliance

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-P-1525-Attach-1.DOC

#1525

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 ± 3 standard deviations from the national mean of the log CCRs within each
iii) Compute hospital-specific Medicare costs using the all-payer revenue center CCR and the Medicare charges for the revenue center on the cost
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) 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.

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

(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

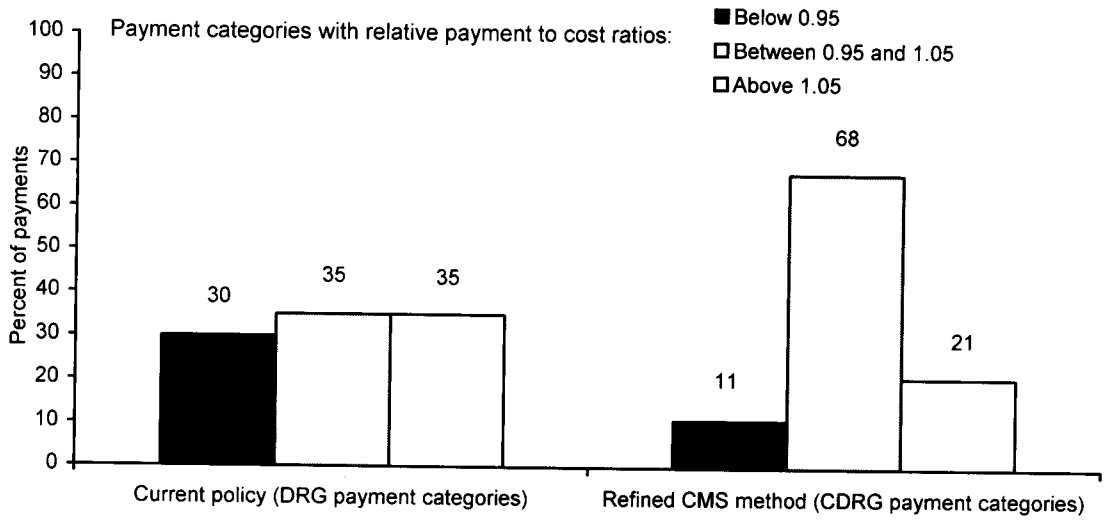
Source: MedPAC analysis of Medicare hospital inpatient claims and cost reports from CMS, primarily fiscal year 2002.

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

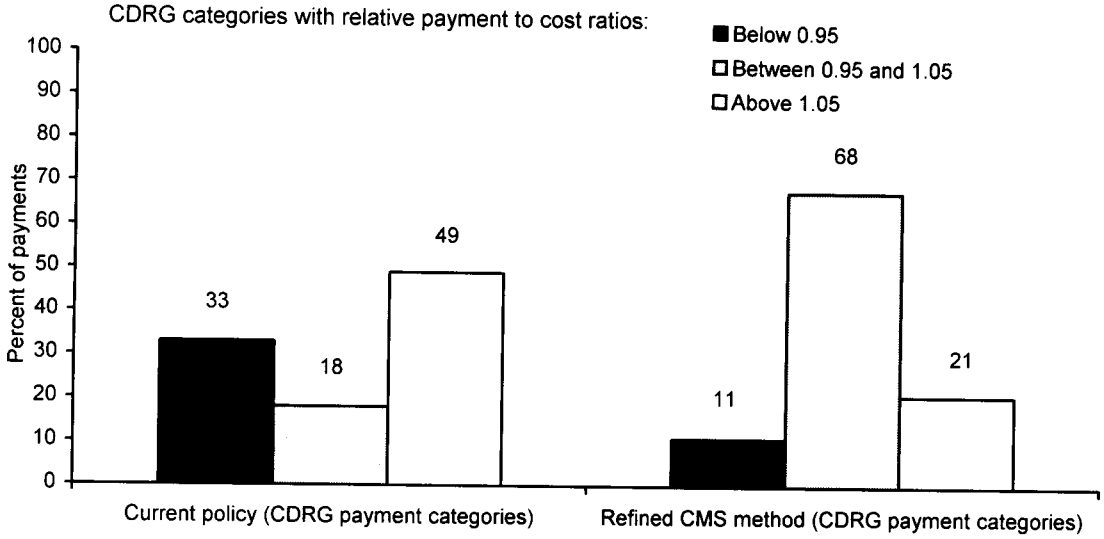


Note: DRG (diagnosis-related group). Refined CMS method for CDRGs (MedPAC's proposed revisions to the CMS method for computing cost-based HSRV weights, applied to CDRGs). CDRGs (consolidated severity-adjusted diagnosis-related groups).

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 : **Dr. Geraldine Urse** **Date: 06/12/2006**

Organization : **Dr. Geraldine Urse**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

As a family physician, I appreciate the opportjunity 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 activitieis 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, Diretor, 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 didacctic sessions and keep count of patient care time. Such documentation requirements are unreasonable and would add an exxtremely 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,

Geraldine N. Urse, D.O., FACOFP

Submitter :

Date: 06/12/2006

Organization :

Category : **Health Care Industry**

Issue Areas/Comments

DRG Weights

DRG Weights

Please see the comments attached. Thank you

CMS-1488-P-1527-Attach-1.DOC

CMS-1488-P-1527-Attach-2.DOC

#1527

June 5, 2006

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

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

Dear Administrator McClellan:

IntraNexus is grateful for the opportunity to submit comments on the proposed rule regarding Medicare's inpatient hospital payment system. For more than 13 years, IntraNexus and our strategic partners have provided customized, integrated software solutions for more than 1,000 hospitals, behavioral health & long term care facilities, ambulatory care centers, and physicians' offices across the United States.

While we are not paid by Medicare under the inpatient hospital prospective payment system (IPPS), our clients are paid under this system. In this capacity, we have identified a number of concerns with the proposed rule, particularly related to the proposed changes to the Diagnosis Related Group (DRG) classification system. Foremost among these concerns is the need for transparency with regard to any changes to the DRG classification system because the lack of such transparency has the potential to cripple our ability to continue to assist our customers. We believe that CMS should not rush into this change in the upcoming fiscal year and that it should consider the complexity of any revision and the impacts on hospital coding and billing. These concerns are discussed below.

A. Transparency

Currently, we are able to access the complete DRG classification methodology, which CMS makes available equally to all members of the public. Complete and timely access to this methodology is crucial to the business operations of our clients. It is important that as CMS changes the DRG system, vendors such as us retain access to the underlying methodology at a level equivalent to what we experience today. There seems to be no guarantee that this would remain the case under the proposed move to All Patient Refined Diagnosis Related Group (APR-DRG) classification system. As you know, the APR-DRG system is a proprietary system. Nothing in the proposed rule provides us with sufficient comfort that the same level of detail currently available would continue to be available if CMS were to move to the APR-DRG

system. Although the proposed rule offers a website for more detail on APR-DRGs, that site contains an insufficient amount of disclosure about the methodology. CMS needs to insure that all interested parties are able to get access to source code, comprehensive system and user documentation, test data and quality support from the owner of the methodology at costs similar to what the industry now pays.

Given the above issues, we strongly urge CMS to ensure that as much detail about the new system is made available as CMS currently makes available under the existing DRG system. We also ask that details regarding the new system become available as soon as possible so the impact of this system on hospital data processing, billing and management systems can be fully evaluated.

B. Need for Time to Adapt to DRG Change

According to the proposed rule, CMS might move to the APR-DRGs as soon as October 1, 2006. Based on our experience in working with hospitals, we believe this would be an unrealistic time frame for such a dramatic change to the inpatient hospital payment system. Hospitals would not have time to effectively plan for and implement this system. Quite simply, it is highly unlikely that all necessary actions could be accomplished by October 1 of this year and we therefore recommend that CMS not change the classification system in fiscal year 2007.

C. Minimizing Complexity and Burden

Not only will a change to the DRG system be a complex endeavor that will be burdensome for hospitals, adoption of the complex changes as proposed will decrease coder productivity and lengthen revenue cycles. As an industry we are already facing changes required by UB-04, ICD-10 and the quality provisions of the Deficit Reduction Act. Coordination of these changes would provide a positive overall impact on healthcare management and the associated expense of this process.

We also foresee the overlay of the proposed DRG system change and the movement to the International Classification of Diseases, 10th Revision (ICD-10). We suggest that CMS carefully consider the timing of these two major changes, as it may make more sense to implement these changes concurrently rather than consecutively.

Again, IntraNexus appreciates the opportunity to comment on the proposed rule. Thank you for your consideration.

Sincerely,

Laurie Shoaf, CPAM
VP, Corporate Compliance
IntraNexus
Email: lshoaf@intranexus.com
Phone: 757-422-1222 x5506

June 9, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P and P2
7500 Security Boulevard
Baltimore, Maryland 21244-8012

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

Dear Dr. McClellan:

On behalf of University of Rochester Medical Center, I welcome the opportunity to express my strong concerns over the proposed rule issued by the Centers for Medicare & Medicaid Services (CMS) on April 12th entitled *" Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates."* The proposed rule, if implemented, represents the most significant changes to the IPPS since its inception in 1983, and will have profound implications on Strong Memorial Hospital and other hospitals nationwide.

Under the proposed rule, CMS would implement hospital-specific cost weights in FY 2007 and adopt a consolidated severity diagnosis-related group (DRG) system in FY 2008, if not earlier. These two items would provide a major redistribution of payments among hospitals and, as a result, would severely impact the level of costs that get allocated for specialty services, like cardiac care, offered at Strong Memorial Hospital. The proposed change to the DRG payment weight calculation from a charge-based method to a service mix and cost based method will result in an estimated loss of $5 million to Strong Memorial Hospital in FY 2007 alone. The impact of the second proposed change – adoption of a consolidated severity DRG system – will result an additional loss for Strong of approximately $1.5 million and in a net loss of $100 million New York statewide in FY 2008.

These changes are significant in scope and will require considerable time for hospitals to absorb. However, if enacted, CMS expects hospitals to assume these changes by October 1, 2006. This is not only unreasonable, but unrealistic. As with previous and less significant changes to the IPPS, a re-distributive change of this magnitude should be implemented over a transition period of at least several years to mitigate the potential loss of payments, as well as to allow sufficient time for refinement of the new methodology.

In addition, based on the analysis of the Healthcare Association of New York State and the American Association of Medical Colleges, as well as our own internal review, there are a number of significant errors and technical problems with CMS's new calculation of the proposed Hospital-Specific Relative Value cost center (HSRVcc) weights that need to be corrected. In particular, CMS erred in how they "trimmed" the data used to develop the DRG weights. In doing so, they excluded a significant number of hospitals in the data calculations. Also, by calculating national cost-to-charge ratios (CCRs) through an averaging process that treats each hospital's CCR equally, the "weighting" methodology used in the calculation process does not account for differences in case volume. In other words, a hospital that performed 10 cases of a particular DRG would average equally with a hospital that did 100 of those same DRGs.

As a result, the tables and impact statements provided in CMS in the proposed rule are based on flawed calculations that result in an inaccurate representation of the effects that the revised weights would have on hospital payments. In order to assure the accuracy of the hospital payment system and lead to better incentives for hospital quality and efficiency, these discrepancies need to be examined further and corrected. Further, the recalculated weights should be released for public review and comment before any decision can be made regarding the proposal.

While we understand that one of the intentions of CMS's proposed rule is to prevent hospitals from specializing in certain types of highly profitable services at the expense of others, it is important to note that, in addition to being the region's leading cardiac care center and Western New York's only Cardiac Transplant Center, Strong Memorial Hospital also provides a comprehensive range of general and other highly specialized services (these include neurosurgery, urology, gynecology, cancer and pediatrics) to the underserved and general population. IPPS payments should accurately reflect the costs associated with these medically complex cases and procedures.

Again, I urge you to delay the proposed changes to Medicare's IPPS for FY 2007 to allow further review of CMS's methodology and the proposed impact of these changes will have on hospitals and their patients.

Thank you for your consideration. As always, if you have any additional questions please do not hesitate to contact me.

Sincerely,

C. McCollister Evarts, M.D.

C. McCollister Evarts, MD

CE/jf

Submitter : **Dr. C. McCollister Evarts**

Date: 06/12/2006

Organization : **University of Rochester**

Category : **Hospital**

Issue Areas/Comments

DRG Weights

DRG Weights

Please refer to attached letter

CMS-1488-P-1528-Attach-1.RTF

#1528

June 9, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P and P2
7500 Security Boulevard
Baltimore, Maryland 21244-8012

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

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Under the proposed rule, CMS would implement hospital-specific cost weights in FY 2007 and adopt a consolidated severity diagnosis-related group (DRG) system in FY 2008, if not earlier. These two items would provide a major redistribution of payments among hospitals and, as a result, would severely impact the level of costs that get allocated for specialty services, like cardiac care, offered at Strong Memorial Hospital. The proposed change to the DRG payment weight calculation from a charge-based method to a service mix and cost based method will result in an estimated loss of $5 million to Strong Memorial Hospital in FY 2007 alone. The impact of the second proposed change – adoption of a consolidated severity DRG system – will result an additional loss for Strong of approximately $1.5 million and in a net loss of $100 million New York statewide in FY 2008.

These changes are significant in scope and will require considerable time for hospitals to absorb. However, if enacted, CMS expects hospitals to assume these changes by October 1, 2006. This is not only unreasonable, but unrealistic. As with previous and less significant changes to the IPPS, a re-distributive change of this magnitude should be implemented over a transition period of at least several years to mitigate the potential loss of payments, as well as to allow sufficient time for refinement of the new methodology.

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As a result, the tables and impact statements provided in CMS in the proposed rule are based on flawed calculations that result in an inaccurate representation of the effects that the revised weights would have on hospital payments. In order to assure the accuracy of the hospital payment system and lead to better incentives for hospital quality and efficiency, these discrepancies need to be examined further and corrected. Further, the recalculated weights should be released for public review and comment before any decision can be made regarding the proposal.

While we understand that one of the intentions of CMS's proposed rule is to prevent hospitals from specializing in certain types of highly profitable services at the expense of others, it is important to note that, in addition to being the region's leading cardiac care center and Western New York's only Cardiac Transplant Center, Strong Memorial Hospital also provides a comprehensive range of general and other highly specialized services (these include neurosurgery, urology, gynecology, cancer and pediatrics) to the underserved and general population. IPPS payments should accurately reflect the costs associated with these medically complex cases and procedures.

Again, I urge you to delay the proposed changes to Medicare's IPPS for FY 2007 to allow further review of CMS's methodology and the proposed impact of these changes will have on hospitals and their patients.

Thank you for your consideration. As always, if you have any additional questions please do not hesitate to contact me.

Sincerely,

C. McCollister Evarts, M.D.

C. McCollister Evarts, MD

CE/jf

Submitter : **Dr. Teresa Johnson**

Date: 06/12/2006

Organization : **Via Christi Family Medicine Residency**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As an Associate Residency 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 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. In addition, 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,

Teresa K. Johnson MD
Associate Director
Via Christi Family Medicine Residency Program
1121 S Clifton
Wichita, KS 67218

Submitter : **Dr. Lori Stiefel** **Date: 06/12/2006**

Organization : **Dr. Lori Stiefel**

Category : **Individual**

Issue Areas/Comments

GME Payments

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).

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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.

Submitter : **Dr. John Gnassi** **Date: 06/12/2006**

Organization : **Tufts Unviersity Family Medicine Residency**

Category : **Individual**

Issue Areas/Comments

GME Payments

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).

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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,

John Angelo Gnassi, MD

Submitter : **Vincent Tallarico** **Date: 06/12/2006**

Organization : **Lehigh Valley Hospital**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1532-Attach-1.PDF

#1532

LEHIGH VALLEY

June 12, 2006

The Honorable Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8011
Baltimore, MD 21244-1850

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

Commenting on: General Comments; HSRV weights

Dear Dr. McClellan:

As a leader in heart care in the Lehigh Valley, the third largest population base in Pennsylvania, we provide a complete continum of medical and surgical cardiovascular services.

We appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' Proposed Changes to the Hospital Inpatient Payment Systems and Fiscal Year 2007 Rates (CMS-1488-P). While we are supportive of many of the provisions in the proposed rule, we are very concerned about the proposed methodologies resulting in inaccurate payment amounts, particularly for the cardiovascular services we provide our patients.

As such, we urge CMS to allow time for further study of the proposals until further analyses can be performed to understand the full impact to hospitals and patients, but in the meantime continue with the current charge-based system.

We agree that payment rates should accurately reflect the cost of services provided. Inaccurate rates could limit hospitals' capabilities to perform services, and thus limit patient access to some therapies. The current proposal, if implemented, could have unintended and inappropriate consequences.

- **Questions have been raised about CMS's proposed rate setting methodology.** Some of these issues include:

  - **CMS used old data to calculate the payment rates.** DRG weights under the new rule are based on data that are 3–5 years old. This particularly impacts technology-based DRGs. Medical technologies typically have a short lifecycle, meaning that many of the innovative technologies available today, such as cardiac resynchronization therapy defibrillation (CRT-D), were not widely in use at the time these data were collected.

  - **The use of nonstandard data leads to increased inaccuracy**. The current cost reports were designed for a different purpose; CMS should put more thought into how to improve and verify the accuracy of this data prior to making it the basis of its new payment system.

  - **Technical mistakes as well as questionable technical assumptions alter the estimated impact on payments**. In one example, CMS excluded approximately one-quarter of large hospitals' routine day charges in calculating cost-to-charge ratios, which almost doubled the cuts in some DRGs and raised the increase in equal amounts in others. Had these data been included, the large shift in payments for some DRGs would be reduced by nearly half. Another example is in how the cost-to-charge ratios were calculated; CMS failed to adjust for volume of care among hospitals, resulting in a small hospital having as much weight as a large-volume hospital.

  - **Charge compression continues to be a major issue, particularly for costly, high-value medical devices**. Despite continued pleadings from industry, hospitals, Congress, and others, charge compression was not addressed in the FY2007 rule, and is in fact, made worse. Instead of individually analyzing the high cost, high value devices to better understand real costs, CMS decided to put everything together in ten national cost centers. The problem is that there are no standards — most devices and supplies are put in a single cost center, and hospitals across the country put them in different categories, so the real costs may never be captured.

- **The current proposed DRG payment rates are in some cases the same or lower than the purchase price for ICDs and CRT-Ds.** Proposed rates for ICD and CRT-D procedures are sometimes below the device acquisition cost, not allowing hospitals payment for operating procedures, supplies, and personnel. For example, DRG 515, where a majority of ICD implants fall, was paid at a base of $28,441 in 2006; for 2007 Medicare is proposing a sharp decrease in payment of 23%, down to $22,015 — one of the biggest percentage decreases any DRG faces this year.

- **If this change is implemented, hospitals could find themselves with limited capabilities to offer their patients leading-edge, high value lifesaving technologies.** Hospitals cannot sustain themselves economically when inaccurate

payments do not cover the cost of supplies, equipment, staff, and medical devices. This could result in hospitals altering normal treatment patterns, restricting technology selection, and limiting patient access in order to avoid extraordinary financial losses. As a result, patients may be limited access to this lifesaving technology because hospitals are not receiving payment that recognizes the full cost of the services provided.

We urge CMS to delay the 2007 proposed changes until more careful analyses are performed, and the full impact to hospitals and patients is understood. Although the proposed changes are in many cases, directionally correct, the sheer magnitude of the changes, coupled with the many unintended flaws, requires CMS to delay implementation until a thorough and detailed analysis can be performed that results in more accurate payment for all hospitals.

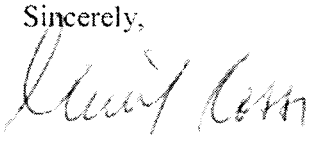
- **This proposed system does not have precedence or transparency**. While the rule provides some description of the methodology for the changes, it does not provide adequate information to calculate the overall impact for the individual measures, nor for the complete proposal. Therefore we urge CMS to wait, at a minimum, until FY2008 to consider making such drastic and sweeping changes until such a time that more thorough and considered analyses can be performed, and a coalition of stakeholders can research the recommendations that will be better accepted by those affected.

- **The 60-day comment period does not allow the stakeholders adequate time to fully evaluate the consequences.** The major changes and the aforementioned errors in methodology require more than the typical 60-day comment period for stakeholders.

- **As such, CMS should continue with the stable, charge-based system that has been in place for 23 years until a better, more accurate alternative can be found**.

We appreciate CMS's efforts to improve the inpatient payment system, and agree that it is our mutual goal to improve the lives of Medicare beneficiaries. We all must work together with diligence and with dedication to address these complex issues.

Sincerely,



Michael Rossi, MD
Chief of Cardiology

Vincent J. Tallarico
Vice President-Regional Heart Center

Cc: Elliot J. Sussman, MD, President & CEO, LVHHN
Brent Ennis, Dir of Government Relations, LVHHN

Submitter : **Dr. Peggy Gardner** **Date: 06/12/2006**

Organization : **Via Christi Regional Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

GME Payments

GME Payments

Centers for Medicare and Medicaid Services

Dear Sirs:

I appreciate the opportunity to comment on the 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 its clarification in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments.

Any decision which suggests that formal educational processes, including research and other scholarly activities, are not a vital part of resident physician education is a refutation of U.S. graduate medical education. No one will deny that patient care is the focal point of training resident physicians; however, to suggest that the direct patient care environment constitutes the sole learning environment poses considerable issues in a learning environment which is increasingly complex--and increasingly demands public accountability.

In order to provide patient care within the framework of "evidence-based medicine," resident physicians must develop life-long study habits which include not only the classic literature within their discipline, but continual review of peer-reviewed journals to be ever aware of changes in medicine.

The American public seeking excellence in medical care expects its physicians trained in the GME system to have a quality education--to meet that quality goal, that education must occur in different educational settings, from the patient's bedside to the case study discussion at a journal club to asking and refining the research questions and designing the research methodology which supports excellence in medicine. Everyone one of these learning activities--regardless of the location--is ultimately focused on improving patient care.

We are facing a shortage of physicians in this country--and in Kansas many of our counties are in the underserved category. Our residency programs in Wichita, Kansas, have provided many physicians to serve our communities in Kansas. Continual reductions in funding put these programs at risk--and, consequently, our communities at risk.

I urge CMS to rescind its clarification of the proposed rule relating to the counting of didactic time for the purposes of DGME and IME payments. By doing so, CMS will send a clear message to the American public that it values the quality of the graduate medical education system and recognizes that formal learning and good patient care are inextricably bound together.

Sincerely,

Peggy C. Gardner, PhD
Director, Graduate Medical Education
Via Christi Regional Medical Center
Wichita, KS

Submitter : **Ms. Laura Loeb** **Date: 06/12/2006**

Organization : **American Dental Education Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

Oppose CMS' position to not include didactic time in D-GME and IME resident counts.

CMS-1488-P-1534-Attach-1.PDF

ATTACHMENT TO # 1534

The Mission of the American Dental Education Association is to lead individuals and institutions of the dental education community to address contemporary issues influencing education, research, and the delivery of oral health care for the improvement of the health of the public

2006-2007
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June 12, 2006

Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 443-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201
Attention: CMS-1488-P

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

Dear Administrator McClellan:

The American Dental Education Association (ADEA) appreciates the opportunity to comment on the proposed rule for changes to hospital inpatient prospective payment systems for fiscal year 2007, as published in the April 25, 2005 *Federal Register*. Specifically, we will comment on proposed changes to graduate medical education (GME) policies which will have a very deleterious impact on residency training.

ADEA is the national organization that speaks for dental education. It is dedicated to serving the needs of all 56 U.S. dental schools, 731 U.S. dental residency programs, 266 dental hygiene programs, 259 dental assisting programs, and 25 dental laboratory technology programs, as well as the 11,332 full- and part-time dental school faculty, more than 5,060 dental residents (both hospital- and school-based) and the nation's 36,286 dental and allied dental students.

Comments Regarding Section IV(F)(5) -- Resident Time Spent in Nonpatient Care Activities as Part of Approved Residency Programs (Sections 413.9 and 413.78(a))

We are gravely concerned with the entire discussion in this section of the proposed rule regarding didactic activities that are a seminal component of every residency program. CMS's view regarding the treatment of this issue over the years, in our opinion, bears little resemblance to the actual language in the Medicare statute, regulations, manual and CMS's own correspondence.

1400 K Street, NW • Suite 1100 • Washington, DC 20005 • Phone: 202.289.7201 • Fax: 202.289.7204 • Internet: www.ADEA.org

We agree with CMS that only time spent by residents training in a nonprovider setting performing "activities relating to patient care" may be counted towards direct graduate medical education (D-GME) and indirect medical education (IME) funding. However, in using this language, it is very clear that Congress intended for more than just direct patient care to be included. Indeed, as described below, CMS regulations, manual provisions and correspondence also support this conclusion.

The Medicare Statute

In a very misleading fashion in the proposed rule, CMS does not quote the entire section of the relevant portion of the Medicare statute, which reads in full:

> "Counting Time Spent in Outpatient Settings. Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted toward the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training in that setting." (Emphasis added). Section 1886(h)(4)(E) of the Social Security Act.

Congress and CMS itself know what language describes care directly provided to individual patients. That term is "direct patient care". Congress uses the term "direct patient care" in 42 USC Section 1395m regarding special payment rules for compensation provided to a referring physician for direct patient care services, and again in Section 1395nn, in distinguishing administrative services from direct patient care.

Significantly, however, the statutory language regarding this GME issue does not use the term "direct patient care," but rather employs the much broader language of "activities relating to patient care." Further, the law states that "all the time so spent by a resident under an approved medical residency training program shall be counted . . . without regard to the setting in which the activities are performed." (Emphasis added.)

In addition to Congress using the phrase "direct patient care" when that is what it means, CMS uses the phrase "direct patient care" frequently. Examples include:

- ✓ 42 CFR Sections 460.71, 460.62, 418.70, 418.100, 413.106;
- ✓ Proposed rule for physician services for 2005 (69 Fed. Reg. 150 at 47491);
- ✓ Interim final rule for Programs of All-inclusive Care for the Elderly (PACE) (67 Fed. Reg. 190 at 61499);
- ✓ Medicare Provider Reimbursement Manual, Transmittal 13, October 2003;
- ✓ Medicare Benefit Policy Manual, Chapter 11, Section 80.2, Physicians' Services - Outpatient Maintenance Dialysis;
- ✓ Medicare Benefit Policy Manual, Chapter 9, Coverage of Hospice Services;
- ✓ Medicare Claims Processing Manual, Chapter 3, Section 141.1.3Q, Inpatient Hospital Billing; and
- ✓ State Medicaid Manual, Chapter 4, Section 4307 (Payment for Physician Services Under Hospice).

Medicare regulations also define "direct medical and surgical services" of physicians in a teaching setting as "services to individual beneficiaries that are either personally furnished by a physician or furnished by a resident under the supervision of a physician in a teaching hospital . . . ." 42 CFR Section 415.152.

In all these situations where Congress or CMS used the phrase "direct patient care" or "direct medical and surgical services," it meant care provided directly to specific patients. To describe hands on care provided directly to individual patients, neither Congress nor CMS has used the phrase "activities relating to patient care."

Medicare Regulations and Provider Manual

The Medicare regulations relating to training in a nonprovider setting state:

> "For portions of cost reporting periods occurring on or after January 1, 1999, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physician offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met: (i) The resident spends his or her time in patient care activities . . . ." (Emphasis added). 42 CFR 413.78(a).

Consistent with the statutory language, the reference in the regulations is to patient care "activities" and not to direct patient care.

CMS states that the regulations at 42 CFR Section 413.9 support its position that didactic time is not a patient care activity. Actually, these regulations fully support the interpretation that the costs of didactic training are in fact related to patient care.

Section 413.9 requires that the costs that a hospital places on its cost report be related to patient care to be reimbursed.

> "Costs related to patient care . . . . Necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities." (Emphasis added). 42 CFR 413.9

The Provider Manual expands on this language by stating that all costs of an approved Interns and Resident training program are allowable as "Costs Related to Patient Care". PRM Section 2148.

In addition, "Costs Related to Patient Care" also is defined in the Provider Manual as "all necessary and proper costs which are appropriate and helpful in maintaining the operation of patient care facilities and activities." PRM Section 2102.2

Moreover, the Provider Manual also lists examples of "Costs Not Related to Patient Care". (Emphasis added). The Provider Manual states that costs not related to patient care are the cost of meals sold to visitors, cost of drugs sold to other than patients, cost of operating a gift shop, cost of entertainment, cost of educational expenses for spouses or other dependents of providers of services, etc. PRM Section 2102.

Thus, in listing the costs that are not related to patient care, the Provider Manual specifically mentions the education expenses for spouses and other dependents of providers of services. Notably, the Provider Manual does not mention the educational expenses of providers of services, such as residents, themselves. Therefore, the educational expenses

of these providers of services must be related to patient care. That is the only reasonable interpretation.

Further, in a recent Q and A that CMS issued on April 8, 2005, entitled "Medicare Policy Clarifications on Graduate Medical Education Payments for Residents Training in Non-Hospital Settings," CMS defines in its answer to Question #5 what are the teaching supervisory costs that a hospital must incur with respect to training occurring in a nonhospital site in order to quality for D-GME and IME funding. CMS states that the teaching physician costs that the hospital must incur do not include billable direct patient care time, but rather include time spent on non-billable GME teaching activities, "such as general clinical didactic training or assessing the resident's performance." (See Answer #5, at Attachment #1.)

Therefore, according to this CMS instruction, the hospital must incur the cost of the faculty teaching the didactic seminars, but then, according to this proposed rule, the hospital cannot count the time the residents spend in these seminars. Such a result would be absurd policy.

CMS Correspondence

Perhaps most significant, the CMS official who directly oversees GME policy issues, addressed the very question at issue here in 1999. In response to correspondence asking how CMS interprets the phrase "patient care activities" with respect to training occurring in nonprovider settings, Tzvi Hefter, Director, CMS Division of Acute Care, in a letter dated September 24, 1999, attached, responded:

> "HCFA interprets the phrase 'patient care activities' broadly to include any patient care oriented activities that are part of the residency program. As you stated in your letter, this can include . . . scholarly activities such as educational seminars, classroom lectures, research conferences, patient care related research as part of the residency program and presentations of papers and research results to fellow residents, medical students, and faculty. Therefore, as long as the residents are primarily involved in patient care oriented activities and other program requirements are met, a hospital may include other educational activities as part of the entire time spent by residents in non-hospital settings and include this time in its FTE count and GME/IME payment calculations." (Emphasis added.) (See Attachment #2).

We do not believe the CMS letter could have been more clear or to the point. Further, as described above, this CMS interpretation of "patient care activities" is supported by the language of the Medicare statute and regulations, neither of which refer to "direct patient care," but rather mention "activities relating to patient care."

CMS's main argument in the proposed rule is that the plain meaning of "patient care activities" clearly means direct patient care. If the meaning was not plain to the CMS Director overseeing GME issues himself, how then could it have been plain to hospitals and medical and dental schools?

As CMS is well aware, and contrary to its implication in the proposed rule, this 1999 CMS correspondence was distributed widely to many hospitals and universities. Indeed, ADEA explained this to CMS officials in a meeting in April of 2004. Many hospitals and medical

and dental schools have relied upon the CMS letter's unequivocal language, which states that hospitals could include resident didactic time in a nonhospital setting in calculating FTEs for D-GME and IME.

Federal District Court Opinion in *Riverside*

In a case involving Riverside Methodist Hospital in Ohio, the fiscal intermediary denied IME payments to the hospital for time the family practice residents were in journal club, practice management seminars, ob/gyn seminars, and psychiatric seminars. The basis for the intermediary's denial was that this time was not related to "hands-on patient care." All of these activities, however, were required components of the family practice residency program under the ACGME standards.

The hospital appealed the fiscal intermediary's denial to the Provider Review Reimbursement Board (PRRB), and the PRRB sided with the hospital, concluding that this didactic time should be counted. The CMS Administrator reversed the PRRB's decision in November of 2001, however, and the hospital appealed to Federal District Court.

A Federal District Court in 2003 reversed the CMS Administrator's position that didactic time couldn't be counted for IME payments at least for training occurring in a hospital setting, in Riverside Methodist Hospital v. Thompson, 2003 U.S. Dist Lexis 15163 (S.D. Ohio, July 31, 2003). In Riverside, the Court held that in the hospital setting there was no requirement that a resident's time be counted only if it involved patient care.

The Court did not need to resolve or decide the question of whether this didactic time was related to patient care. However, the Court did take note of the issue in footnote 11, stating:

> "It could be very difficult to define exactly what is included in the Secretary's phrase 'patient care costs.' For example, if a resident suspects that a patient has a mental disorder, and does some research in order to better understand the patient's condition and treatment, is this time spent for 'patient care'? If the same resident, for the same purpose, attends a psychiatric seminar, is this time spent for 'patient care'?"

Didactic Activities Are Relating To Patient Care

Lastly, the didactic activities that are included in all ACGME and CODA accredited residency programs are activities relating to patient care as the Medicare statute and regulations require. In conferences and seminars, the residents are encouraged to discuss how the material relates to patients whom they are treating. The journal clubs, literature reviews, case presentation, laboratory techniques are related to patients who are being treated. Even seminars on communication skills are related to patient care, as communication with patients, family, and other professionals is discussed in the context of how to care for patients presently.

Conclusion

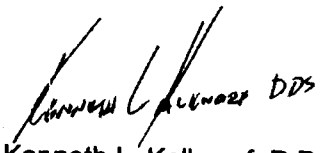
As described above, the Medicare statute and regulations do require that residents be involved in activities relating to patient care for the time to be counted towards D-GME and IME in a nonhospital setting. However, the Medicare statute, regulations, manuals, and

CMS's own correspondence make very clear that "activities relating to patient care" include more than just direct patient care and that didactic time that is part of an ACGME- or CODA-accredited program is an activity relating to patient care. Therefore, this didactic time meets the statutory and regulatory definition of activities related to patient care and should be counted for both D-GME and IME purposes.

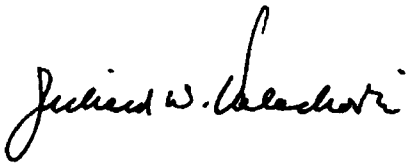
* * * *

We look forward to working with CMS staff to resolve this critical issue. If there are any questions concerning these comments, please contact Jack Bresch, Associate Executive Director and Director of the Center for Public Policy and Advocacy, American Dental Education Association, at 202/667-9433, Ext. 120.

Respectfully submitted by,



Kenneth L. Kalkwarf, D.D.S.
President



Richard W. Valachovic, D.M.D., M.P.H.
Executive Director

ATTACHMENT 1

04/08/2005

MEDICARE POLICY CLARIFICATIONS ON GRADUATE MEDICALEDUCATION PAYMENTS FOR RESIDENTS TRAINING IN NON-HOSPITAL SETTINGS

Question 1) How does Medicare support Graduate Medical Education (GME) programs?

Answer 1) Medicare makes both direct GME and indirect GME (IME) payments to hospitals that train residents in approved medical residency training programs. The calculation of both direct GME and IME payments is affected by the number of full-time equivalent (FTE) residents that a hospital is allowed to count. Generally, the greater the number of FTE residents a hospital counts, the greater the amount of Medicare direct GME and IME payments the hospital will receive. The Medicare statute provides for direct GME payments to hospitals to cover Medicare's share of the **hospital's** direct costs of the residency training taking place at the hospital. The direct GME payment is based on a hospital-specific per resident payment amount that is based on the **hospital's** direct graduate medical education program costs (including teaching physician and resident salaries) incurred in a base year. IME payments to a hospital are paid under the Inpatient Prospective Payment System (IPPS) as a percentage add-on for each Medicare patient discharged from the hospital. IME payments are designed to cover Medicare's share of the higher indirect costs of providing patient care at teaching hospitals relative to non-teaching hospitals. The higher costs are primarily due to increased or inefficient testing of patients by residents and the relatively increased level of patient acuity at teaching hospitals.

Question 2) Does Medicare make both direct GME and IME payments to hospitals for training residents at nonhospital sites?

Answer 2) Prior to October 1, 1997, hospitals could receive only direct GME payments for the time that residents train in nonhospital settings. However, Congress recognized the importance of moving more resident training out of the hospital setting and into settings that more closely reflect the settings where most physicians will practice. Accordingly, beginning with discharges occurring on or after October 1, 1997, the Balanced Budget Act of 1997 (BBA), amended the Medicare statute to allow hospitals to count residents in nonhospital sites for IME payment purposes as well. In making this change Congress intended to encourage hospitals to rotate more residents to nonhospital sites. In implementing this provision, CMS acknowledges the value of training more residents in nonhospital sites and it is our intent to make sure our rules encourage and facilitate this kind of activity.

However, since the per resident direct GME payment is based on all of the costs incurred by the hospital in training residents during a base year (including teaching physician costs), we believe Congress intended to permit hospitals to count time spent by residents training in nonhospital sites for purposes of IME and direct GME payments only if the hospital is actually incurring "all or substantially all the costs" of the residents training at

the nonhospital site. For this reason, our current regulations require a hospital to incur the residents' salaries and fringe benefits, travel and lodging costs where applicable and the cost of teaching physicians' salaries and fringe benefits attributable to supervision of resident training in the nonhospital setting.

Question 3) Are there situations where it's ok for a physician to volunteer his/her time to supervise residents in a nonhospital site?

Answer 3) Under section 1886(d)(5)(B)(iv) of the Social Security Act for IME, and section 1886(h)(4)(E) for direct GME, the time residents spend training in nonhospital settings in connection with approved programs may be included in determining the hospital's number of full time equivalent (FTE) residents, if, in addition to other requirements, the hospital incurs "all or substantially all" of the costs for the training program in the nonhospital setting. Accordingly, the relevant question is *not* whether volunteerism is permissible, but whether *there is a cost* to the nonhospital site for supervising the resident training. If there is a cost, the hospital must reimburse the nonhospital site for those costs. If there are no costs, then no payment for supervisory physician time is required. Typically, there is a cost for teaching physician time if, for example, the physician receives a predetermined compensation amount for his/her time at the nonhospital site that does not vary with the number of patients he/she treats. In contrast, there is typically no cost for teaching physician time if the physician's compensation at the nonhospital site is based solely and directly on the number of patients treated and for which he/she bills. The most obvious example of this situation would be a solo practitioner that serves as a nonhospital training site. With respect to compensation for teaching physicians, the hospital is required to compensate the nonhospital site for the costs of the teaching physician's activities provided in connection with an approved residency program <u>other</u> than the supervision of residents while furnishing billable patient care services. That is, only the costs associated with teaching time spent on activities within the scope of the GME program, but <u>not</u> in billable patient care activities, would be considered direct GME costs that would need to be incurred by the hospital.

Question 4) In the context of GME training in nonhospital sites, what is the difference between a "solo practitioner" and a "member of a group practice"?

Answer 4) A solo practitioner works in his/her own private office and a member of a group practice is typically one of several physicians employed at a particular nonhospital site. The solo practitioner's compensation is based solely and directly on number of patients treated and for which he/she bills. When the solo practitioner is not treating patients, he/she is not receiving payment for any other duties at the nonhospital site. In this instance, there is <u>no</u> cost to the nonhospital site for the teaching physician's time. In the case of the group practice or clinic setting, however, the physician often receives a predetermined payment amount, such as a salary, for his/her work at the nonhospital site. This predetermined payment amount reflects *all* of his/her responsibilities at the nonhospital site, including treating patients, training residents, and other administrative activities (as applicable), and he receives that predetermined payment from the nonhospital site regardless of how many patients he/she actually treats. The

predetermined amount implicitly compensates the physician for supervising residents. A portion of this implicit compensation is the *cost* attributable to teaching activities, and the hospital must pay the nonhospital site this amount.

Question 5) How do we determine the amount of teaching physician costs that the hospital must pay the nonhospital site?

Answer 5) Determination of the teaching physician costs to the nonhospital site is dependent upon the teaching physician's salary and the percentage of time he/she devotes to activities related to non-billable GME activities at the nonhospital site. Assume, for example, that a resident spends 30 hours per week training at the nonhospital site and the teaching physician works 40 hours per week at the nonhospital site. Also assume that 20 out of the resident's 30 hours are spent in billable patient care activities supervised by the teaching physician, leaving 10 hours of the time the teaching physician spends with the resident in non-billable GME teaching activities, such as general clinical didactic training or assessing the resident's performance. Accordingly, 25 percent (10/40) of the teaching physician's time is spent with the resident in non-billable GME activities. Additionally, the teaching physician may take some time beyond the 30 hours spent with the resident to perform some administrative tasks related to the program, such as completing resident evaluation forms. Again, for illustrative purposes, assume the teaching physician spends one hour out of the 40-hour workweek, or 2.5 percent of his/her time, completing evaluation forms. Therefore, in this example, the teaching physician spends 27.5 percent (25 percent plus 2.5 percent) of his/her time in non-billable GME activities. If the teaching physician receives a salary of $100,000 per year, then 27.5 percent, or $27,500 is the direct GME cost of the physician's teaching activities in the nonhospital site for a whole year. In this example, the hospital would need to pay $27,500 to the nonhospital site in order to count the FTE resident time spent in the nonhospital site for direct GME and IME payment purposes. (If residents are not trained at the nonhospital site throughout the whole year, then $27,500 would be prorated based on the number of weeks that residents train at the nonhospital site).

Question 6) Should the written agreement be with the teaching physician or with the nonhospital site where the physician works?

Answer 6) If the physician is self-employed (e.g., a solo practitioner in his/her own private office), then the physician and nonhospital site are one and the same, and the agreement would be with the physician. However, if the physician is an employee, or must report to another official(s) at the nonhospital site, then the written agreement must be between the hospital and an authorized representative of the nonhospital site.

Question 7) What if the physicians supervising the resident training at the nonhospital sites are employees of the hospital?

Answer 7) If the teaching physicians are employees of the hospital, and the physicians do not receive any additional compensation from the nonhospital site, no additional payment from the hospital is needed since the salaries paid by the hospital to the physicians cover

teaching costs inside and outside of the hospital. In such a case, the written agreements should indicate that the teaching physicians are on staff at the hospital, and the hospital is already incurring the teaching physician costs for training time in nonhospital settings (unless, after October 1, 2004, the hospital opts to forego a written agreement and, instead, documents that it pays the nonhospital site for the teaching physician costs concurrently with the training at that site in accordance with 42 CFR §413.78(e)).

Question 8) Must the hospital incur the teaching physician costs and have a written agreement with the nonhospital site if a) the nonhospital site is owned by the hospital, or b) the nonhospital site is owned by the same organization that owns the hospital?

Answer 8) In either scenario, the hospital must incur the teaching physician costs, and there must be a written agreement in place before the time the residents begin training in the nonhospital site (unless 42 CFR §413.78(e) applies, in which case a written agreement is not required). The hospital would need to demonstrate, under either ownership scenario, that it is paying all or substantially all of the costs of the training program by actually paying the nonhospital site through the hospital's accounts payable system. (If the hospital and nonhospital site share a single accounting system, the hospital could demonstrate payment of the nonhospital site training program costs using journal entries that expense these costs in the hospital's GME cost center and credit the nonhospital site.)

Question 9) What if the teaching physician is on the staff of a medical school and supervises residents in the hospital and in clinics owned by the medical school?

Answer 9) In this case, (unless the hospital opts to pay for the training program costs concurrently under 42 CFR §413.78(e)), rather than having a written agreement with each clinic, it would be appropriate for the hospital to have a written agreement with the medical school, since the medical school owns the clinics. If the residents are training in various medical school clinics, the hospital must have written agreement(s) reflecting the compensation arrangements for each clinic.

Following are examples of situations where there is no teaching physician cost associated with resident training in nonhospital sites, and, therefore, the hospital would not be required to pay the nonhospital site for teaching physician time in order to count the residents for direct GME and IME purposes:

a) A physician trains residents in his private practice. He is a solo practitioner; he does not share the office with other physicians. His compensation is based solely and directly on the number of patients treated and for which he bills.
b) A physician that supervises residents in her private practice shares office space with two other physicians. The three physicians share overhead expenses, such as electricity and rent, but otherwise, there is no sharing of revenues from patient care activities, and the physicians are not compensated according to some predetermined arrangement. Despite sharing office space, the physician that supervises the residents essentially operates as an independent practitioner,

receiving her compensation solely and directly from the number of patients she treats and for which she bills.

c) A resident goes along with a *solo practitioner* to see the physician's patients in a freestanding nursing home (not a Medicare-certified skilled nursing facility). The physician does not receive any payment from the nursing home, and bills independently for the patient care services he provides.

Following are examples of situations where there could be a teaching physician cost associated with resident training in nonhospital sites since, in each instance, the physician receives a predetermined compensation amount regardless of the number of patients he/she treats. In these instances, the hospital is required to identify and pay for the costs of supervising resident training at the nonhospital sites in order to count the residents for direct GME and IME purposes:

a) A physician receives a predetermined salary as compensation for working at a nonhospital site.
b) The compensation of a member of a group practice consists of a base salary, plus a percentage of revenues based on productivity (i.e., the number of patients he treats relative to other physicians in the practice), or seniority.
c) A physician that supervises residents is a member of a group practice. His compensation at the practice is based on the number of patients that he sees and for which he bills, plus additional compensation for other duties that he performs at the practice.
d) A physician is employed and paid by the State (or some other third party) to provide services in various state-owned nonhospital settings. The physician does not receive any predetermined compensation from the nonhospital settings themselves, and bills independently for the patients that she treats in these settings. At the request of Hospital A, the physician has agreed to teach several residents when she is working in some of these nonhospital settings. Hospital A would be required to pay the State (i.e., the employer of the physician) for the portion of the physician's salary attributable to GME activities at the applicable nonhospital sites. The written agreement(s) between the hospital and the State would list each clinic and would specify the amount of compensation attributable to each clinic (unless 42 CFR § 413.78(e) is applicable).

ATTACHMENT 2

Vinson & Elkins
ATTORNEYS AT LAW

VINSON & ELKINS L.L.P.
2300 FIRST CITY TOWER
1001 FANNIN STREET
HOUSTON, TEXAS 77002-6760
TELEPHONE (713) 758-2222
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Web: www.velaw.com

June 24, 1999

Ms. Rebecca Hirshorn
Health Care Financing Administration
7500 Security Blvd.
Mail Stop C4-07-07
Baltimore, Maryland 21244

Re: Calculation of FTE Count in Nonhospital Settings

Dear Ms. Hirshorn:

This letter is to confirm our conversation of last week regarding the calculation of the full-time equivalent ("FTE") resident count in nonhospital settings for determining direct ("GME") and indirect ("IME") graduate medical education payments. Specifically, 42 C.F.R. § 413.86(f)(4)(i) states that the time residents spend in nonhospital settings may be included in the FTE count and GME payment calculations if the residents spend their time in "patient care activities." The same requirement exists for IME payment calculations under 42 C.F.R. § 412.105(f)(1)(ii)(C). Based on our conversation, it is my understanding that the Health Care Financing Administration ("HCFA") interprets the phrase "patient care activities" broadly to encompass all patient care oriented activities that relate to the residency program, including, for example, resident participation in (1) the direct delivery of patient care, such as clinical rounds, discussions, and conferences, and (2) scholarly activities, such as educational seminars, classroom lectures, research conferences, patient care related research as part of the residency program, and presentations of papers and research results to fellow residents, medical students, and faculty. Accordingly, a hospital may include the entire time spent by residents in nonhospital settings in its FTE count and GME/IME payment calculations as long as the resident is involved in patient care oriented activities and other program requirements are met. If my understanding is incorrect, please notify me promptly at 713/758-3480.

Thank you for your assistance in this matter.

Very truly yours,

B. Scott McBride

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

SEP 24 1999

Mr. B. Scott McBride
Vinson & Elkins L.L.P.
2300 First City Tower
1001 Fannin Street
Houston, TX 77002-6760

Dear Mr. McBride:

This is in response to your letter regarding the calculation of full time equivalent (FTE) resident counts in nonhospital settings for determining direct (GME) and indirect (IME) graduate medical education payments. You specifically inquired about Health Care Financing Administration's (HCFA) interpretation of "patient care activities" in relation to the time residents spend in nonhospital sites.

HCFA interprets the phrase "patient care activities" broadly to include any patient care oriented activities that are part of the residency program. As you stated in your letter, this can include resident participation in "1) the direct delivery of patient care, such as clinical rounds, discussions, and conferences, and 2) scholarly activities, such as educational seminars, classroom lectures, research conferences, patient care related research as part of the residency program, and presentations of papers and research results to fellow residents, medical students, and faculty." Therefore, as long as the residents are primarily involved in patient care oriented activities and other program requirements are met, a hospital may include other educational activities as part of the entire time spent by residents in nonhospital settings and include this time in its FTE count and GME/IME payment calculations.

If you have further questions, please call Rebecca Hirshorn at 410-786-3411 or Michelle Lefkowitz at 410-786-5316 of my staff.

Sincerely,

Tzvi M. Hefter
Director
Division of Acute Care
Plan and Provider Purchasing Policy Group

Submitter : **Mr. David McClure** **Date: 06/12/2006**

Organization : **Tennessee Hospital Association**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#1535

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 : **Wanda Marvel** **Date: 06/12/2006**

Organization : **Missouri Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#1536

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 : **Wendy Yang** **Date: 06/12/2006**

Organization : **Wendy Yang**

Category : **Individual**

Issue Areas/Comments

GME Payments

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.

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,

Wendy Yang

Submitter : **Mr. Michael Tretina** **Date: 06/12/2006**

Organization : **St. Vincent's Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#1538

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. Ron Bunnell** **Date: 06/12/2006**

Organization : **Banner Health**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachement

CMS-1488-P-1539-Attach-1.PDF

#1539

Banner Health

1441 North 12th Street, Phoenix, AZ 85006
602-495-4000
BannerHealth.com

June 7, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
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, MD 21244-1850

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

Dear Administrator McClellan:

Banner Health is a healthcare system consisting of twenty (20) hospitals located in seven (7) states in the western United States, with corporate headquarters located in Phoenix, Arizona. As a provider of hospital and other services, we treat a significant number of Medicare and Medicaid patients. Consequently we have a significant interest in any changes in government regulations that impact our ability to deliver care to these patients. I am writing to express my concerns regarding the several areas in the proposed Inpatient Regulations.

Hospital-Specific Relative Value Cost Center Weights (HSRVcc):

Our initial analysis of the change from basing DRG relative weights on costs instead of charges reflects a significant adverse financial impact on our facilities that deliver surgical services, and more specifically, cardiology services. It is a well-known fact that heart disease and related maladies are the number one killer in America today. Our hospitals, like all others, have responded by investing heavily in cardiology services to help treat this disease which afflicts a large number of Medicare patients. Our analysis indicates that payment reductions in our cardiology programs would be significant (in excess of $1,000 per case in some instances) under the proposed methodology. This reduction will undoubtedly require us to review the continuing feasibility of this program. Additionally, I would like to note that while the above payment reductions will likely reduce the incentives that specialty hospitals presently enjoy, I am concerned that the reductions also will significantly affect community and teaching hospitals that provide significant amounts of cardiac care. Unlike many specialty hospitals, however, these hospitals have emergency rooms, treat significant numbers of Medicaid and uninsured patients, and also accept complex cardiac cases.

Aside from the net effect of the proposed payment changes, I want to highlight several shortcoming in the methodology used to develop the HSRVcc, including:

1. The methodology of using Medicare cost reports as true indicators of our costs is badly flawed. The cost- based system should be developed based on refined cost accounting systems and methodologies, and not specifically from Medicare cost reports. Hospital cost reports were never intended for use in developing accurate procedure-specific payment weights. Additionally, although the Medicare cost report is supposed to be standardized, variation exists in reporting and allocating similar kinds of costs. Two examples of this variation are:

    a. Central Supply revenue and expenses. Expenses may be either directly assigned to the various departments for cost report purposes or allocated to departments through the overhead allocation on the Worksheet B and B-1.

    b. Depreciation expense may be handled in a similar method as Central Supply.

2. There is a significant time-lag in the cost reports CMS used to develop the cost weights. CMS used hospital claims data from Fiscal year 2005 and hospital cost reports from fiscal year 2003. Many of the new technologies, especially in the cardiology and implant areas, that will be available in FY 2007 will not be included in either the claims or cost report data used to calculate the proposed payments. Many of our hospitals have received the Notice of Program Reimbursement (NPR) on their 2002 cost reports.

3. The manner in which costs are derived from charges assumes that higher cost items such as implantable devices are marked up to the same extent as low-cost items. This is certainly not the case.

4. The hospital charges are not weighted by volume, meaning that a small hospital of 50 beds would carry as much weight as a 1,000-bed hospital.

5. Methodology validations indicate that there are many technical errors in the CMS development of the HSRVcc, and that the data trimming methods used exclude 260 large hospitals with high room and board mark-ups (accounting for 25% of routine room and board charges) from the national cost-center calculations.

Severity-Based Patient Classification System

CMS has proposed a new severity-based patient classification system to be implemented in FY 2008 (or sooner). Initial estimates indicate that the impact to Banner hospitals may be positive, however, the tools we have to make these estimates are rough at best. Banner Health supports meaningful changes and improvements that result in overall payment accuracy for the related treatment of Medicare and Medicaid patients. However, we ask that CMS work with the hospital industry to analyze these very significant changes to long-standing payment methodologies. The convergence of a significant change to the methodology of computing base DRG rates (using the HSRVcc above) and the prospect of a completely new classification system a year later will create significant uncertainty for our organizations and others.

As such, I ask for a one-year delay in the implementation of the proposed FY 2007 cost-weight changes and that this change be implemented simultaneously with an appropriate expansion to the severity-based DRG system. Additionally, there should be a reasonable transition period to

accompany these changes. Historically, Medicare changes having large impacts have included various transition periods. For example, the move to a PPS for capital was transitioned in over a 10 year period.

Resident Time in Patient Activities

I strongly urge you 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 and indirect medical education payments. The stated rationale for the exclusion of time devoted to these activities is that they are not related to "patient care". Some of the areas cited as being didactic activities were journal clubs, classroom lectures, and seminars. CMS has recognized these activities in the past as being patient care items, and that these activities are an integral component of the patient care activities engaged in by residents during their residency programs. Why would there now be such a narrow interpretation of the rules? Additionally, the rule raises the question as to how such time would be adequately documented while at the same time increasing the administrative burden on hospitals.

I thank you for the opportunity to respond to the proposed FY 2007 Inpatient PPS rules and regulation changes. I would ask that you seriously consider the items mentioned above and work with us and the entire hospital community to make any improvements necessary relative to the delivery and payment for quality patient care to Medicare and Medicaid beneficiaries.

Sincerely,

Ron Bunnell
Executive VP/Chief Administrative
Officer/CFO

Submitter : **Dr. James Scully** **Date: 06/12/2006**

Organization : **American Psychiatric Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1540-Attach-1.PDF

#1546

American Psychiatric Association

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Arlington, VA 22209
Telephone 703.907.7300
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E-mail apa@psych.org
Internet www.psych.org

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Steven A. Rubloff
Executive Director, American Psychiatric Foundation

June 12, 2006

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
P.O. Box 8011
Baltimore, MD 21244-1850

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

Dear Dr. McClellan:

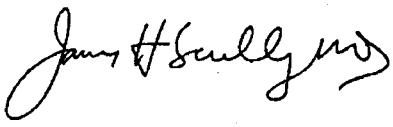
I am writing on behalf of the American Psychiatric Association, the medical specialty representing more than 36,000 psychiatric physicians nationwide, to urge you to rescind a damaging reversal of prior CMS policy on payment for didactic training for Direct and Indirect Graduate Medical Education, as proposed in 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).

As you know, the clarification in the proposed rule would exclude medical resident time spent in didactic activities in the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments because such activities 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.

This represents a reversal of CMS policy expressed as recently as 1999, in which CMS affirmed that patient care activities included didactic activities such as seminars, lectures, and research presentations. We do not understand how CMS can argue that such didactic activities are not completely interwoven with "patient care" activities. The exclusion of such payments would have a very damaging impact on assuring that residents are appropriately trained in patient care, and would be particularly damaging to cognitive specialties such as psychiatry.

We strongly oppose the unwise and ill-considered "clarification." We urge you to withdraw the provision 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,



James H. Scully, Jr., M.D.
Medical Director & C.E.O., American Psychiatric Association

Submitter : **Wanda Marvel** **Date: 06/12/2006**

Organization : **Missouri Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#1541

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. Adrian Billings** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

CMS-1488-P-1542-Attach-1.DOC

#1542

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

Someone at CMS will need to explain to me, how the teaching, curriculum development and evaluation process for the six required ACGME physician skill competencies is not related to patient care. Isn't this exactly what the IOM has criticized our training professions for? In fact, our program currently evaluates us in all these competencies as a continuing quality improvement process DURING patient care. Without time to discuss and reflect our experiences and outcomes we will not be serving the needs of our current and future patients.

Should indeed this come to pass, we will have faculty who will be caught in the productivity race with no time for us. We may get pop-up feed back from an Electronic Health Record in sites that have them that we have made an error or we are not following a guideline. No discussion there. What is being proposed is dangerous for our current patients and our future patients. Our patients deserve for us to have a better education than you are proposing.

Why does the American taxpayer support medical students at over $200,000 per student per year and offers the faculty of residencies less than $15,000 for teaching per resident per year? I am getting a lot more from my residency training to protect and serve my patients of the future than all of medical school combined. Please do not cut us any more – rescind the clarification of this dangerous and capricious rule.

Medical Resident

Submitter : **Mr. Jayson Slotnik**

Date: 06/12/2006

Organization : **Biotechnology Industry Organization**

Category : **Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1543-Attach-1.PDF

#1543

June 12, 2006

BY ELECTRONIC DELIVERY

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

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

Dear Administrator McClellan:

The Biotechnology Industry Organization (BIO) appreciates this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule regarding the hospital inpatient prospective payment systems (PPS) for operating and capital-related costs and fiscal year 2007 rates, published in the Federal Register on April 25, 2006 (the Proposed Rule).[1] BIO is the largest trade organization to serve and represent the biotechnology industry in the United States and around the globe. BIO represents more than 1,100 biotechnology companies, academic institutions, state biotechnology centers, and related organizations in the United States. BIO members are involved in the research and

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1 71 Fed. Reg. 23995 (April 25, 2006).

development of health-care, agricultural, industrial and environmental biotechnology products.

To achieve a goal of making payments to hospitals more fair and accurate, the Proposed Rule would implement the "first significant revision of the inpatient PPS since its implementation in 1983."[2] Although CMS refers to these changes as "refinements" of the DRG system,[3] they are far more substantial than the changes typically discussed in an annual proposed rule. CMS proposes to implement two significant changes to the payment methodology for acute hospital inpatient services: hospital-specific relative value cost center (HSRVcc) weights and severity-adjusted diagnosis related groups (DRGs). Both of these changes involve entirely new methodologies for analyzing hospitals' cost and charge data and assigning services to DRGs and will have considerable impact on payments for many inpatient services.

BIO shares CMS's goal of assuring beneficiary access to services in the most appropriate setting,[4] and we agree that improving the accuracy of Medicare payment systems will help to achieve this goal. BIO has long argued that appropriate payments are critical to protecting patient access to advanced drug and biological products and to promoting continued innovation. In our comments on prior inpatient PPS proposed rules, we have expressed concern that payments under the inpatient PPS were not adequate to ensure that hospitals can provide new technologies to patients. We are hopeful that CMS' attempts to make inpatient PPS rates more accurately reflect the costs of providing care also will include the costs of providing advanced drug and biological therapies.

Although we agree, in principle, with CMS' efforts to make the inpatient PPS more accurate, we are concerned that neither the agency nor independent evaluators have had the time to evaluate whether the Proposed Rule's methodologies are more accurate than the current system. We sincerely appreciate the Herculean efforts made by CMS' staff to complete the new methodology in the Proposed Rule in record time. By CMS' own admission, however, the agency was hard-pressed to complete this proposal for publication this spring and did not have time to confirm fully the accuracy of its methodology or its calculations. In the limited weeks since CMS released the Medicare Provider Analysis and Review File (MedPAR) data upon which the Proposed Rule is based, we are aware of

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2 CMS, Medicare Proposes Payment and Policy Changes for Acute Care Hospital Services to Inpatients, April 12, 2006, http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1833.

3 See, e.g., 71 Fed. Reg. at 23996.

4 CMS, Medicare Proposes Payment and Policy Changes for Acute Care Hospital Services to Inpatients, April 12, 2006, http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1833.

independent evaluations that have attempted to replicate CMS' results. In the course of these replications, questions about CMS' methodology have come to light. It is not clear from the Proposed Rule exactly how CMS applied this methodology to reach the published results. These changes should not be adopted in the inpatient setting until CMS explains its methodology in more detail, the agency and its stakeholders have had the opportunity to analyze the changes more fully, and CMS has responded to stakeholders' input. This explanation and analysis cannot be completed during this comment period or before the final rule is published.

BIO believes that the proposed changes are too significant and too untested to be implemented in 2007. We urge CMS to delay implementation by at least one year to allow the agency and stakeholders more time to assess, refine, and validate these proposals and update claims processing systems. We also recommend that CMS implement a refined DRG weight methodology (rather than the proposed HSRVcc method) and severity-adjusted DRGs at the same time, as recommended by the Medicare Payment Advisory Commission (MedPAC), to minimize distortions in the payment system. Severity-adjusted DRGs should be modified to recognize technologies that represent increased complexity, but not necessarily greater severity of illness. Finally, we urge CMS to reconsider its analysis of applications for new technology add-on payments in light of any methodological changes the agency adopts to ensure that access to innovative therapies is not disrupted during this transition to a new system.

I. CMS should delay implementation of the revised DRG weight methodology for at least one year

BIO recommends that CMS delay implementation of a refined DRG weight methodology for at least one year to allow the agency and stakeholders time to evaluate the proposed methodology, confirm the accuracy of CMS' calculations, and allow hospitals time to adjust to any changes in payment rates. CMS estimates that its entirely new methodology for calculating the HSRVcc weights would reduce the total weights for surgical services by 5.7 percent and increase the weights for medical services by 6 percent,[5] but the effect on individual DRGs can be much larger, ranging from cuts of over 30 percent to increases of more than 80 percent.

Although we believe that all payment rates must be calculated accurately, these dramatic changes raise particular concerns about whether

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5 71 Fed. Reg. at 24020.

Medicare payment truly will reflect the resources involved in providing care. Independent review of the proposed methodology and CMS' calculations is critical to ensure that the new DRG weights are accurate. Given the sheer complexity of the calculations, however, few stakeholders have been able to perform a thorough review of effects of the changes in methodology. Additionally, because CMS' proposal includes significant changes to the methodology developed and tested by MedPAC, CMS cannot rely on MedPAC's analysis to argue that the actual proposed rule methodology results in more accurate payments. In order to ensure that the CMS receives the "comprehensive feedback from hospitals, suppliers, and other stakeholders that will help to refine and improve the final version of the rule,"[6] we need more time to study the data and methodology and work with CMS to resolve our concerns. A delay of at least one year will allow both the public and the agency to evaluate and refine the proposal.

Based on stakeholders' limited review of the proposal, we have learned of serious unanswered questions regarding the methodology. For example, CMS calculates unweighted national geometric mean cost-to-charge ratios (CCRs),[7] rather than CCRs weighted by hospital size. This methodology gives small hospitals' CCRs the same weight as large hospitals' CCRs, although large hospitals have more claims and are more likely to use advanced technologies that could possibly lead to higher CCRs. Because each hospital's CCR is given the same weight, this methodology creates distortions in payments to all hospitals and is likely to harm access to new technologies by failing to account for the true costs of providing care with innovative drugs, biologicals, and devices. We ask CMS to further explain its methodology and work with stakeholders to determine if it is the most accurate way to calculate weights. We also recommend that CMS present any revised weights to the public for independent verification.

Additionally, the proposed methodology assumes that hospitals allocate costs consistently to certain cost centers. In practice, however, many hospitals assign costs to their cost centers in non-standard ways and provide cross-walks with their cost reports. The assignments do not reflect the departments to which charges are assigned in the MedPAR data. The accuracy of the proposed methodology relies on a uniform mapping of costs and charges to cost centers. Delaying implementation of a refined DRG weight methodology by at least one year would allow CMS time to study the effects of non-standard cost mappings on the results.

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6 CMS, Medicare Proposes Payment and Policy Changes for Acute Care Hospital Services to Inpatients, April 12, 2006, http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1833.

7 71 Fed. Reg. at 24010.

We also are concerned that the HSRVcc weight methodology relies on out-of-date data that do not include the costs of many newer treatment options. CMS used fiscal year 2003 cost report data and fiscal year 2005 MedPAR data to calculate the HSRVcc weights.[8] This means that cost data from October 2002 will be used to set payments in effect five years later, in September 2007. CMS' efforts to clean the data and eliminate outliers may have removed many large hospitals' claims, which include advanced technologies, from the calculations. We recommend that CMS explain further how its methodology will ensure that all hospitals' costs are included in refined DRG weight methodology calculations.

Finally, we request a delay to allow hospitals enough time to make the budgetary and administrative adjustments necessitated by the new weights. CMS proposes to implement the HSRVcc weights for payment for services beginning October 1, 2006.[9] This proposal would give hospitals and other stakeholders only the 60-day comment period to evaluate this methodology and only a few weeks after the final rule is published to plan for payment changes, adjust their budgets, and implement and test billing system revisions. This simply is not enough time for hospitals to adapt to these substantial changes to the Medicare inpatient payment system. A delay of at least one year will help to ensure that hospitals are prepared for them.

II. CMS should implement the severity of illness DRGs at the same time as the refined DRG weight methodology and should include a method of recognizing technologies that increase complexity of care (DRGs: Severity of Illness)

In addition to substantial changes to the DRG weights, CMS proposes to refine DRGs based on severity of illness in 2008 or earlier.[10] BIO agrees with MedPAC's recommendation that any severity-based DRGs be implemented at the same time as a refined DRG weight methodology. In March 2005, MedPAC recommended four policy changes to make payments more accurate: (1) use hospital-specific relative value weights instead of charge-based weights; (2) use refined DRGs that account more completely for differences in severity of illness among patients; (3) use weights based on estimated costs of providing care instead of charges; and (4) account for differences in frequency of outliers across patient

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8 Id. at 24008, 24045.
9 Id. at 23996.
10 Id. at 23966.

categories.[11] MedPAC found that these four changes, taken together, have the best potential to make payments more accurate.[12] MedPAC recently reiterated this conclusion in comments on the Proposed Rule in which it explained that each recommendation "targets a specific source of distortion in the current payment rates. . . . Failure to adopt any of them would leave some payment distortions in place."[13] Implementing a refined DRG weight methodology without the severity-adjusted DRGs not only would allow potential payment distortions to continue, it could create additional instability in payment rates. We urge CMS to implement any changes to the inpatient PPS as smoothly as possible by implementing both the severity-adjusted DRGs and a refined DRG weight methodology, as revised with stakeholder input, at the same time.

As CMS continues to develop the severity-adjusted DRGs, BIO urges the agency to include in this system a method of recognizing technologies that represent increased complexity, but not necessarily greater severity of illness. We agree with CMS' conclusion that such a method is necessary.[14] For many years, BIO has advocated for better recognition and more appropriate payment of advanced technology in the inpatient PPS. We are pleased that CMS recognizes that factoring complexity of care into the severity-adjusted DRGs would be one method of addressing this concern. BIO believes such an adjustment is particularly important in light of the fact that the five-year old cost data used to create the HSRVcc weights does not include many currently used therapies.

Complexity must be factored into DRG groupings to ensure that hospitals will be appropriately reimbursed for providing advanced treatments to all of their patients, regardless of the severity of the patient's condition. For example, for fiscal year 2004, CMS made an important policy change to ensure that Proleukin (high-dose IL-2), a therapy for patients with metastatic renal cell cancer or malignant melanoma that is administered primarily in the inpatient setting, was appropriately reimbursed. This change was imperative to ensure that Medicare beneficiaries continued to have access to the therapy because the prior DRG assignment so dramatically under-reimbursed for the therapy that programs across the country were threatened. Now CMS' proposed implementation of the severity-adjusted DRGs would reverse the agency's prior policy decision. Specifically, although patients must be in relatively good health to receive Proleukin, and thus

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11 Medical Payment Advisory Commission, Report to the Congress: Physician-Owned Specialty Hospitals, March 2005, at 36.

12 Id. at 37.

13 Letter from Glenn M. Hackbarth, Chairman, MedPAC, to Mark McClellan, Administrator, CMS, April 19, 2006, at 4.

14 71 Fed. Reg. at 24014.

would map to low severity DRGs in the new proposed system, the treatment itself is complex and requires careful management of its potentially severe side effects. Under the proposed severity-adjusted DRGs, these patients would map to CSA-DRG 736 (chemotherapy SOI 2) or CSA-DRG 737 (chemotherapy SOI 3). Because these DRGs were created without regard for the complexity of care, they fail to account for the costs of providing this therapy. As proposed, payment for treatment with Proleukin would fall from $16,925 in 2006 (DRG 492) to $5,187 (CSA-DRG 736) or $13,529 (CSA-DRG 737), cuts of 69 percent and 20 percent, respectively. If these cuts are implemented, many hospitals may not be able to continue to provide Proleukin, the only possibility of long-term survival for patients with metastatic renal cell cancer or malignant melanoma.

BIO is also concerned that the proposed severity-adjusted DRGs would reverse the important policy change finalized last year to create DRG 559, Acute Ischemic Stroke with Use of a Thrombolytic Agent. This policy change allows hospitals to be reimbursed for the additional costs of caring for more complex stroke patients in need of thrombolytic therapy. As CMS stated in last year's final rule: "We agree... that there is an increased cost in caring for these [stroke tPA] patients including increased use of the intensive care unit, more diagnostic imaging studies, and laboratory and pharmacy resources. We also agree that-(1) the data indicate that patients receiving thrombolytic therapy have increased severity; and (2) reperfusion therapy is a good means to segregate these patients into a separate DRG." (Federal Register, Vol. 70, 47288, August 12, 2005.) However, the proposed severity-adjusted DRGs would essentially reverse this DRG change by assigning stroke patients receiving reperfusion therapy to CSA-DRGs 56-58 with other less severe stroke patients. Overall, we estimate that hospitals would experience a weighted-average 35 percent reduction for treating thrombolytic patients compared to FY 2006 if such a policy were finalized. We urge CMS to carefully examine the proposed severity-adjusted DRGs to ensure that these and other potential problems are addressed and allow for adequate public notice and comment on these changes during the FY 2008 regulatory process.

Until CMS develops a method of recognizing complexity in the severity-adjusted DRG system and makes available for comment any criteria for determining how and when to recognize increased complexity in the structure of the DRG system, CMS should not implement the severity-adjusted DRGs.

III. As CMS implements the severity of illness DRGs and HSRVcc weights, it must protect access to innovative therapies (New Technology)

The biotechnology industry provides innovative and potentially life-saving technologies for Medicare beneficiaries. When new technologies come to market, however, inadequate payment can pose a barrier to their use. Under the current and proposed DRG payment systems, it may take two or three years for the increased costs associated with the use of new technologies to be reflected in DRG payment rates. New technology add-on payments can provide support to hospitals while ensuring access to the highest quality of care for Medicare beneficiaries. In order to preserve patient access to cutting-edge care, it is critical for CMS to use the add-on payment mechanism appropriately for qualified new technologies and services under the current payment methodology as well as in whatever new methodology is adopted in the future.

In the Proposed Rule, CMS discusses several technologies that have received or have applied for new technology add-on payments but does not describe how the changes to DRG weights and groupings will affect these payments.[15] Because the regulations make new technology payments available only if the technology is inadequately paid under the DRG system,[16] changes in the rates or definitions of DRGs would affect CMS' assessment of whether a technology is adequately reimbursed. CMS also acknowledges that a method of including complexity in the severity-adjusted DRGs would "interact with the existing statutory provisions for new technology add-on payments."[17] Before CMS implements a refined DRG weight methodologyand severity-adjusted DRGs, we ask the agency to examine the effect of these changes on new-technology add-on payments. In particular, we urge the agency to reconsider recent applicants for new technology add-on payments in light of any methodological changes CMS adopts in the inpatient PPS.

We also believe that implementation of the International Classification of Diseases, 10th Revision (ICD-10) coding system is a critical element of any effort to improve the accuracy of inpatient PPS reimbursement, especially for new technologies. This revised coding system offers more granularity than the ICD-9, allowing hospitals to describe their patients' conditions and the care provided in greater detail. As hospitals submit claims using these

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15 Id. at 24068.
16 42 C.F.R. § 412.87(b)(3).
17 71 Fed. Reg. at 24014.

codes, CMS will be able to use this data to set more accurate payment rates. The ICD-10 also will improve CMS' ability to recognize new technologies and reimburse hospitals appropriately for their use. Unlike the ICD-9, which is running out of codes, the ICD-10 can be expanded to add new codes as new technologies and procedures are developed. BIO recommends that CMS adopt the ICD-10 as soon as possible to ensure that the inpatient PPS can continue to recognize new technologies and to help CMS set appropriate rates for all services.

BIO reiterates its request that CMS correct its narrow interpretation of the new technology add-on provisions. As we have explained in prior years' comments, CMS' statements that the two to three-year period for new technologies to receive add-on payments begins on the date the technology is approved by the Food and Drug Administration (FDA)[18] is contrary to both the statute and CMS' own regulations. The statute clearly requires data collection and add-on payments beginning the "date on which an *inpatient hospital code* is issued with respect to the service or technology."[19] The regulation implementing this section acknowledges that an "inpatient hospital code" is an International Classification of Diseases – 9th Revision – Clinical Modification (ICD-9-CM) code and requires a medical service or technology to be considered new within two or three years after the "point at which data begin to become available reflecting the ICD-9-CM code assigned to the new service or technology (depending on when a new code is assigned and data on the new service or technology become available for DRG recalibration).)"[20] Neither the statute nor the regulation refers to the date of FDA approval in determining whether a technology is "new." By using the date of FDA approval instead of the date of issuance of an ICD-9-CM code, CMS risks denying add-on payments to new technologies and cuts short its opportunity to collect data on the technologies that receive add-on payments. BIO again urges CMS to protect beneficiaries' access to these technologies as Congress intended by using the issuance date of a new code, not the date of FDA approval, as the starting date for new technology status.

We also urge CMS to revise the new technology add on formula to better reflect true provider costs and provide payment equity across treatment settings. The current payment formula chosen by CMS does not adequately reimburse providers for use of the new service or technology.

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18 Id. at 24068.
19 Social Security Act § 1886(d)(5)(K)(ii)(II) and (III) (emphasis added).
20 42 C.F.R. § 412.87(b)(2).

Currently, once a new service or technology has been granted new technology add on status, "Medicare pays a marginal cost factor of 50 percent for the costs of a new medical service or technology in excess of the full DRG payment. If the actual costs of a new medical service or technology case exceed the DRG payment by more than the 50-percent marginal cost factor of the new medical service or technology, Medicare payment is limited to the DRG payment plus 50 percent of the estimated costs of the new technology."[21]

This approach does not adequately compensate the hospitals for the new service, as in most cases they receive only half of the cost of the new technology. Given that so few technologies have met the new technology add on standard set by CMS, it would make more sense for CMS to fully compensate hospitals for those few technologies that do meet the new technology add on standards. This could be accomplished by paying on a cost basis, which could be ASP+6% for FDA approved drugs and biologicals and list price plus a percentage for devices. The use of ASP+6% for drugs and biologicals or list price plus a percentage for devices as the payment formula would ensure that providers recoup their costs, Medicare pays a fair rate, and that payment is harmonized across treatment settings.

Finally, in some instances, existing therapies have new FDA-approved indications or new therapies are appropriately captured under existing ICD-9-CM codes. We request that CMS provide clear guidance and greater transparency as to how a determination of "new" will be made when these technologies meet the substantial clinical improvement and cost thresholds of the new technology provision.

IV. Conclusion

BIO appreciates this opportunity to comment on our concerns about the Proposed Rule, and we look forward to working with CMS to protect Medicare beneficiaries' access to new and advanced therapies. Toward this end, we urge CMS to delay implementation of the significant changes it has proposed in this rule for at least one year until we and other stakeholders have more time to assess, refine, and validate them. In addition, we recommend that CMS implement the refined DRG weight methodology and the severity-adjusted DRGs at the same time and find a way to modify these methodologies to pay more appropriately for advanced technologies, particularly those that increase complexity. Please contact

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21 70 Fed. Reg. 47342 (August 12,2005)

Jayson Slotnik at 202-312-9273 if you have any questions regarding our comments. Thank you for your attention to this very important matter.

Respectfully submitted,

/s/

Jayson, Slotnik, Director, Medicare
Reimbursement and Economic Policy
Biotechnology Industry Organization

Submitter : **Dr. Stan Bradshaw** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

CMS-1488-P-1544-Attach-1.DOC

#1514

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

Submitter :

Date: 06/12/2006

Organization : **Consumer-Purchaser Disclosure Project**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

See attached comments from Consumer-Purchaser Disclosure Proejct on Hospital Quality Data, Value-Based Purchasing, and Health Care Information Transparency Initiative.

CMS-1488-P-1545-Attach-1.DOC

#1545

Consumer-Purchaser
DISCLOSURE
PROJECT Improving Health Care Quality through Public Reporting of Performance

June 12, 2006

Mark McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Ave., NW
Washington, DC 20201

File Code: CMS-1488-P (Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 Rates)

RE: Comments on Medicare Hospital Reporting and Payment Policies:
- Hospital Quality Data;
- Value-Based Purchasing; and
- Health Care Information Transparency Initiative

Dear Dr. McClellan:

Thank you for the opportunity to comment of the proposed changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 Rates. We applaud your efforts to promote and foster increased transparency and we believe that Medicare should lead the way to promoting a market that recognizes and rewards high-quality, efficient, equitable, and patient-centered care. Some overarching comments introduce responses to specific questions on three sections of the proposed rules that address hospital quality data, value-based purchasing, and the health care information transparency initiative.

OVERARCHING COMMENTS

The Federal Government must support the development and endorsement of a robust set of hospital (and other provider) performance measures: Medicare should evaluate the performance of each health care provider that bills Medicare, using nationally-endorsed, scientifically-valid, risk-adjusted, and regularly-updated measures that address:
- Clinical quality (safe, timely, and effective care);
- Efficiency (prices and resource use over time);
- Equity (gender, race, ethnicity); and
- Patient-centeredness.

There is currently a huge need for more nationally endorsed standardized measures in these areas.

Recommended Actions
- HHS or CMS should provide substantial and ongoing funding to support development of consumer-relevant measures that fill existing gaps (especially efficiency, patient-centered/continuum of care, and equity). Developing measures is a public good that requires significant financing from the public sector. Because of

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the lack of well-specified and endorsed measures that meet consumers' and purchasers' needs, the federal government should specifically support the rapid development of measures that are:

- Reasonably scientifically acceptable. Consumers and purchasers want measures to be scientifically sound and evidence-based, but do not want the pursuit of perfection to delay the availability of good and useful information.
- Feasible to implement. Rapid reporting necessitates measures are constructed and specified so that the data needed are currently available or can be collected with limited reporting burden.
- Relevant to consumers and purchasers. The needs of consumers and purchasers for important and actionable information must drive the development of measures.
- Reflect the continuum of care/care coordination from a patient's perspective. Measures should address the extent to which comprehensive, patient-centered care is delivered, often by multiple providers and across multiple settings.

- HHS or CMS should provide core ongoing operating support for the National Quality Forum (NQF) to ensure an ongoing, independent consensus process reviews, endorses, and updates measures to enable the availability of comparative information and the reduction of provider reporting burden.

CMS should ensure that measures are reported publicly to foster improvement, accountability and consumers' ability to make better informed decisions. Medicare should provide the public with the information on the aspects of provider performance described above. Doing so, will allow: 1) consumers to make informed decisions about their health care; 2) insurers and purchasers to make value-based contracting decisions and use differential payments as incentives; and 3) providers' improvement efforts to be supported with better information.

Recommended Actions

- CMS should immediately make available physician-identifiable Medicare claims data (fully protecting patient privacy), to allow for better quality and efficiency performance reporting.
- CMS should continue to allow private-sector organizations to have full access to provider performance information from the CMS Compare websites.
- CMS should require that hospital claims data submissions be augmented with clinical data elements to enable a better understanding of patient acuity and more robust quality reporting.

CMS should implement financial incentives that are sensitive to the provision of high-quality, efficient, equitable, and patient-centered care: Medicare should phase in a system that differentially pays providers based on nationally standardized measures.

Recommended Actions

- Continue to rapidly expand the number and type of measures that hospitals must report to obtain annual payment update.
- Medicare payments must be sensitive to provider performance and create financial incentives to more efficiently provide higher quality care.
- Incentives should take into account performance on quality, efficiency, equity, and patient experience.
- Provider incentives should be budget-neutral and, in the near-term, based on a combination of improvement and meeting thresholds.

What follow are specific comments on the three sections that address hospital quality data, value-based purchasing, and the health care information transparency initiative.

SECTION: HOSPITAL QUALITY DATA

Reporting of Hospital Quality Data for Annual Hospital Payment Update
Fiscal Year 2007: We support CMS' recommendation to reduce the FY 2007 annual hospital payment update by 2% for any hospital that does not submit data on 21 measures (8 heart attack, 4 heart failure, 7 pneumonia, 2 surgical infection prevention) for patients discharged starting January 1, 2006 through December 31, 2006.

Fiscal Year 2008: CMS must do far more than merely "explore the feasibility of adopting additional measures for FY 2008 update, including HCAHPS." There should be a **substantial** expansion of measures for hospitals to obtain the FY 2008 annual update. We strongly urge that CMS adopt the measures identified in the Institute of Medicine's *Performance Measurement: Accelerating Improvement*, i.e., Hospital-CAHPS and three structural measures (computerized provider order entry, intensive care staffing with intensivists, and evidence-based hospital referral) as well as consider and adopt as many additional NQF-endorsed measures as can be feasibly collected, for example:

Outcomes
- 30-day heart failure mortality
- 30-day heart attack mortality
- Failure to rescue

Complications
- Urinary catheter-associated infection rate
- Central line-associated blood stream infection rate
- Ventilator associated pneumonia rate

Clinical
- Surgery patients with recommended venous thromboembolism prophylaxis ordered
- Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hour prior to surgery to 24 hours after surgery.

Procedures for Validating Hospital Compare Date (pages 337-343): As CMS continues to work to ensure the accuracy of the information posted on the Hospital Compare website, the methodology adopted should be fully transparent to allow all stakeholders to clearly assess hospital-level reliability. CMS should also engage representatives from the research, provider, and consumer communities to obtain input on the different potential methodologies and their impact on data validity, accuracy, and completeness.

Electronic Medical Records (p. 343)
Health information technology (HIT) – which includes software applications for care management (EMR, EHR, practice management systems, registries) – has the potential to dramatically improve the quality and efficiency of health care, however implementation has been slow. In addition, if appropriately implemented, HIT can and should serve as the platform for the collection of information to supply future performance measurement, reporting and payment systems. The Secretary should ensure that the data necessary for quality measurement are captured by using conditions of participation that require hospitals to implement HIT/software applications that:

- Comply with interoperability standards;
- Adequately protect privacy and confidentiality of patient data;
- Enable standardized quality, performance, and efficiency measurement as a routine by-product of their use; and

- Are designed to enable the merger of their data with others in both the public and private sectors for the purpose of facilitating the production of standardized quality, performance, and efficiency information.

[NOTE: Adapted from AQA Data Sharing and Aggregation Subgroup on HIT: www.ambulatoryqualityalliance.org/files/PrinciplesforHITandMeasAgg-May06.doc]

Further, the Secretary should tie the annual hospital payment update to the reporting of hospitals' progress toward CPOE implementation (see previous comments under Hospital Quality Data for Annual Payment Update).

Until HIT becomes wide-spread the Secretary can enable much more robust hospital performance reporting by requiring hospitals to report the following data elements on both paper and electronic claims:

- A unique physician identifier for each coded procedure;
- Capture the referring/ordering physician for each coded procedure;
- Vital signs (heart rate, blood pressure, temperature, and respiratory rate) recorded at presentation;
- Key lab values (BUN, hematocrit, platelets, WBC, sodium, potassium, and creatinine) if obtained at the time of admission, excluding hospitalizations for psychiatric, obstetrical and newborn services;
- Do Not Resuscitate order present (including date and time), if recorded during first 24 hours of patient presenting; and
- Time of day of admission, discharge, and each procedure.

SECTION: VALUE-BASED PURCHASING

Plan for Implementing Hospital Value-Based Purchasing Beginning with FY 2009
As CMS works to develop a plan to implement hospital value-based purchasing beginning in FY 2009, the following issues must be addressed: (a) the ongoing development, selection, and modification process for hospital quality and efficiency measures; (b) the reporting, collection, and validation of data; (c) the structure of payment adjustments; and (d) the disclosure of hospital performance information.

Measure development and refinement (p.350-353)
As noted in our overarching comments, the development of consumer relevant measures is critical and the Secretary should provide substantial funding to support development of consumer-relevant measures that fill existing gaps (especially efficiency, patient-centered/continuum of care, and equity). Developing measures is a public good that requires significant financing from the public sector. Because of the lack of well-specified and endorsed measures that meet consumers' and purchasers' needs, the federal government should specifically support the rapid development of measures that are:

- Reasonably scientifically acceptable. Consumers and purchasers want measures to be scientifically sound and evidence based, but do not want the pursuit of perfection to delay the availability of good and useful information.
- Feasible to implement. Rapid reporting necessitates measures are constructed and specified so that the data needed are currently available or can be collected with limited reporting burden.
- Relevant to consumers and purchasers. The needs of consumers and purchasers for important and actionable information must drive the development of measures.
- Reflect the continuum of care/care coordination from a patient's perspective. Measures should address the extent to which comprehensive, patient-centered care is delivered, often by multiple providers and across multiple settings.

HHS or CMS should provide core operating support for the NQF to ensure ongoing, independent consensus process for the review, endorsement, and updating of measures so as to enable the availability of comparative information and the reduction of provider reporting burden.

Incentive Methodology (p. 357-367)
Incentive Structure: Incentives should initially be based on a combination of improvement and meeting performance thresholds based on standard measures adhering to the Consumer-Purchaser Disclosure Project's *Guidelines for Measurement of Provider Performance* (*http://healthcaredisclosure.org/docs/files/Guidelines.pdf*). Current experience indicates that shifting over time to basing incentives on attaining specific performance-based thresholds allows hospitals (including those serving disenfranchised populations or unique communities) an opportunity to meet targeted performance levels and focus their efforts on those that would yield the most improvement. Because of the evidence that performance dramatically varies within hospitals, incentives should be available and calculated both at the service-line level (e.g., for specific clinical areas) and hospital-wide (e.g., for H-CAHPS).

Many private sector incentive programs, operated by health plans and other organizations, such as The Leapfrog Group's "Leapfrog Hospital Rewards Program", reward both *top performers* and *performance improvers*. The goal is to provide incentives for hospitals to improve continuously and to sustain that improvement once it is achieved. As Medicare moves to institutionalize performance-based payment, it should consider how to use baseline thresholds of performance and the potential of relative comparisons to help all hospitals make improvements appropriate to their current level of performance.

Level of Incentive: The share of payment tied to performance should be substantial. Clearly what constitutes "substantial" will differ from one type of provider to another (i.e., the same percentage may not be appropriate for both hospitals and physicians). Initially, we believe that the performance incentive for hospitals should be on the same order of magnitude as the level of incentive that rewards public reporting for the FY07 annual market basket update, which is 2% of total Medicare payments. The overall proportion of CMS payments to hospitals that are directly linked to performance should grow significantly over time and could eventually reach a level so that 10% or more of total Medicare payments is sensitive to performance. CMS should set and revise the appropriate level using the information that continues to develop from its implementation of performance-based payments for all hospitals, its demonstration projects, and from private-sector efforts.

Source of Incentive: Performance incentives should be budget neutral. Providing additional funding to finance performance incentives is an unrealistic option given the current economic and cost pressures faced by CMS. One central way to ensure budget-neutrality is to measure and report comparative information and base hospital incentives on efficiency as one of a number of different performance domains.

Development of Composite Scores: The development of composite scores is critical to help consumers integrate complex information into their decision making. Below, we outline additional work that needs to be done around the development and display of composites (see Public Reporting section), but consumer testing should be a key factor in CMS's assessment of alternative methodologies, i.e., "appropriate care measures" versus the "opportunity model." [Note: It is our understanding that in initial testing done by Mathematica for CMS in July, 2005, consumers preferred composites based on the appropriate care measure.]

Public Reporting (p. 362)

CMS should further stimulate public reporting to increase the transparency and meaningfulness of health care performance information by taking the following actions:

- Continue to allow private-sector organizations to have full access to provider performance information from the CMS Compare websites.
- Support further research and consumer testing around the development and display of measure composites, including how different tiers of composite scores could be constructed. (E.g., a total, overall score combining clinical quality, patient experience, and efficiency; a score on each of those three respective domains, and a composite by service line, such as diabetes, cardiac care, etc.)
- While improving the utility of the CMS Compare websites through using composites and presentation of providers that shows their differential performance, CMS should maintain the ability for consumers to "drill down" to a granular level of performance detail.

Beyond these suggested actions, we would call your attention to the Principles for Public Reporting of Health Care Information that were developed and endorsed by the members of the AQA (formerly the Ambulatory Care Quality Alliance) as an additional useful reference. These Principles can be found at:
http://www.ambulatoryqualityalliance.org/files/ConsumerPrinciplesMay06.doc

Hospital Acquired Infections (p. 363)
Given the tremendous toll – both human and financial – caused by hospital-acquired infections, the Secretary should do more than meet the statutory minimum of identifying "at least two conditions that are (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines." The Secretary should work with those states that currently collect the "Present on Admission" identifier (e.g., California and Pennsylvania) to determine all those conditions that meet the above criteria and implement policies by which hospitals would have payments adjusted for any care that could have reasonably been prevented in the hospital had evidence-based care been provided.

With the requirement for hospitals to submit the secondary diagnoses that are present on admission for discharges after October 1, 2007, we anticipate much more robust hospital outcomes reporting due to the increased ability to differentiate co-morbidities from complications.

Promoting Effective Use of HIT (p. 364)
Health information technology (HIT) – which includes software applications for care management (EMR, EHR, practice management systems, registries) – has the potential to dramatically improve the quality and efficiency of health care, however implementation has been slow. In addition, if appropriately implemented, HIT can and should serve as the platform for the collection of information to supply future performance measurement, reporting and payment systems. The Secretary can spur HIT adoption and ensure that the data necessary for quality measures are captured by using conditions of participation that require hospitals to implement HIT/software applications that:

- Comply with interoperability standards;
- Adequately protect privacy and confidentiality of patient data;
- Enable standardized quality, performance, and efficiency measurement as a routine by-product of their use; and
- Are designed to enable the merger of their data with others in both the public and private sectors for the purpose of facilitating the production of standardized quality, performance, and efficiency information.

[NOTE: Adapted from AQA Data Sharing and Aggregation Subgroup on HIT: www.ambulatoryqualityalliance.org/files/PrinciplesforHITandMeasAgg-May06.doc]

Further, the Secretary should tie the annually hospital payment update to the reporting of hospitals' progress toward CPOE implementation (see previous comments under Hospital Quality Data for Annual Payment Update).

Until HIT becomes wide-spread the Secretary can enable much more robust hospital performance reporting by requiring hospitals to report the following data elements on both paper and electronic claims:

- A unique physician identifier for each coded procedure;
- Capture the referring/ordering physician for each coded procedure;
- Vital signs (heart rate, blood pressure, temperature, and respiratory rate) recorded at presentation;
- Key lab values (BUN, hematocrit, platelets, WBC, sodium, potassium, and creatinine) if obtained at the time of admission, excluding hospitalizations for psychiatric, obstetrical and newborn services;
- Do Not Resuscitate order present (including date and time), if recorded during first 24 hours of patient presenting; and
- Time of day of admission, discharge, and each procedure.

SECTION: HEALTH CARE INFORMATION TRANSPARENCY INITIATIVE

As the Department builds upon its current transparency efforts, we would encourage the Secretary to increase both the scope and breadth of consumer-friendly cost and quality information by employing the following strategies. The critical need to directly link, wherever possible, consumers' cost information with quality information reinforces the importance of the federal government supporting the development and endorsement of a robust set of hospital (and other provider) performance measures (see "Overarching Comments").

Actions the federal government should take to increase the breadth and scope of performance information available to the public include:

- Making available physician-identifiable Medicare claims data (fully protecting patient privacy), to allow for better quality and efficiency performance reporting.
- Continue to allow private-sector organizations to have full access to provider performance information from the CMS Compare websites.
- Release the risk-adjusted DRG rates for every hospital (and rates for physicians), by region in easily accessible formats.
- Develop BOTH total costs of episodes AND total estimated beneficiary out-of-pocket costs for episodes of care (with estimates for beneficiaries with and without Medigap supplemental coverage). This release should include contextual and background information that makes clear the relevance of Medicare costs to beneficiaries to their circumstance (e.g., having Medigap plan) or to commercially insured individuals.
- Price information should be presented in a manner that reflects the following principles:
  - **Linked directly to Quality measures** (outcomes, patient experience, compliance with evidence-based medicine). Whenever possible price information should be directly linked to quality information to facilitate total value consideration by the consumer. When it cannot be, there should be context and background (including that price does not correlate to quality, i.e., more expensive does not mean better and less expensive does not mean worse).
  - **Understandable**: Information should be "transmissible", that is, it can be communicated from one consumer to another and must recognize that different consumer audiences will have different information seeking and comprehension skills.
  - **Actionable**: Information should include relevant comparisons of providers based on quality and cost; link to a consumer being able to select a particular option; and should provide context and background on how to not just compare price of providers/treatments selected, but information on potentially relevant alternatives.
  - **Accessible**: Should be available on-line with no barriers and designed for ease of use.
  - **Relevant to consumers' circumstances** (health and coverage status): Information should be useful in the context of an individual's or family's particular health coverage and health status (including potentially a discrete condition OR considering a combination of conditions).
  - **Predictive (accurate)**: Information should predict likely expense accurately and/or have clear explanation of the reason for range of cost variation.

CMS/HHS should consider using the following mechanisms to further enhance transparency of quality and cost information by:

- Establishing conditions of participation for hospitals that require posting of prices and/or policies regarding discounts and other payment options for uninsured patients. For insured individuals, health plans will likely be the primary vehicle for information that is specific to their condition or coverage, but CMS should play a

central role in ensuring that the uninsured have access to information relevant to their circumstances, though true transparency and informed consumer decision-making will require actionable tools.

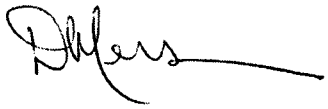
- The Administration through its various contracting mechanisms with health plans (via OPM or Medicare), should ensure they are providing tools for enrollees to make informed choices, considering both quality and costs.

- Requiring hospitals to augment claims form with additional clinical data elements. Accurately assessing provider performance would be greatly enhanced if the severity of the patient's condition could be captured from administrative claims data. The public reporting of quality and cost information would benefit greatly from claims data with richer detail. Adding the following data elements to the inpatient paper and electronic claim form would enable much more robust hospital outcomes reporting:
  - A unique physician identifier for each coded procedure;
  - Capture the referring/ordering physician for each coded procedure;
  - Vital signs (heart rate, blood pressure, temperature, and respiratory rate) recorded at presentation;
  - Key lab values (BUN, hematocrit, platelets, WBC, sodium, potassium, and creatinine) if obtained at the time of admission, excluding hospitalizations for psychiatric, obstetrical and newborn services;
  - Do Not Resuscitate order present (including date and time), if recorded during first 24 hours of patient presenting; and
  - Time of day of admission, discharge, and each procedure.

Again, thank you for the opportunity to comment.

Sincerely,

Peter V. Lee
Disclosure Project Co-Chair
Chief Executive Officer
Pacific Business Group on Health



Debra L. Ness
Disclosure Project Co-Chair
President
National Partnership for Women & Families

Submitter : **Dr. Mark Mabee** **Date: 06/12/2006**

Organization : **Yankton Medical Clinic**

Category : **Individual**

Issue Areas/Comments

GME Payments

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.

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,

Mark Mabee MD

Submitter : **Mrs. Kelly Slone** **Date: 06/12/2006**

Organization : **National Venture Capital Association**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1547-Attach-1.PDF

#1547

National Venture Capital Association

June 12, 2006

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

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

Dear Dr. McClellan:

The National Venture Capital Association (NVCA) appreciates this opportunity to comment on the proposed Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates, as issued by the Centers for Medicare and Medicaid Services (CMS) on April 25, 2006.

NVCA applauds your continued commitment to modernizing the health care delivery system, as well as your efforts to bring innovative medical technologies to market as rapidly as possible. The venture capital community works closely with many of the companies developing these new technologies. The NVCA therefore offers a unique and important perspective on several of the issues raised in the proposed rule. NVCA proposes to work closely with CMS to develop a refined pathway for Medicare coverage and reimbursement of new technologies used in the inpatient setting, including innovative new medical devices, drugs, and biological products.

Background on the National Venture Capital Association

The National Venture Capital Association is the trade association that represents the U.S. venture capital industry. NVCA's mission is to foster greater understanding of the importance of venture capital to the U.S. economy and to support entrepreneurial activity and innovation. The NVCA advances the common interests of the venture capital community by maintaining high professional standards, providing reliable information and data regarding our industry, sponsoring professional development, and facilitating interaction among Association members.

The life sciences industry has traditionally been one of the largest sectors of investment for venture capitalists, in 2004 totaling almost $6 billion, or approximately 30% of all venture capital dollars invested. It is estimated that more than 100 million Americans have benefited from innovations developed by life sciences companies originally financed with venture capital.

Many such innovations have revolutionized the practice of medicine by helping physicians detect diseases earlier, treat chronic diseases, and reduce mortality. For example, innovations in treating heart disease—the leading cause of death in the U.S.—such as angioplasty, minimally invasive by-pass, and implantable defibrillators, were all originally pioneered by venture-backed companies. Much of the current innovation in medical technology is focused in particular on replacing surgery with minimally invasive or noninvasive procedures that eliminate or substantially reduce the need for cost-intensive hospitalization and inpatient services. Such cost-effective technologies have dramatically improved the quality of life for millions of patients by lengthening their productive years, decreasing the incidence and duration of disability, and ultimately extending life expectancy.

Venture capital investment is especially important for the life sciences industry because of the significant time and expense associated with bringing innovative new technologies to market. Due to the high costs of clinical trials required to satisfy FDA safety standards, life sciences companies tend to require greater investment than startup companies in other industries. In most cases, these costs must be incurred before the company starts generating revenue. Further, due to the long span of time before any return on investment is typically realized, as well as the high degree of risk involved, investment by individuals is usually insufficient, and investment from banks and public capital markets is unlikely. Venture capital is thus the only viable source of funding to support the development of the majority of life sciences innovations.

DRGs: Severity of Illness

NVCA has long been concerned that the diagnosis-related group (DRG) assignment system does not always adequately capture the costs of many new technologies and that, as a result, hospitals are often not appropriately reimbursed. CMS's proposal to undertake the largest overhaul in the history of the DRG system presents an opportunity to address this problem. The proposed rule would modify the DRG classification system to better recognize the severity of illness among patients. Specifically, CMS proposes to refine the system by consolidating the 1,258 All Patient Refined Diagnosis Related Groups (APR-DRGs) into 861 severity-adjusted DRGs. NVCA supports this proposed reform.

NVCA is concerned, however, that the proposed APR-DRG system does not explicitly recognize technologies that involve increased complexity in the absence of greater severity of illness. For example, CMS currently uses separate DRGs for coronary angioplasty with and without the insertion of stents. However, the APR-DRGs do not differentiate between the two. By accounting for complexity in DRG assignment, CMS would help to ensure that hospitals provide optimal treatment to each patient notwithstanding the relative severity of his or her condition. Indeed, the proposed rule acknowledges that reform of the DRG system should incorporate "*a method of recognizing technologies that represent increased complexity*" of particular products. To that end, CMS solicits comments on the development of "*criteria for determining when it is appropriate to recognize increased complexity in the structure of the DRG system and how these criteria interact with existing statutory provisions for new technology add-on payments.*" 71 Fed. Reg. 24014 (April 25, 2006).

NVCA is pleased that CMS recognizes the importance of both making the DRG system more granular and accounting for the complexity of new technologies in DRG assignments. Many new technologies, particularly medical devices, are used in the hospital inpatient setting, and payment is bundled into the applicable DRG. Hospitals are often reluctant to use new technologies, however, when they are not accompanied by an increase in hospital payment. This in turn limits the utilization of many new technologies that benefit patients and, by reducing medical complications and readmission rates, provide potential long-term cost savings to Medicare.

An inpatient procedure that uses a new technology with increased complexity should be assigned to a DRG with a higher payment weight. Under the current inpatient system, complexity is classified by CMS according to the type and relative volume of diagnostic, therapeutic, and bed services required for the treatment of a particular illness.

Additional factors that CMS could consider when evaluating the complexity of a new technology for DRG assignment include:

- whether the technology entails clinically meaningful advantages over existing approved alternative treatments;
- whether the technology represents a breakthrough that provides a clinically meaningful advantage over existing technology; and
- the absence of an approved alternative treatment or means of diagnosis.

New Technology

NVCA expresses its strong support for the new technology add-on payment, and commends CMS for its efforts to open the process to the public. Congress has expressed its expectation that CMS will utilize the new technology add-on payment. Until recently, such payments were subject to the budget neutrality requirements of the inpatient hospital prospective payment system. However, section 503(d)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 removed this requirement, providing that "there shall be no reduction or other adjustment in payments under section 1886 of the Social Security Act because an additional payment is provided under subsection (d)(5)(ii)(III) of such section." Congress clearly intended this affirmative exemption to encourage the approval of additional payments.

As it is currently administered, however, the new technology add-on payment is flawed and underutilized. Relatively few products have been approved for such payments, and the payments themselves are often quite limited. To qualify for a new technology add-on payment, (1) the product must be "new"; (2) the product must represent a "substantial clinical improvement" over existing products; and (3) the cost of cases in which the product is used must be substantially higher than the cost for comparable cases, thus making the typical Medicare reimbursement rate inadequate. A manufacturer that fails to meet any of these criteria may re-apply, but such

reapplications are often denied because the passage of time since the initial application renders the product no longer new.

NVCA is concerned that these criteria have been selectively applied and have not been developed through the rulemaking process, consistent with congressional intent. NVCA wishes to draw particular attention to certain difficulties in the operation of two of the three criteria.

Newness

The current CMS framework often reduces considerably the period of time for which a product would otherwise be considered "new." CMS measures a product's "age" from the date of FDA approval, rather than the date that the date of issuance of the ICD-9-CM code describing the administration of the product, as provided by both the Social Security Act and CMS's own regulations.[1] The application process itself can also consume a significant portion of the two-to-three-year period during which products will qualify as "new." For example, applications for new technology status for FY '07 were due on October of 2005, but payments will not be effective until October 2006. Products that received FDA approval after August 1, 2005, will therefore not be eligible for a new technology add-on payment until more than one year after launch.

We encourage CMS to take advantage of the full two to three years of data collection permitted under the Medicare statute and regulation. NVCA proposes that CMS allow manufacturers to apply for a new technology add-on payment on an ongoing basis, and that the agency issue quarterly updates announcing the approval of new add-on payments. A similar process has been implemented for pass-through and new technology payments in the hospital outpatient setting.

Furthermore, a product that otherwise qualifies as new based on age nevertheless will not be considered new if it is "substantially similar" to an existing product. For example, in the proposed rule CMS requested comments on whether Cardica's C-Port Distal Anastomosis System is new, and how to distinguish it from other predicate services. CMS notes that C-Port was found to be substantially equivalent to predicate devices under the FDA 510(k) approval process.

A determination of substantial equivalence by the FDA under 510(k) does not mean that the new and predicate devices are identical. Rather, approval simply indicates that the new device is at least as safe and effective as the predicate device. 510(k) approval should not be used by CMS as a bar to a determination of "newness." Any clinical determination for New Technology status should instead be addressed under the "substantial clinical improvement" prong discussed below.

[1] *See* Social Security Act § 1886(d)(5)(K)(ii)(III); 42 C.F.R. 412.87(b)(2).

Substantial Clinical Improvement

A manufacturer applying for a new technology add-on payment must also prove, through the submission of clinical evidence, that a product represents a "substantial clinical improvement" over existing products. Under 42 C.F.R. § 412.87(b)(1), *"[a] new medical service or technology represents an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries."* A high percentage of applicants for new technology payments fail to satisfy this requirement.

CMS should broaden the definition of "substantial clinical improvement." In the hospital outpatient context, for example, CMS views as a "separate factor" "*improvements in the medical technology itself that are so significant that we may wish to recognize them for separate payment even though they do not directly result in substantial clinical improvements.*" Such technological improvements might include advances that enhance a product's "*convenience, durability, [or] ease of operation,*" such as "*the strength of the materials, increased battery life, [and] miniaturization.*" 66 Fed. Reg. 55853 (Nov. 2, 2001). CMS could similarly recognize additional indices of clinical advancement when evaluating whether an improvement is "substantial" in the inpatient context. In addition to the factors just noted, these might include, for example, patient comfort and convenience, ease of administration, and the like.

Pathway for Emerging Technologies

NVCA's expertise in emerging companies and their technologies provides a unique and important perspective on several of the issues raised in the proposed rule. NVCA would like to work closely with CMS to help the agency refine the regulatory framework under which it evaluates new innovative treatments for Medicare beneficiaries.

NVCA has worked with the FDA on various small-company issues in the past, and would like to engage in similar collaboration with CMS. There has already been considerable discussion about coordination between CMS and FDA. CMS could create a clear pathway for small companies engaged in the FDA review process to elect to meet concurrently with CMS to discuss coverage, payment and coding of emerging technologies.

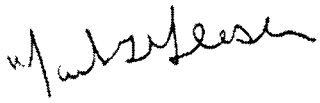
For example, the Center for Devices and Radiological Health operates a Division of Small Manufacturers, International and Consumer Assistance that provides substantial outreach to small and startup manufacturers. The Center for Drug Evaluation and Research (CDER)'s Office of Training and Communication (OTC) provides similar services to small business owners, and participates in programs on emerging topics of interest to small business. In collaboration with the U.S. Small Business Administration (SBA), CDER held a public workshop on April 25th of this year to provide information to small pharmaceutical businesses about FDA's premarket requirements; good manufacturing practices; OTC and generic drug issues; and the SBA's training, counseling, and contracting programs.

We suggest holding a meeting of the Council for Technology and Innovation (CTI) that focuses on emerging technologies and small companies. At present there is an annual New Technology Town Hall where companies can present on the "substantial clinical improvement" requirement. The Town Hall meeting has made the process more transparent and allowed early-stage companies an opportunity to present directly to CMS. The CTI should hold a forum with early-stage companies to discuss a wide range of issues relating to coding, coverage and payment for new technologies.

Finally, CMS should harmonize its approach to clinical data with that of the FDA. As the agencies increasingly collaborate, as they did on the Oncology Biomarker Qualification Initiative, for example, it will become even more important for CMS to align its interest in clinical evidence with the clinical study requirements associated with FDA review. Stakeholders would benefit, in particular, from discussions of both the formal criteria with which CMS evaluates data produced for FDA premarket review, as well as the informal and professional perspective that the agency brings to that data. Such discussions would enable stakeholders to better understand the value and significance of FDA premarket review data to the Medicare program.

The twenty-first century will be the life sciences century, and the venture capital community will play critical roles in shaping and fueling that growth. We look forward to working collaboratively with CMS to help make the next generation of medical breakthroughs available to Medicare beneficiaries.

Very truly yours,



Mark G. Heesen
President, NVCA

cc: Marc Hartstein, M.D.
Deputy Director, Division of Acute Care

Submitter : **Dr. Paul Pearson** **Date: 06/12/2006**

Organization : **Peacehealth**

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,

Paul Pearson, M.D.

Submitter : **Dr. Robert Clark** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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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.

CMS-1488-P-1549-Attach-1.DOC

#15419

Dear CMS policy maker

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being un related to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. That hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty . Rescind the interpretation of the IME and DME support rule

Sincerely,

Submitter : Dr. Scott Early **Date:** 06/12/2006

Organization : Dr. Scott Early

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

I am the family medicine residency program director of the Lawrence Family Medicine Residency in Lawrence, Massachusetts. I am writing 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). Lawrence, MA is one of the poorest Latino communities in United States. As a direct result of the opening of their residency program in 1994, access to health care has been dramatically improved. Also as a result, to cite one example, infant mortality has declined from 17 per thousand live births to single digits. This equates to 10-15 fewer infant deaths each and every year.

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. 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 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.

I strogly 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. It would have an enormous deleterious effect on our program and consequently all in the 45,000 patients we currently care for and all of the future patients of our residents.

Sincerely,

Scott Early M.D.

Submitter : **Dr. Joseph Cordova** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

CMS-1488-P-1551-Attach-1.DOC

#1551

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

Submitter : **Mr. David McClure** **Date: 06/12/2006**

Organization : **Tennessee Hospital Association**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#1552

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 : **Date: 06/12/2006**

Organization :

Category : **Individual**

Issue Areas/Comments

GME Payments

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.

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,
Matthew Logan, M.D.

Submitter : **Wanda Marvel** **Date: 06/12/2006**

Organization : **Missouri Hospital Association**

Category : **Health Plan or Association**

Issue Areas/Comments

GENERAL

GENERAL

See attached comments

CMS-1488-P-1554-Attach-1.DOC

#1559

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4105-P
P.O. Box 8010
Baltimore, MD 21244-1850

Office of Information and Regulatory Affairs
Office of Management and Budget
Room 10235
New Executive Office Building
Washington, D.C. 20503
Attention: Carolyn Lovett, CMS Desk Officer, CMS-4105-P

RE: CMS-4105-P — Hospital Quality Data

On behalf of our 141 member hospitals and health care systems, The Missouri Hospital Association welcomes an opportunity to comment on the proposed rule in the April 25, 2006, *Federal Register* for the Medicare proposed changes to the hospital inpatient prospective payment systems (PPS) for fiscal year 2007.

In accordance with the requirements in the Deficit Reduction Act of 2005 (DRA), the Centers for Medicare & Medicaid Services (CMS) has proposed expansion of the 10 quality measure starter set and linked the reporting of a total of 21 quality measures to the CMS data warehouse to the hospital annual payment update (APU) for FY 2007. This rule proposes to add 11 additional measures from the focus areas of acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN) and surgical infection prevention (SIP). Since AMI, HF and PN were utilized for the FY 2006 APU, most Missouri acute care hospitals already have implemented the collection of these three measure sets, however, surgical infection prevention was not part of FY 2006 APU and many Missouri hospitals were not abstracting and submitting this data to CMS, which is the association's greatest concern regarding this proposal.

The rule also proposes that the data collection for the expanded set of quality measures began with discharges occurring in the first calendar quarter of 2006. For hospitals paid under the CMS PPS to receive the full marketbasket update, this data must be submitted to the CMS data warehouse no later than August 15, 2006. Failure to submit the data on these additional measures in the time frame proposed will result in those hospitals losing two percent of their APU.

TIME FRAME CONCERNS

The rule was published in the April 25, 2006, *Federal Register*, well after Missouri hospitals had finished January and February 2006 data abstraction for first quarter 2006 discharges. Comments on the rule are not due until June 12, 2006, but hospitals have to comply with the rule at or about the time comments are due in order to meet the requirement to have the first quarter discharge information in the warehouse August 15, 2006, in order to qualify for the update.

In order for hospitals to meet the deadlines proposed in this rule, Missouri hospitals needed to have implemented SIP in the summer of 2005. The proposed time line is the most significant

obstacle for the successful implementation by Missouri hospitals to enable them to receive full marketbasket.

Under this time line, hospitals must:

- enter into an agreement and begin data collection if their vendor does not offer SIP as a measure set as vendors are not required to offer all measure sets

- obtain resources for additional abstraction and data collection, which incurs additional expenses and potentially overtime to collect this data after the normal abstraction time period

- educate and train staff for abstraction, which ideally would occur six months in advance — in this example, July or August 2005

Ideally, hospitals would have an opportunity to have a dry run of at least two quarters of data prior to submission and validation, which is not an option under this proposal.

Although data is not required to be in the CMS data warehouse until August 15, 2006, hospitals must have their data abstracted and data entry completed for submission to the Joint Commission and other accrediting organizations no later than July 30. Some vendors require the abstraction to be complete for 1 Q 06 as early as June 30. Operationally, this allows hospitals about six weeks to educate staff and implement a new data collection initiative to meet the time lines in this proposed rule. Without adequate preparation and education, hospitals quickly must abstract data that will be utilized for validation purposes and potential future marketbasket. For this reason, hospitals do not believe they have been given sufficient time to ensure appropriate training of their clinical and medical record staff to ensure a high degree of accuracy in the data abstraction, particularly with respect to the SIP measures.

RECOMMENDATION

In light of these identified problems with the retroactive nature of the proposed rule, MHA requests that CMS require the submission of the additional measures, specifically the SIP measures, begin collecting with fourth quarter 2006 discharges and that the annual payment update be tied to successful transmission of the additional measures beginning with fourth quarter 2006 discharges.

Further recommendations include the SIP measures not be included in the formal validation process for the annual payment update until after at least 12 months of reporting and subsequent validation of the additional measures. Hospitals do support a review of the records by the Clinical Data Abstraction Center (CDAC) for these additional measures, especially the SIP measures, to permit hospitals to obtain feedback about the data abstraction for learning purposes.

Since the DRA calls for further expansion of the measures reported to the data warehouse, MHA recommends CMS develop a process that affords organizations sufficient time prospectively to begin education, collection and reporting of any additional measures that will be considered in any future annual payment updates.

CHART VALIDATION

MHA recognizes the importance of ensuring that the data reported by hospitals to the data warehouse is accurate and appreciates the volume of charts that must be reviewed by the CDAC in order to ascertain whether the reported data is reliable and valid. In the proposed rule, CMS has indicated that hospitals must pass validation with a minimum of 80 percent reliability based on the CMS chart-audit validation process for the first three quarters of data from calendar year 2005. CMS has combined the chart samples for the first three quarters of 2005 or a total of 15 charts into a single stratified sample to determine whether the 80 percent reliability is met.

Hospitals have concerns with the present number of medical records selected each quarter for validation as well as the random selection of those charts. Currently, hospitals may be submitting data to CMS for three or four measure sets and the five charts selected per quarter may have several of one measure and none of another measure set. This potentially means in a truly randomized selection there could be zero charts in the three quarters of validation for any one of the entire measure sets which the hospitals do not believe meets the goals and expectations of the intended data quality CMS seeks.

Hospitals also agreed with the minimum threshold passing score established by CMS. However, given that CMS is proposing to combine the chart samples over several quarters in this rule and may propose the same in subsequent years, hospitals strongly believe that they should have the opportunity to appeal all mismatches that they have with the CDAC and not just those situations where they have failed to meet the 80 percent threshold. Hospitals view this as critical to being able to ensure that they meet the 80 percent threshold because a higher score in any one quarter might compensate for a lower score in another quarter and allow the hospital to meet the 80 percent threshold score.

In the event of a validation score less than 80 percent, the ability for hospitals to appeal scoring for all time periods is necessary, regardless of whether or not the hospital initially passed or failed validation. Also, MHA believes the ability to challenge any mismatch between their organization and the CDAC represents an important learning opportunity for the organization. Since the goal is to improve patient care by having appropriate recognized interventions provided to each patient, hospitals have indicated that having the ability to challenge mismatches may permit them to identify a problem or concern that could be rectified, which will help prevent the same from occurring in subsequent quarters.

RECOMMENDATIONS

MHA strongly encourages CMS to allow hospitals to challenge any mismatches in the chart validation that they may have with CDAC in order to score as high as they possibly can in any quarter, learn from the process, and remedy any identified problems to prevent them from reoccurring in subsequent quarters.

At a minimum, CMS should prospectively establish a time line and communicate to the hospital which quarters will be used in the calculation of the validation threshold and which measure sets will be utilized as this is critically important to receiving the APU.

MHA recommends a minimal of four quarters of data be utilized for validation purposes and at least two charts from each measure set be validated each quarter.

RECONSIDERATION PROCESS

The CMS has indicated that hospitals who do not meet the APU requirements for the applicable fiscal year may appeal this determination to the Provider Reimbursement Review Board and any such requests for FY 2007 must be made by no later than November 1, 2006. The CMS also has proposed that the November 1, 2006, deadline apply to FY 2005 and FY 2006 APU decisions and a November 1 deadline would apply in all future fiscal years. Further, CMS is seeking public comment on the need for a more structured reconsideration process to precede any Provider Reimbursement Review Board appeal for FY 2008 and subsequent years.

RECOMMENDATIONS

Missouri hospitals are not that familiar with the Provider Reimbursement Review Board, however, they are supportive of a process that could potentially consider the reasons why a hospital was not able to meet the APU requirements for the applicable fiscal year and allow the hospital to meet the requirements to qualify for the annual payment update. MHA believes CMS should allow a reconsideration process if requested in writing by a senior level official of the hospital.

Specific reasons for these reconsiderations should include:

- the inability to timely resubmit data to the data warehouse as a result of CMS or vendor transmission failures
- identification of information that may have been communicated inaccurately to CMS
- issues related to final chart validation scores when the incorrect patient information was sent to the CDAC for validation
- charts sent to the CDAC were misplaced or lost which may have adversely affected the hospital's validation scores for a particular quarter

FUTURE MEASURES

The DRA requires the expansion to other quality measures. The types of measures that may be added include the HCAHPS® patient perception of care survey findings, structure measures and outcome measures, such as the 30-day mortality for AMI and heart failure patients.

RECOMMENDATIONS

The patient perception or HCAHPS is a new measure set for hospital data collection. Missouri hospitals have been measuring patient satisfaction internally for quite some time but not necessarily utilizing a vendor's standardized tool necessitating a defined methodology that must be followed. For this reason, MHA is opposed to the potential utilization of HCAHPS for public reporting or annual payment update until at least 12 months of data has been abstracted, submitted and processes validated.

MHA does not believe the use of a 30-day risk-adjusted mortality for AMI and heart failure patients represents the best outcome measures that could be selected by Medicare to represent the quality of care delivered to patients in hospitals. The Missouri hospitals are uncomfortable with

the comparison of thirty-day post acute care discharge mortality rate being utilized when there are potentially multiple reasons why a patient may expire after discharge unrelated to hospital stay. Example of factors outside the hospital's control include variances in physician care, non-compliance patient behaviors such as not taking the prescribed medications, an individual's specific life style, or obesity. MHA strongly recommends that Medicare work with the Hospital Quality Alliance partners to identify outcome measures that better reflect the quality of hospital care.

Submitter : Dr. Brent Duncan

Date: 06/12/2006

Organization : j

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

GME Payments

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.

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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.

CMS-1488-P-1555-Attach-1.DOC

#1555

Dear CMS policy maker

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being un related to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

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Please help us be better physicians to our patients by supporting a competent and refreshed faculty . Rescind the interpretation of the IME and DME support rule

Sincerely,

Submitter : **Dr. Zane Harvey** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

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CMS-1488-P-1556-Attach-1.DOC

#1556

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

Someone at CMS will need to explain to me, how the teaching, curriculum development and evaluation process for the six required ACGME physician skill competencies is not related to patient care. Isn't this exactly what the IOM has criticized our training professions for? In fact, our program currently evaluates us in all these competencies as a continuing quality improvement process DURING patient care. Without time to discuss and reflect our experiences and outcomes we will not be serving the needs of our current and future patients.

Should indeed this come to pass, we will have faculty who will be caught in the productivity race with no time for us. We may get pop-up feed back from an Electronic Health Record in sites that have them that we have made an error or we are not following a guideline. No discussion there. What is being proposed is dangerous for our current patients and our future patients. Our patients deserve for us to have a better education than you are proposing.

Why does the American taxpayer support medical students at over $200,000 per student per year and offers the faculty of residencies less than $15,000 for teaching per resident per year? I am getting a lot more from my residency training to protect and serve my patients of the future than all of medical school combined. Please do not cut us any more – rescind the clarification of this dangerous and capricious rule.

Medical Resident

Submitter : **Donna Zimmerman** **Date: 06/12/2006**

Organization : **HealthPartners, Inc.**

Category : **Health Plan or Association**

Issue Areas/Comments

DRG Reclassifications

DRG Reclassifications

We are writing to support changes in DRG weights and the resulting shift away from specialty hospitals and toward the general hospital services tht many Medicare beneficiaries need - general medical care, obstetrics and gynecology, general suregery and, particularly, psychiatry. We agree with the recommendations made by the Medicare Payment Advisory Commission (MedPAC) to address the proliferation of physician owned, limited service hospitals. Implementing those recommendations would significantly, and we believe, appropriately redistribute payments among the DRGs and among hospitals. We acknowledge, as does the proposed rule, that there are details and implementation issues to be addressed. In particular, we support a one year delay in order to allow hospitals to be able to appropriately implement the proposed changes. Beyond that we are very supportive of this important initiative in bringing equity and accuracy of payments to the inpatient prospective payment system.

GENERAL

GENERAL

See attachment

Hospital Quality Data

Hospital Quality Data

We also support the continued expansion of hospital reporting of quality data as described in the proposed rule. The proposed rule envisions moving beyond the NQF "starter set" of 10 measures and adding an additional 11 NQF-endorsed measures. As a founding member of the Minnesota Community Measurement program, we are strong advocates for improved public information on the quality of care provided to patients. Transparency for consumers and providers allows informed decision making and improvements in quality.

Value-Based Purchasing

Value-Based Purchasing

The proposed rule explores development of a plan to implement hospital value-based purchasing. Pay-for-Performance programs, properly designed, can be an excellent motivator for improving the quality of care provided to patients. We also encourage CMS to not only explore hospital value-based purchasing but to expand to value-based purchasing of Medicare Advantage plans.

CMS-1488-P-1557-Attach-1.DOC

#1557

HealthPartners®

June 9, 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 HealthPartners and Regions Hospital, we 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) proposed rules. HealthPartners is a consumer-governed family of nonprofit Minnesota health care organizations focused on improving the health of its members, its patients and the community, and includes Regions Hospital, a 427-bed, full-service, private hospital located in St. Paul, Minnesota. Both Regions and HealthPartners are long term partners with CMS in serving Medicare beneficiaries. Our promise to patients is to deliver break-through experience through exceptional care and service that is safe, timely, effective, efficient, equitable, and most importantly, patient-centered. As such, the proposed provisions of the 2007 IPPS rule are of significant interest to us.

The rule proposes significant and welcome changes in the calculation of diagnosis-related group (DRG) relative weights by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc). It also proposes refining the DRGs to account for patient severity, with implementation likely in FY 2008. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education, among other policies. Among these, there are three overall topics on which we are providing supportive comments. However, as Regions Hospital is a teaching hospital, we do have concerns with some of the GME provisions of the new IPPS rules and their effect on our Institute for Medical Education, which have been addressed in a comment letter from Regions Hospital submitted on June 9, 2006.

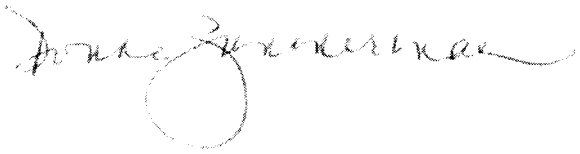
DRG Reclassifications
We are writing to support the proposed changes in DRG weights and the resulting shift away from specialty hospitals and toward the general hospital services that many Medicare beneficiaries need – general medical care, obstetrics and gynecology, general surgery and, particularly, psychiatry. We agree with the payment recommendations made by the Medicare Payment Advisory Commission (MedPAC) to address the proliferation of physician-owned, limited service hospitals. Implementing those recommendations would significantly, and we believe, appropriately redistribute payments among the DRGs and among hospitals. We acknowledge, as does the proposed rule, that there are details and implementation issues to be addressed. In particular, we support a one year delay in order to allow hospitals to be able to appropriately implement the proposed changes. Beyond that, we are very supportive of this important initiative in bringing equity and accuracy of payments to the inpatient prospective payment system.

Hospital Quality Data and Value Based Purchasing
We also support the continued expansion of hospital reporting of quality data as described in the proposed rule. The proposed rule envisions moving beyond the NQF "starter set" of 10 measures and adding an additional 11 NQF-endorsed measures. As a founding member of the Minnesota Community Measurement program, we are strong advocates for improved public information on the quality of care provided to patients. Transparency for consumers and providers allows informed decision making and improvements in quality.

The proposed rule explores development of a plan to implement hospital value-based purchasing. Pay for Performance programs, properly designed, can be an excellent motivator for improving the quality of care provided to patients. We also encourage CMS to not only explore hospital value based purchasing but to expand to value based purchasing of Medicare Advantage plans.

HealthPartners appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me or Stephanie Frost, Senior Policy Manager, at 952-883-6132.

Sincerely,



Donna Zimmerman
Vice President

Submitter : **Mr. Todd Gillenwater** **Date: 06/12/2006**

Organization : **California Healthcare Institute**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

Please find attached the comments of The California Healthcare Institute (CHI) on the Centers for Medicare and Medicaid Services (CMS) proposed rule regarding revisions to the hospital inpatient prospective payment system (IPPS), published in the Federal Register on April 25, 2006.

CMS-1488-P-1558-Attach-1.PDF

#1558

C·H·I CALIFORNIA HEALTHCARE INSTITUTE
WWW.CHI.ORG

June 12, 2006

SUBMITTED ELECTRONICALLY

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

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

Dear Administrator McClellan:

The California Healthcare Institute (CHI) welcomes this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule regarding revisions to the hospital inpatient prospective payment system (IPPS), published in the Federal Register on April 25, 2006 (the Proposed Rule).[1] CHI represents the full biomedical sector of the California economy and unites more than 250 of California's leading biomedical firms, universities, and private research institutes in support of biomedical science, biotechnology, and pharmaceutical and medical device innovation. California is the global leader in biomedical R&D, with more than one-third of all U.S. biotechnology and medical device firms turning scientific discoveries into medical products at an unprecedented rate. California companies lead the nation in bringing to market frontline therapies for diseases such as AIDS, breast cancer, stroke, and diabetes.

As the advocate for California's biomedical industry, CHI appreciates CMS' goal of establishing a fairer and more accurate payment methodology for inpatient hospital services. CMS has proposed major changes to this payment system – by far the most substantial changes since the IPPS was established in 1983. In particular, the Proposed Rule would adopt hospital-specific relative value cost center (HSRVcc)

[1] 71 Fed. Reg. 23995 (April 25, 2006).

HEADQUARTERS
1020 Prospect Street, Suite 310
La Jolla, California 92037
858.551.6677 ▪ Fax 858.551.6688

SACRAMENTO
1215 K Street, Suite 970
Sacramento, California 95814
916.233.3497 ▪ Fax 916.233.3498

weights and severity-adjusted diagnosis related groups (DRGs). These proposed changes, if implemented, would dramatically alter reimbursement for many inpatient services by establishing a completely new methodology both for analyzing a hospital's cost and charge data as well as for assigning services to DRGs.

CHI supports CMS' efforts to make the inpatient PPS more accurate and to protect patient access to critical medical care. Ensuring appropriate payment for services is central to providing Medicare beneficiaries with access to medically necessary services, including new drug and biological therapies, devices, and other innovative technologies, in the most appropriate setting. We hope that a more accurate inpatient payment system will recognize more appropriately the value of innovative drugs and biologicals and provide beneficiaries with improved access to life-saving and life-prolonging treatments.

Nonetheless, CHI is concerned that this Proposed Rule, if finalized, would implement changes without giving either CMS or stakeholders adequate time to assess the accuracy of the proposed rate changes or fully prepare for the implementation challenges that arise with such significant changes. These proposed changes are far broader than the types of refinements usually set forth in a proposed rule. We believe that both CMS and independent evaluators need more time to assess the accuracy of these proposals. In addition, hospitals need time to implement such sweeping changes, and we do not believe that they will be able to do so in the next few months. CHI also is concerned that implementing the shift to a cost-based payment methodology at a different time than the severity and complexity adjusted DRGs could have the result of denying Medicare beneficiaries access to medically appropriate treatments. Thus, CHI urges CMS to delay the implementation of the Proposed Rule for at least one year to allow more robust analysis as well as increased stakeholder involvement in developing a cost based payment methodology that accurately reflects costs. We also request that CMS implement any future cost-based payment system at the same time as the severity and complexity adjusted DRGs. Finally, it is not clear from the Proposed Rule how new technologies will be taken into account in the new metholodologies for calculating DRG payment rates. We urge CMS to clarify how new technologies will be reflected and reimbursed appropriately in the proposed changes to the inpatient PPS. We have discussed the comments in greater detail below.

1. Delayed Implementation of HSRVcc Weights to Develop a More Accurate Cost-Based Payment Methodology (HSRV Weights)

CHI respectfully requests that CMS delay the implementation of the proposed new methodology for HSRVcc weights. We believe this delay is needed in order to allow CMS, independent evaluators, and stakeholders sufficient time to assess this entirely new proposed methodology, fix the technical flaws in the proposed methodology, and evaluate better alternatives such as the Outpatient

Prospective Payment System (OPPS) cost-based payment calculation methodology. Regardless of the methodology, any move to a cost-based system should include an adjustment mechanism to address the known phenomenon of charge compression. Charge compression occurs when CMS uses a single cost-to-charge ratio (CCR) for the many items and services in a single department without regard for the fact that hospitals use a lower percentage mark-up for higher cost items than they do for lower cost items. Methodologies that rely on uniform CCRs underestimate the cost of more expensive items and overestimate the cost of less expensive ones, resulting in a systematic distortion of the estimated costs, and of the resulting cost-based prospective payment rates.

CHI acknowledges and appreciates the tremendous effort that CMS has put forth in releasing the Proposed Rule this spring. Yet as CMS itself has acknowledged, CMS did not have sufficient time to fully confirm the accuracy of the proposed methodologies or the calculations set forth in the Proposed Rule. As a result, the proposed methodology contains significant flaws which may inappropriately skew inpatient payments. Before changes of this magnitude are implemented, we believe it is imperative for CMS to take the necessary time to more fully analyze its methodology and the resulting payment rates, as well as time to explain this methodology to stakeholders and allow for more robust stakeholder input. CHI supports CMS' efforts to increase the accuracy of inpatient payment rates, yet we believe that such changes can be implemented in a manner that is both more accurate and less disruptive to hospitals if CMS and stakeholders have the opportunity to fully vet any potential flaws in the proposed methodology changes.

The proposed changes to DRG weights, if finalized, would result in dramatic changes in the payment rates for many DRGs. Although these new payment rates are intended to better reflect the actual costs to a hospital of providing particular services, CHI is concerned that there has not been adequate time for CMS or stakeholders to assess fully whether the proposed methodology actually produces more accurate rates. The calculations are complex and, because the proposed methodology contains significant departures from the methodology developed and tested by the Medicare Payment Advisory Commission (MedPAC), it is not possible to rely on MedPAC's analysis to evaluate CMS' proposed methodology. Although CMS has released the data to the public to permit stakeholder analysis of these changes, the time available for such analysis during this comment period is not adequate to fully consider the many factors that went into designing this new methodology. As a result of this compressed timeframe, it is difficult for the public to comment in any intelligent way on the methodological issues upon which the agency has specifically requested comment. We believe that providing an additional year of methodology development and analysis coupled with increased stakeholder involvement will result in the creation of a more accurate cost-based payment system that could be implemented in fiscal year 2008.

In particular, it is not entirely clear from the Proposed Rule how CMS approached certain aspects of its methodology. For example, it appears that the proposed methodology uses unweighted geometric mean national average cost-to-charge ratios, rather than cost-to-charge ratios weighted by a hospital's size.[2] The result of this approach is to give the same weight to cost-to-charge ratios for a small hospital as for a large hospital without regard for differences in the number of claims each hospital files. This also ignores that fact that large hospitals tend to use advanced technologies that may result in higher cost-to-charge ratios. The result may be a less accurate payment system rather than the more accurate system CMS envisions. CMS and stakeholders would benefit from time to more fully review this and other proposed methodology changes in order to ensure the new HSRVcc weight methodology is, in fact, a more accurate reflection of hospital costs.

The methodology for establishing HSRVcc weights also relies on data that is out-of-date and, as a result, may not reflect the costs of providing many newer treatments. In calculating the HSRVcc weights, CMS has relied on cost report data from fiscal year 2003, as well as MedPAR data from fiscal year 2005. The result of this reliance on out-of-date data is that cost report data from the fall of 2002 will be used to establish payments for the fall of 2007. Furthermore, it appears likely that efforts to eliminate outliers may in fact have the result of removing claims in which newer treatment options were used, thus further reducing the likelihood that the proposed HSRVcc weights will accurately reflect the cost of advanced technology. In order for these substantial changes to be implemented in a manner that truly reflects the actual costs of providing treatment, CMS, Congress, MedPAC, and other stakeholders should engage in a focused effort to improve the actual collection of cost information to support the development of accurate cost-based DRG weights.

Finally, CHI also is concerned that hospitals have sufficient time to understand and plan for such significant changes in reimbursement for inpatient services. CHI believes that the proposed changes are far too sweeping to be implemented by hospitals this year. Again, due to technical flaws in the proposed HSRVcc weights and the time required for hospitals to plan for and adjust to these payment changes, we strongly recommend that CMS delay implementation of HSRVcc weights for at least one year to allow more robust stakeholder involvement in the development of cost-based payments and to ensure that the weights are accurate.

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[2] 71 Fed. Reg. at 24010.

2. Simultaneous Implementation of HSRVcc Weights and Changes to the DRG Methodology (HSRV Weights; DRGs: Severity of Illness)

CMS has proposed substantial changes to DRG methodology to take into account the severity of illness. The proposed methodology would allow for differentiation between patients within a DRG based on the patients' comorbidities and extent of physiologic decompensation. This proposal is one of four policy changes MedPAC recommended that, together, would make hospital inpatient payment more accurate.[3] These policy recommendations included the use of hospital-specific relative value weights instead of charge-based weights as well as refinement of DRGs to better account for differences in severity of illness among beneficiaries. CHI supports this multipronged approach to IPPS reform and we agree with MedPAC's recommendation that all of the changes should be adopted at the same time. MedPAC noted that failure to adopt any of these recommendations would "leave some payment distortions in place."[4] Payment fluctuations and distortions also will occur if HSRVcc weights and severity-adjusted DRGs are implemented in different years. For example, some hospitals, particularly rural hospitals, are likely to gain from the adjustment of the HSRVcc weights and lose reimbursement dollars from the severity adjustment to the DRGs. Other hospitals will experience the opposite effect. This instability will pose significant challenges for hospital budgets. For these reasons, CHI urges CMS to implement both of the changes to hospital payments at the same time, in order to avoid the instability that would result from different implementation timelines.

CHI also is concerned that the severity-adjusted DRGs do not adequately account for the increased complexity associated with the use of advanced medical technology. As CMS has recognized in its proposed implementation of severity-adjusted DRGs, hospitals experience very different actual costs among cases assigned to the same DRG. CHI appreciates CMS' recognition of the importance of improving the accuracy of this DRG methodology. Certainly, in many cases these differences arise in part out of the severity of illness of the beneficiary. Another factor, however, is the range of complexity that various treatments require. The use of advanced drugs and devices may increase the complexity of care while preventing further deterioration of the patient's condition, yet the proposed severity-adjusted DRGs do not consider complexity of care in assigning cases to DRGs. As a result, many of the proposed payment rates may not be adequate to reimburse hospitals for the appropriate use of advanced technology. CHI consistently has supported a payment system that better incorporates the role of new and advanced technology,

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[3] Medical Payment Advisory Commission, Report to Congress: Physician-Owned Specialty Hospitals, March 2005, at 36.

[4] Letter from Glenn M. Hackbarth, Chairman, MedPAC, to Mark McClellan, Administrator, CMS, April 19, 2006, at 4.

and we are concerned that the proposed severity-adjusted DRGs may take Medicare farther away from this goal.

For example, the proposed severity-adjusted DRGs would dismantle a DRG that CMS created specifically to identify cases using an advanced drug technology. In the final rule for 2006, CMS created DRG 559 for treatment of stroke patients with tissue plasminogen activator (tPA). When it created this DRG, CMS acknowledged that patients who receive tPA have both increased severity of illness and increased complexity of care.[5] Although the proposed consolidated severity-adjusted DRGs (CSA-DRGs) are intended to recognize increased severity of illness, they do not recognize the increased complexity of treatment with tPA. In fact, procedure code 99.10 (injection or infusion of a thrombolytic agent), the code that currently allows a stroke case to be assigned to DRG 559, does not map to any of the CSA-DRGs. As a result, administration of tPA would cease to be a factor in DRG assignments and reimbursement for treatment of stroke with tPA would fall by 28 to 63 percent under the proposed stroke DRGs. We are disturbed that the measures CMS took in 2006 to protect beneficiary access to appropriate treatment for stroke would not be carried forward under the new DRG assignments. Unless complexity of care, including administration of tPA, is factored into these DRG definitions, hospitals may not be adequately reimbursed for providing this critical therapy.

It is crucial that complexity of treatment be factored into the DRGs in order to ensure that payments appropriately reflect the advanced therapies hospitals provide to their patients. We agree with CMS that the system should include a method of recognizing cases that involve increased complexity, but not necessarily greater severity of illness.[6] Any new DRG structure should include the recent DRG refinements that have been implemented to appropriately pay for advanced therapies. To better address both patient severity of illness and patient complexity, CMS could use the current DRG system will all its recent refinements and add severity of illness adjustments to the current DRGs, similar to the addition of Major Cardiovascular Diagnoses that were implemented for cardiac service DRGs in FY 2006. We urge CMS to delay implementing the severity-adjusted DRGs until CMS develops a methodology for recognizing complexity of treatment as part of the severity-adjusted DRGs and makes such methodology available for public comment.

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[5] 70 Fed. Reg. 47278, 47288 (Aug. 12, 2005).
[6] 71 Fed. Reg. at 24014.

3. Access to New Technologies (New Technology)

CHI remains concerned that IPPS rates that fail to adequately take into account advanced therapies could deprive Medicare beneficiaries' access to these much needed therapies – not only to therapies that exist today but those on the horizon that offer patients and their families a much brighter future. It is essential that Medicare adequately reimburse acute care hospitals for the costs of providing innovative drugs, biologicals, radiopharmaceuticals, and devices. Medicare beneficiaries rely on acute care hospitals, including those of our member hospitals, to provide advanced treatments for cancer and other complex conditions. For many of the most vulnerable patients, the hospital inpatient setting is the only setting in which they can receive appropriate care. Appropriate reimbursement is particularly critical due to the added complexity of the therapies provided in the inpatient setting, the more intense needs of many of these patients, and the increased regulatory oversight applicable to hospitals. Where hospitals are inadequately reimbursed for the provision of such advanced care, hospitals may be forced to cease such treatment. To protect beneficiary access to care in the hospital setting, Medicare reimbursement for services performed in an inpatient setting must accurately reflect the cost to the hospital of providing such care.

CMS' system for new-technology add-on payments helps to protect beneficiary access to critical therapies during the two or three years it may take for the increased costs associated with a new technology to be appropriately reflected in the DRG payment rates. This delay remains in place under the Proposed Rule's new rate-setting methodologies. Yet in describing in the Proposed Rule several new technologies that have sought add-on payments, CMS does not address how the proposed changes to the DRG weights and groupings will affect eligibility for these new technology add-on payments. New technology add-on payments are available only where the technology is not adequately paid under the existing DRG system,[7] and because the proposed methodologies produce significant changes in payments, some technologies may no longer be adequately paid. CHI believes it is critical that CMS address how the proposed changes to the HSRVcc weights and the severity-adjusted DRG methodology will take into account new technologies prior to implementing these changes. We also recommend that CMS reconsider recent applications for new technology add-on payments in light of any substantial methodological changes to the IPPS.

CHI also recommends that CMS implement the International Classification of Diseases, 10th Revision (ICD-10) as soon as possible to ensure that the IPPS rates are based on the most detailed data available. The ICD-10 includes significantly more diagnosis and procedure codes, which will allow hospitals to describe their

[7] 42 C.F.R. § 412.87(b)(3).

patients' conditions and treatment in much more detail than is possible with the ICD-9. Over time, CMS will be able to use these detailed claims data to set more accurate payment rates for inpatient services. Not only is the ICD-10 more granular than the ICD-9, but unlike the ICD-9, it can be expanded to recognize new conditions, drugs, devices, and procedures. This will help to ensure that coding, as well as the IPPS, can keep up with changes in innovation in medical technology. CHI suggests that CMS include adoption of the ICD-10 among its efforts to improve the accuracy of IPPS rates.

Conclusion

CHI appreciates this opportunity to comment on the Proposed Rule, and we look forward to working with CMS to protect Medicare beneficiaries' access to life-improving drug and device therapies. We hope our suggestions will help CMS address these important issues in the final rule. In brief, we urge CMS to:

- Delay implementation of the HSRVcc weights for at least one year in order to fix technical flaws with the proposed method and to evaluate other potentially more accurate options;
- Implement the severity of illness DRGs at the same time as the HSRVcc weights, and include a method for recognizing new and advanced technologies that increase the complexity of care; and
- Protect patient access to new technology in implementing both the severity of illness (and complexity of care) DRGs and HSRVcc weights.

Please contact Todd Gillenwater, Vice President, Public Policy, at (858) 551-6677 if you have any questions regarding our comments. Thank you for your attention to this very important matter.

Respectfully submitted,

David L. Gollaher, Ph.D.
President and CEO

1559

CMS-1488-P-1559

Submitter : Dr. Suzanne Delbanco

Date: 06/12/2006

Organization : The Leapfrog Group

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See attached comments from The Leapfrog Group pertaining to Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 Rates - 1) Overarching Comments; 2) Hospital Quality Data; 3) Value-Based Purchasing; and 4) Health Care Information Transparency Initiative

CMS-1488-P-1559-Attach-1.DOC

#1539

June 12, 2006

Secretary Michael O. Leavitt
Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attn: CMS-1488-P
P.O. Box 8011
Baltimore, MD 21244-1850

RE: Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 Rates: 1) Overarching Comments; 2) Hospital Quality Data; 3) Value-Based Purchasing; and 4) Health Care Information Transparency Initiative

Dear Secretary Leavitt:

Thank you for the opportunity to comment of the proposed changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 Rates. We applaud your efforts to promote and foster increased transparency and we believe that Medicare should lead the way to promoting a market that recognizes and rewards high-quality, efficient, and patient-centered care. First, let us offer some overarching comments for your consideration before providing more granular feedback on three sections of the proposed rules that address hospital quality data, value-based purchasing, and the health care information transparency initiative.

OVERARCHING COMMENTS

Assess provider performance using robust measures: Medicare should evaluate the performance of each health care provider that bills Medicare, using nationally-endorsed, scientifically-valid, risk-adjusted, and regularly-updated measures that address:

- Clinical quality (safe, timely, and effective care);
- Efficiency (prices and resource use over time);
- Equity (gender, race, ethnicity);
- Patient experience; and
- Structure or systems (e.g., use of quality-enhancing information technology).

Recommended Actions

- Provide substantial funding to support development of consumer-relevant measures that fill existing gaps (especially efficiency and equity). Developing measures is a public good that requires significant financing from the public sector. Because of the lack of well-specified and endorsed measures that meet consumers and purchasers' needs, measure developers and their funders should be guided by the following considerations:
  - Reasonably scientifically acceptable. Consumers and purchasers want measures to be scientifically sound, but do not want the pursuit of perfection to delay the availability of good and useful information.

- Feasible to implement. Rapid reporting necessitates measures are constructed and specified so that the data needed is currently available or can be collected with limited reporting burden.
- Relevant to consumers and purchasers. The needs of consumers and purchasers for important and actionable information must drive the development of measures.
- Reflect the continuum of care/care coordination from a patient's perspective. Measures should address the extent to which comprehensive, patient-centered care is delivered, often by multiple providers.

- Provide core operating support for the National Quality Forum (NQF) to ensure ongoing, independent consensus process for the review, endorsement, and updating of measures so as to enable the availability comparative information and the reduction of provider reporting burden.

Collect and report information that will enable informed decision making and provider selection. Medicare should provide the public with the information on the aspects of provider performance described above. Doing so, will allow: 1) consumers to make informed decisions about their health care; 2) insurers and purchasers to make value-based contracting decisions and use differential payments as incentives; and 3) providers' improvement efforts to be supported with better information.

Recommended Actions

- Release physician-identifiable Medicare claims data (fully protecting patient privacy), to allow for better quality and efficiency performance reporting.
- Continue to allow private-sector organizations to download granular provider performance information from the Compare websites.
- Augment hospital claims data with additional clinical data elements to better understand patient acuity.

Implement financial incentives that are sensitive to the provision of high-quality, efficient, patient-centered care: Medicare should phase in a system that differentially pays providers based on nationally standardized measures.

Recommended Actions

- Continue to rapidly expand the number and type of measures that hospitals must report to obtain annual payment update.
- Medicare payments must be sensitive to provider performance and create financial incentives to provide quality care.
- Incentives should take into account performance on quality, efficiency, and patient experience.
- Provider incentives should be budget-neutral and based on a combination of improvement and meeting thresholds.

Now let us offer specific comments on the proposed changes to the three sections that address hospital quality data, value-based purchasing, and the health care information transparency initiative.

SECTION: HOSPITAL QUALITY DATA

Reporting of Hospital Quality Data for Annual Hospital Payment Update
Fiscal Year 2007: We support CMS' recommendation to reduce the FY 2007 annual hospital payment update by 2% for any hospital that does not submit data on 21 measures (8 heart attack, 4 heart failure, 7 pneumonia, 2 surgical infection prevention) for patients discharged starting January 1, 2006 through December 31, 2006.

Fiscal Year 2008: CMS must do far more than merely "exploring the feasibility of adopting additional measures for FY 2008 update, including HCAHPS." There should be a **substantial** expansion of measures for hospitals to obtain the FY 2008 annual update. We strong urge that CMS adopt the measures identified in the Institute of Medicine's *Performance Measurement: Accelerating Improvement*, i.e., Hospital-CAHPS and three structural measures (computerized provide order entry, intensive care staffing with intensivists, and evidence-based hospital referral) as well as consider and adopt a number of other NQF-endorsed measures, for example:

Outcomes
- 30-day heart failure mortality
- 30-day heart attack mortality
- Failure to rescue

Complications
- Urinary catheter-associated infection rate
- Central line-associated blood stream infection rate
- Ventilator associated pneumonia rate

Clinical
- Surgery patients with recommended venous thromboembolism prophylaxis ordered
- Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hour prior to surgery to 24 hours after surgery.

Electronic Medical Records (p. 343-344)
Health information technology (HIT) – which includes software applications for care management (EMR, EHR, practice management systems, registries) – has the potential to dramatically improve the quality and efficiency of health care, however implementation has been slow. The Secretary should ensure that the data necessary for quality measurement are captured by using conditions of participation that require hospitals to implement HIT/software applications that:
- Comply with interoperability standards;
- Enable standardized quality, performance, and efficiency measurement are a routine by-product of their use. [NOTE: Adapted from AQA Data Sharing and Aggregation Subgroup on HIT: www.ambulatoryqualityalliance.org/files/PrinciplesforHITandMeasAgg-May06.doc]
- Are designed to enable the merger of their data with others for the purpose of facilitating the production of standardized quality, performance, and efficiency

information. [NOTE: Adapted from AQA Data Sharing and Aggregation Subgroup on HIT]

Further, the Secretary should tie the annually hospital payment update to the reporting of hospitals' progress toward CPOE implementation (see previous comments under Hospital Quality Data for Annual Payment Update).

Until HIT becomes wide-spread the Secretary can enable much more robust hospital performance reporting by requiring hospitals to report the following data elements on both paper and electronic claims:

- A unique physician identifier for each coded procedure;
- Capture the referring/ordering physician for each coded procedure;
- Vital signs (heart rate, blood pressure, temperature, and respiratory rate) recorded at presentation;
- Key lab values (BUN, hematocrit, platelets, WBC, sodium, potassium, and creatinine) if obtained at the time of admission, excluding hospitalizations for psychiatric, obstetrical and newborn services;
- Do Not Resuscitate order present (including date and time), if recorded during first 24 hours of patient presenting; and
- Time of day of admission, discharge, and each procedure.

SECTION: VALUE-BASED PURCHASING (p. 344 – 367)

Plan for Implement Hospital Value-Based Purchasing Beginning with FY 2009

As CMS works to develop a plan to implement hospital value-based purchasing beginning in FY 2009, the following issues must be addressed: (a) the ongoing development, selection, and modification process for hospital quality and efficiency measures; (b) the reporting, collection, and validation of data; (c) the structure of payment adjustments; and (d) the disclosure of hospital performance information.

Measure development and refinement (p.350-353)

- As noted in our overarching comments, the development of consumer relevant measures is critical and the Secretary should provide substantial funding to support development of consumer-relevant measures that fill existing gaps (especially efficiency and equity). Developing measures is a public good that requires significant financing from the public sector. Because of the lack of well-specified and endorsed measures that meet consumers and purchasers' needs, measure developers and their funders should be guided by the following considerations:
  - Reasonably scientifically acceptable. Consumers and purchasers want measures to be scientifically sound, but do not want the pursuit of perfection to delay the availability of good and useful information.
  - Feasible to implement. Rapid reporting necessitates measures are constructed and specified so that the data needed is currently available or can be collected with limited reporting burden.
  - Relevant to consumers and purchasers. The needs of consumers and purchasers for important and actionable information must drive the development of measures.
  - Reflect the continuum of care/care coordination from a patient's perspective. Measures should address the extent to which comprehensive, patient-centered care is delivered, often by multiple providers.

- Provide core operating support for the NQF to ensure ongoing, independent consensus process for the review, endorsement, and updating of measures so as to enable the availability comparative information and the reduction of provider reporting burden.

Incentive Methodology (p. 357-367)

- *Incentive Structure*: Incentives should be based on a combination of improvement and meeting quality thresholds based on standard measures adhering to the consumer-purchaser disclosure project guidelines. Our experience with incentives programs indicates that basing the incentives on attaining specific quality-based thresholds allows hospitals (including those serving disenfranchised populations or unique communities) to focus their efforts on the highest-yield improvements. Because of the evidence that performance dramatically varies within hospitals, incentives should be available and calculated at both the service-line level (for clinical areas) and hospital-wide (e.g. for HCHAPS). In the private sector, The Leapfrog Group designed the Leapfrog Hospital Rewards Program to reward both *top performers* and *performance improvers*. The goal is to provide incentives for hospitals to improve continuously and to sustain that improvement once it is achieved. Because the LHRP measures a hospital's performance relative to the performance of other hospitals, even top performers will need to improve continually in order to maintain their status. This use of relative performance to determine which hospitals earn rewards and the level of those rewards was advanced by the current CMS-Premier Hospital Quality Incentive Demonstration. As reported, this Demonstration has experienced quality improvement among participating hospitals on care processes that help ensure better outcomes. As Medicare moves to a permanent use of incentives for quality, setting both baseline thresholds of performance and a relative ranking system will help all hospitals make improvements appropriate to their current level of performance.
- *Level of Incentive*: The share of payment tied to performance should be substantial, though what constitutes "substantial" will differ from one provider to another, i.e., the same percentage may not be appropriate for both hospitals and physicians. The overall proportion of CMS payments dependent on incentives should grow significantly and could eventually reach a level so that 10% or more of total Medicare payments is sensitive to performance. CMS should set and revise the appropriate level using the information that continues to develop from its demonstration projects and private-sector efforts. Initially, we believe that the performance incentive for hospitals should be on the same order of magnitude as the 2% incentive for the FY07 annual market basket update. In addition to financial rewards, there are two other types of incentives CMS can employ: the potential for increased market share and public recognition. For example, The Leapfrog Group designed the Leapfrog Hospital Rewards Program to increase the patient volume at better hospitals through consumer education and benefit design that encourages patients to seek out the best hospitals. This patient shift creates savings for the purchaser, better care for patients, and incentives in the marketplace for hospital improvement. This phenomenon can be supported by ongoing consumer testing of Hospital Compare and making sure that it displays hospital performance information that is as current as possible. We strongly support the current CMS efforts to increase quality and cost transparency. The Leapfrog Group employer members agree that **public** awareness of hospital quality is a powerful motivator for performance improvement. A powerful example was the significant improvement in nursing home quality that was demonstrated in AHRQ's National Healthcare Quality Report between

2003 and 2004, following when CMS began publicly releasing nursing home quality data.

- *Source of Incentive*: Providing additional funding to finance performance incentives is an unrealistic option given the current economic pressures faced by CMS. As a result, value based purchasing initiatives should be budget neutral. The Leapfrog Hospital Rewards Program is an example of how to accomplish budget neutral incentives. Rewards paid out are based on a share of the savings which accrue in the market due to hospital improvement. If there are no savings, no rewards are paid. This design helps ensure implementers' ability to fund bonus payments is sustainable over time. The dollar amount of hospital rewards is not set in advance, though the methodology by which rewards will be calculated is known by hospitals in advance. As rewards are based on the savings generated by hospital performance, the amount of rewards will vary from one period to the next. While this "shared savings" model is more easily implemented when hospitals earn per-diem reimbursement, The Leapfrog Group, with assistance from private sector stakeholders and CMS, is currently devising a similar methodology for DRG-based reimbursement. Leapfrog's incentive structure design for DRGs adheres to the principles of using measured quality and efficiency performance to create budget neutral incentives for hospital performance. The Leapfrog Group would be eager to continue to share its ideas in this area with CMS as appropriate.

Public Reporting (p. 362)

CMS should further stimulate public reporting to increase the transparency and meaningfulness of health care performance information by taking the following actions:

- Continue to allow private-sector organizations to download granular provider performance information from the Compare websites.
- Support further research and consumer testing around the development and display of measure composites, including how different tiers of composite score could be constructed, e.g., an total score combining clinical quality, patient experience, and efficiency; overall score on those three respective domains, and a composite by service line (diabetes, cardiac care, etc.).
- While improving the utility of the CMS Compare websites through using composites and rank ordering providers by performance, CMS should maintain the ability for consumers to "drill down" to a granular level of performance detail.

Beyond these suggested actions, we would call your attention to the Principles for Public Reporting of Health Care Information that were developed and endorsed by the members of the Ambulatory Care Quality Alliance as an additional useful reference. These Principles can be found at:
http://www.ambulatoryqualityalliance.org/files/ConsumerPrinciplesMay06.doc

Hospital Acquired Infections (p. 363)

Given the tremendous toll – both human and financial – caused by hospital-acquired infections, the Secretary should go much further than the statutory minimum of identifying "at least two conditions that are (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines." The Secretary should work with those states that currently collect Present on Admission (e.g., California and Pennsylvania) to determine all those conditions that meet the above criteria and select a substantial portion of them for which hospitals would not receive additional payments.

With the requirement for hospitals to submit the secondary diagnoses that are present on admission for discharges after October 1, 2007, we anticipate much more robust hospital outcomes reporting due to the increased ability to differentiate co-morbidities from complications.

Promoting Effective Use of HIT (p. 364)
Health information technology (HIT) – which includes software applications for care management (EMR, EHR, practice management systems, registries) – has the potential to dramatically improve the quality and efficiency of health care, however implementation has been slow. The Secretary can spur HIT adoption and ensure that the data necessary for quality measures are captured by using conditions of participation that require hospitals to implement HIT/software applications that:

- Comply with interoperability standards;
- Enable standardized quality, performance, and efficiency measurement are a routine by-product of their use. [NOTE: Adapted from AQA Data Sharing and Aggregation Subgroup on HIT: www.ambulatoryqualityalliance.org/files/PrinciplesforHITandMeasAgg-May06.doc]
- Are designed to enable the merger of their data with others for the purpose of facilitating the production of standardized quality, performance, and efficiency information. [NOTE: Adapted from AQA Data Sharing and Aggregation Subgroup on HIT]

Further, the Secretary should tie the annually hospital payment update to the reporting of hospitals' progress toward CPOE implementation (see previous comments under Hospital Quality Data for Annual Payment Update).

Until HIT becomes wide-spread the Secretary can enable much more robust hospital performance reporting by requiring hospitals to report the following data elements on both paper and electronic claims:

- A unique physician identifier for each coded procedure;
- Capture the referring/ordering physician for each coded procedure;
- Vital signs (heart rate, blood pressure, temperature, and respiratory rate) recorded at presentation;
- Key lab values (BUN, hematocrit, platelets, WBC, sodium, potassium, and creatinine) if obtained at the time of admission, excluding hospitalizations for psychiatric, obstetrical and newborn services;
- Do Not Resuscitate order present (including date and time), if recorded during first 24 hours of patient presenting; and
- Time of day of admission, discharge, and each procedure.

SECTION: HEALTH CARE INFORMATION TRANSPARENCY INITIATIVE (p. 447)
As the Department builds upon its current transparency efforts, we would encourage the Secretary to increase both the scope and breadth of consumer-friendly cost and quality information by employing the following strategies:

Support the development, endorsement, and updating of performance measures

- Provide substantial funding to support development of consumer-relevant measures that fill existing gaps (especially efficiency and equity). Developing measures is a public good that requires significant financing from the public sector. Currently,

because of the lack of well-specified and endorsed measures that meet consumers and purchasers' needs, measure developers must be encouraged to create measures that are:

- Reasonably scientifically acceptable. Consumers and purchasers want measures to be scientifically sound, but do not want the pursuit of perfection to delay the availability of good and useful information.
- Feasible to implement. Rapid reporting necessitates measures are constructed and specified so that the data needed is currently available or can be collected with limited reporting burden.
- Relevant to consumers and purchasers. The needs of consumers and purchasers for important and actionable information must drive the development of measures.
- Reflect the continuum of care/care coordination from a patient's perspective. Measures should address the comprehensive, patient-centered care that may be delivered by multiple providers.

- Provide core operating support for the National Quality Forum to ensure ongoing, independent consensus process for the review, endorsement, and updating of measures so as to enable the availability comparative information and the reduction of provider reporting burden.

<u>Increase the breadth and scope of performance information available to the public</u>

- Release physician-identifiable Medicare claims data (fully protecting patient privacy), to allow for better quality and efficiency performance reporting.
- Continue to allow private-sector organizations to download granular provider performance information from the Compare websites.
- Release the risk-adjusted DRG rates for every hospital (and rates for physicians), by region in easily accessible formats.
- Develop BOTH total costs of episodes AND total estimated beneficiary out-of-pocket for episodes of care (with estimates for beneficiaries with and without Medigap supplemental coverage). This release should include contextual and background information.
- Present price information in a manner that reflects the following principles:
- **Linked directly to Quality measures** (outcomes, patient experience, compliance with evidence-based medicine). Whenever possible price information should be directly linked to quality information to facilitate total value consideration by the consumer. When it cannot be, there should be context and background (including that "more expensive" does not mean better)
- **Understandable**: Information should be "transmissible", that is, it can be communicated from one consumer to another and must recognize that different consumer audiences will have different information seeking and comprehension skills.
- **Actionable**: Information should include relevant comparisons of providers based on quality and cost; link to a consumer being able to select a particular option; and should provide context and background on how to not just compare price of providers/treatments selected, but information on potentially relevant alternatives.
- **Accessible**: Should be available on-line with no barriers and designed for ease of use.
- **Relevant to consumers' circumstances** (health and coverage status): Information should be as specific as possible to an individual or family's health coverage and health status (including potentially a discrete condition OR considering a combination of conditions).

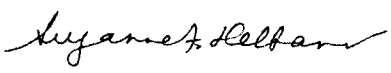
- **Predictive (accurate)**: Information should predict likely expense accurately and/or have clear explanation of the reason for range of cost variation.

CMS/HHS should consider using either voluntary or regulatory/contracting mechanisms to further enhance transparency of quality and cost information by:

- Releasing physician-identifiable Medicare claims data (fully protecting patient privacy), to allow for better quality and efficiency performance reporting.
- Establishing conditions of participation for hospitals that require posting of prices and/or policies regarding discounts and other payment options for uninsured patients. For insured individuals, health plans will be the primary vehicle for this information but disclosure is an important issue for equity reason, though true transparency and informed consumer decision-making will require actionable tools.
- The Administration through its various contracting mechanisms with health plans (via OPM or Medicare), should ensure they are providing tools for enrollees to make informed choices, considering both quality and costs.
- Requiring hospitals to augment claims form with additional clinical data elements. Accurately assessing provider performance would be greatly enhanced if the severity of the patient could be captured off of administrative claims data. The public reporting of quality and cost information would benefit greatly from claims data richer detail. Adding the following data elements to the inpatient paper and electronic claim form would enable much more robust hospital outcomes reporting:
  - A unique physician identifier for each coded procedure;
  - Capture the referring/ordering physician for each coded procedure;
  - Vital signs (heart rate, blood pressure, temperature, and respiratory rate) recorded at presentation;
  - Key lab values (BUN, hematocrit, platelets, WBC, sodium, potassium, and creatinine) if obtained at the time of admission, excluding hospitalizations for psychiatric, obstetrical and newborn services;
  - Do Not Resuscitate order present (including date and time), if recorded during first 24 hours of patient presenting; and
  - Time of day of admission, discharge, and each procedure.

Again, thank you for the opportunity to comment.

Sincerely,



Suzanne Delbanco, PhD
CEO, The Leapfrog Group

#1560

CMS-1488-P-1560

Submitter : Dr. Robert Hein

Date: 06/12/2006

Organization : John Peter Smith Hospital-FMRP

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

GME Payments

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.

CMS-1488-P-1560-Attach-1.DOC

#1560

Dear CMS policy maker

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being un related to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. That hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty . Rescind the interpretation of the IME and DME support rule

Sincerely,

Submitter : **Mr. David McClure** **Date: 06/12/2006**

Organization : **Tennessee Hospital Association**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1561-Attach-1.DOC

#1561

June 12, 2006

Centers for Medicare & Medicaid Services
Attention: CMS-1488-P
P.O.Box 8011
Baltimore, MD 21244-1850

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

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.

While the THA supports many of the proposed rule's provisions, we have serious concerns about the proposed changes to the DRG weights and classifications. THA supports meaningful improvements to Medicare's inpatient PPS. However, more time is needed to understand the significant proposed policy changes, which national organizations note 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. The validity of CMS' proposals versus potential alternatives to improve the DRG weights and classification system is uncertain. Moving forward requires thoughtful change.

Specifically, the THA supports the following:

- **A One-year Delay:** The THA supports a one-year delay in the proposed DRG changes given 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:** The THA does not support a new classification system at this time, 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 an optional three-year transition, given the magnitude of payment redistribution across DRGs and hospitals.

We have enclosed detailed comments that further explain our concerns and recommendations on the proposed DRG weight and classification system changes, as well as our position on many other issues in the proposed rule.

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, vice president of finance, at (615) 256-8240 or dmcclure@tha.com.

Sincerely,

Craig Becker, FACHE
President

cc: Rick Pollack, AHA, Executive Vice President

Proposed Changes

DRG Reclassifications

In response to payment recommendations from the Medicare Payment Advisory Commission (MedPAC) to address the proliferation of physician-owned, limited service hospitals, the Centers for Medicare & Medicaid Services (CMS) proposed the biggest changes to the calculation of diagnosis-related group (DRG) relative weights since the creation of the prospective payment system (PPS). These changes would significantly redistribute payments among the DRGs and among hospitals. Specifically, CMS proposes 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. CMS also proposes an alternative patient classification system called consolidated severity adjusted DRGs (CS-DRGs), with implementation likely in FY 2008.

The THA supports meaningful improvements to Medicare's inpatient PPS and the move to cost-based weights but we believe CMS' proposed method is flawed. Therefore a one year delay is needed to validate CMS corrections. The following details our concerns.

HSRVcc Method Concerns

The THA believes that more time is needed to develop a sound methodological approach to create cost-based weights and to understand their potential impact.

1. **Errors:** While analyzing CMS' proposed rule, national organizations such as the American Hospital Association (AHA) uncovered a series of data errors, inconsistencies across databases and questionable methodological choices. Further analyses commissioned by the AHA, the Association of American Medical Colleges and the Federation of American Hospitals and conducted by The Moran Company, Inc. to investigate these questions showed that small changes in method lead to large changes in DRG weights, signaling that the proposed changes are highly unstable.

    - CMS inadvertently included organ acquisition costs in the data used to set weights for DRGs.
    - CMS was inconsistent in its treatment of certain categories of hospitals between their calculation of the FY 2007 HSRVcc weights and the proposed CS-DRG weights, making it hard to directly compare the results.
    - It is unclear whether the weights published for CS-DRGs included a transfer adjustment.
    - Data cleaning steps used were not always consistent with standard CMS practices (e.g., removal of cases with 0 charges, low volume DRGs, etc.).
    - The cleaning steps applied to the cost report data were not consistent with the cleaning steps applied to the MedPAR claims data, which resulted in different hospitals being included in data sets used for the calculation of the weights and the calculation of the scalers to the weights.

2. **Trimming:** CMS trimmed the cost center CCRs at 1.96 standard deviations from the geometric mean. This skews the CCRs, as the hospitals with high routine charge mark-ups are systematically removed from the calculation. It also creates a mismatch between the CCRs used and the charges they are applied to, as the hospitals that are trimmed out of the CCRs are still included in the charges that are then reduced to costs and determine the cost shares.

3. **Weighting:** CMS also hospital-weighted rather than charge-weighted the calculation of the CCRs which in turn are used to calculate the scaling factors used to convert the charge-based relative weights to "cost." There are several issues with this approach:

    - This approach gives an equal weight to each hospital in the national cost-to-charge ratio calculation even though hospitals can range in size from fewer than 25 to more than 1,000 beds.
    - This method is inconsistent with the method of averaging used to develop the cost center-specific DRG weights to which the scaling factors are applied. For this part of the analysis, CMS calculated hospital-specific DRG relative weights, but then used a case-weighted average to develop the national value.
    - The hospital-weighted approach results in a 1 percent to 54 percent difference versus a charge-weighted approach in the resulting scaling factors used for the conversion to cost.

    The above errors in the calculations over-weight CMS' routine cost shares and under-weight the ancillary cost shares, creating erroneously large swings in DRG weights. These methodological problems have a large impact on the relative weight calculations at the DRG level and a material impact on hospital payment. CMS' method for weighting and trimming redistributes $1.4 billion dollars among hospitals nationally. Charge-weighting the CCRs and trimming them at three standard deviations would reduce the shift in dollars to $900 million – a reduction of ***half a billion dollars***, or 33 percent. This highlights the need for more work to validate each methodological step to understand how it affects payment and ensure it adds to "accuracy."

4. **Failure to Calculate Costs at the Claim Level:** CMS chose to use *charges* to initially calculate the relative weights at the DRG level and then a national scaler to make the conversion to "cost-based" weights. The national scaler converts the 10 cost center charge-based weights to one national weight using the actual share of costs across departments. CMS maintains that this adjusts for differential mark-ups across hospital departments. CMS provided no validation of the methodological shortcut they propose.

5. **Cost Centers:** CMS aggregates charges into 10 cost centers for each DRG, then applies a cost-center level CCR (derived from the cost reports) to charge figures

(from claims data). But because hospitals often report charges on the cost reports differently than charges on the claims, the cost-center level CCRs are calculated based on a different set of charges than the charges to which the CCRs are later applied. We believe this may materially distort the DRG weights and needs to be thoughtfully considered and accounted for in any methodology. If CMS is going to move to cost-based weights, regardless of the methodology, hospitals will need time to align their mapping of cost centers into departments or cost categories for purposes of cost reporting with that of claims reporting.

6. **Validation:** As mentioned above, CMS provided no analysis to validate that the proposed changes result in better payment policy. While measuring improved payment accuracy is difficult, the large degree to which the weights fluctuate given methodological changes alone indicates the need for further analysis and study. CMS should construct a process to test the sensitivity of weights to various methodological assumptions and publicly share the result, including:

    - Compare CMS weights to MedPAC's HSRV-cost approach;
    - Compare CMS weights to an approach using standardized costs (as opposed to HSRV);
    - Compare CMS weights to weights calculated by estimating costs at the claims level using the 10 cost center approach;
    - Evaluate alternative methodologies for estimating costs
      Compare stability of weights over time; and
    - Determine whether payment policy is improved.

New Patient Classification: Severity of Illness

CMS also proposes moving to an entirely new patient classification system beginning in FY 2008 *or earlier*. Currently, Medicare uses 526 DRGs to classify all Medicare patients. CMS considered use of 3M's all-patient refined DRGs (APR-DRGs) as an alternative to its current DRGs, which would increase the number of categories to 1,258. However, CMS ultimately proposed refining the APR-DRG system by consolidating APR-DRGs into fewer categories. This would result in a new DRG system with 861 consolidated severity-adjusted DRGs, or CS-DRGs.

The THA believes that the need for and best approach to changing the patient classification system has not been concretely and objectively demonstrated. More careful analysis is needed, along with greater access to the specifics of CMS's methodology and the new GROUPER. Below we discuss our detailed concerns and questions about this proposal.

CS-DRG METHOD CONCERNS

1. **Validation:** CMS provided no analysis that shows that the proposed changes result in an improved hospital payment system compared to the existing DRG system or APR-DRGs.

Today's DRG system was created to distinguish the resource use required among patients. It has been modified over time to reflect changes in clinical practice and technology. The APR-DRG system is based on severity of illness, not necessarily the resource use required. The impact of a move to CS-DRGs – an APR-DRG hybrid – is unclear. But the implications of moving from a resource-based system to a severity-based payment system must be more fully explored and understood.

2. **Budget Neutrality Adjustment:** CMS suggests in the proposed rule that it would reduce payments to hospitals by instituting a budget neutrality adjustment to offset the fact that case mix may increase because of improved coding rather than actual changes in acuity. However, CMS did not propose an adjustment or even a methodology for determining an adjustment. CMS often institutes such adjustments that are based on assumptions but never checked or later corrected. **THA recommends that CMS hold off on such an adjustment until there is evidence that one is needed.**

3. **Availability of the GROUPER:** The proprietary nature of the proposed CS-DRG GROUPER is of concern. The current DRG GROUPER logic has been in the public domain since the inception of the PPS. Without the new GROUPER logic, it is virtually impossible for hospitals to thoroughly analyze the system and comment – without access to the new GROUPER, we have no understanding of how and why patients fall into certain CS-DRGs and cannot evaluate whether it represents policy improvement. If CS-DRGs are adopted and the GROUPER remains proprietary, the THA would be limited in our ability to educate and assist our member hospitals. Moreover, a single company's monopoly would be both more expensive and more difficult to integrate into our hospitals' existing systems. **THA urges CMS to make any new classification system widely available to the public and not be proprietary logic or software.**

4. **Too Few Diagnoses and Procedures Considered:** We are concerned that CMS' GROUPER does not use all diagnoses and procedures that affect a patient's severity of illness and/or the resources utilized. The current DRG GROUPER only considers nine diagnoses and up to six procedures. Hospitals submit claims to CMS in an electronic format. The HIPAA compliant electronic transaction 837i standard allows up to 25 diagnoses and 25 procedures. Many fiscal intermediaries are ignoring or omitting the additional codes submitted by hospital providers since these additional diagnoses and procedures are not needed by the GROUPER to assign a DRG. **THA recommends the GROUPER consider all diagnoses and procedures.**

THA Recommendations on DRG Reclassifications

- **A One-year Delay:** The THA supports a one-year delay in the proposed DRG changes given 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. **Therefore a one year delay is needed to validate CMS corrections**

- **A New Classification System Only if the Need Can Be Demonstrated:** The THA does not support a new classification system at this time, 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 an optional three-year transition, given the magnitude of payment redistribution across DRGs and hospitals.

Long-term Care Hospital (LTCH) DRGs

The THA is very concerned about the proposed reweighting of the long-term care hospital (LTCH) DRGs for FY 2007. The projected payment cut resulting from the reweighting – 1.4 percent – in combination with the payment cut resulting from the recent LTCH PPS final rule for 2007 – 7.1 percent – will cause substantial volatility for LTCH providers, and ultimately restrict access for patients needing long-term acute care services. **THA urges the agency to forgo the proposed 1.4 percent cut and instead implement the reweighting in a budget-neutral manner.**

Hospital Quality Data

The Deficit Reduction Act of 2005 (DRA) expands quality reporting requirements for hospitals to be eligible to receive a full market basket update. The proposed rule states that to qualify for their full market basket update, hospitals would have to pledge to submit data on all 21 measures currently part of the Hospital Quality Alliance's (HQA) public reporting on www.HospitalCompare.hhs.gov for patients discharged on or after January 1. Hospitals failing to submit data for the first calendar quarter of 2006 by August 15 would receive an inpatient update equal to the market basket minus two percentage points. Hospitals that fail data validation tests for data submitted for the first three calendar quarters of 2005 would also lose the two percentage points from the market basket update.

THA recommends that CMS make the data collection prospective. This could be accomplished by requiring that hospitals that want a full market basket update

beginning October 1 to pledge to submit the relevant data for all 21 measures for patients beginning on or after October 1.

The DRA gave the Secretary of the Department of Health and Human Services (HHS) the authority to further expand the measures that must be reported to qualify for full market basket update in future years. **We strongly urge CMS to select measures only from those used by the HQA for public reporting.** In addition, whenever the Secretary intends to expand the set of measures linked to payment, **CMS should consider publishing the proposal at least one full year prior to the start of the fiscal year.** This will enable hospitals and their vendors to put the needed data collection processes in place to be able to provide the requested data.

Further, we agree with CMS that it is critical that the collected data be validated. **THA strongly encourages CMS to allow hospitals to challenge any mismatches in the chart validation that they may have with the QIO in order to learn from the process, and remedy any identified problems to prevent them from occurring in subsequent quarters. THA also recommends that CMS consider a validation process that would focus more resources on those hospitals that are having difficulty in passing the validation thresholds on a consistent basis. Additionally, going forward, CMS should prospectively establish and communicate to the field which quarters will be used in the calculation of the validation threshold.**

We further urge CMS to review, on a case-by-case basis, any incidence where a hospital's payment would be put in jeopardy as a result of the validation process. It should allow the hospital to submit information showing that it made a good-faith effort to supply the data warehouse with accurate information so that the public could be informed about the quality of its care. If the hospital has made a good-faith effort, it should receive full payment regardless of whether the data are deemed accurate enough for public display. In addition, CMS should instruct its QIO data warehouse to accept any significant corrections so that the public can have a full and accurate picture of hospital quality.

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 remain very concerned that the threshold is too high. According to industry analyses, 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.

The estimated fixed-loss amount that would result in 5.1 percent outlier payments under this methodology is $24,000. If CMS leaves the threshold at $25,530, rather than dropping it to $24,000, we believe that CMS will again significantly under spend by over $300 million.

Core-based Statistical Areas (CBSAs)

In adopting the Core-based Statistical Areas (CBSAs) in FY 2005, a small number of hospitals that were classified as urban in FY 2004 became classified as rural in FY 2005. Because moving from a Metropolitan Statistical Area (MSA) to the rural statewide average would have resulted in a significant decline in these hospitals' wage indexes, CMS implemented a three-year transition period (FYs 2005-2007). **The THA supports the continued transition for these hospitals to give them the opportunity and time to reclassify.**

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.**

However, hospitals will 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 penalize neighboring hospitals.**

Corrections. **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.

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. The results of the survey could be material. **Thus, we urge CMS to publish the occupational mix adjustment changes as an interim-final rule in August with an associated comment period.**

Wage Index Budget Neutrality

CMS eliminates the CAH data from the wage index file it uses to compute the national average hourly wage (NAHW). For FY 2007, 1,191 CAHs representing approximately 24 percent of all inpatient PPS hospitals (as of FY 2000) – 55 percent of all rural hospitals in FY 2000 – have been eliminated from the file. Because CAHs have lower average hourly wages (AHWs) than the average PPS hospital, the elimination of this data results in an overstated NAHW. While the NAHW has been increasing, the systematic withdrawal of low-wage hospitals has artificially inflated the NAHW to some extent. This artificial increase is included in the negative budget neutrality adjustment that consequently reduces payment, resulting in the national inpatient PPS operating payments being understated by an estimated $1.52 billion over five years (2003-2007). **Thus, we believe that CMS should apply a positive budget neutrality adjustment in FY 2007 to compensate for the underpayments.** The understatement increases

each year as more hospitals become CAHs and more data are eliminated from the wage index data. However, we believe that this could be a one-time adjustment as we expect very few hospitals to convert to CAH status now that the necessary provider designation is no longer an option.

Low-volume Hospital Payment Adjustment

Section 406 of the MMA created a payment adjustment under the inpatient PPS to account for the higher costs per case of low-volume hospitals. The law defined eligible hospitals as those located more than 25 miles from another facility with fewer than 800 total discharges annually. The rule proposes to maintain a 25 percent increase, the maximum allowable, in payments to hospitals with fewer than 200 discharges. For those hospitals that have between 200 and 800 discharges, CMS proposes to maintain its current policy, applying no payment increase. Only two hospitals will receive this adjustment in FY 2007 according to CMS estimates. **The THA is concerned that CMS is ignoring congressional intent and denying a group of hospitals – those with more than 200 discharges but fewer than 800 discharges – access to this necessary payment increase.**

SCH/MDH Changes in Qualification Status

The proposed rule would require an approved sole community hospital (SCH) or Medicare dependent hospital (MDH) to notify the appropriate CMS Regional Office of any change affecting its classification as such. To date, it has been the FIs responsibility to evaluate hospitals' continuing qualification for SCH or MDH status. CMS expects the hospital to now self-disclose any material changes in circumstances or potentially face a retroactive cancellation of their designation once an FI discovers its ineligibility.

This appears to be an inappropriate shift of the burden from the FIs to hospitals. For instance, hospitals are neither involved in, nor have any control over, the building of new roads or new hospitals and thus should not be accountable to report such changes. It also would be very difficult for hospitals to know when and for how long there were prolonged severe weather conditions that closed area roads, or to note changes to posted speed limits and traffic patterns. In addition, some of the qualifying criteria, such as inpatient admissions at other regional hospitals, would be hard to monitor as the hospitals do not have this sort of data on their competitors. Requiring hospitals to constantly monitor whether they continue to meet these requirements would impose a tremendous and unreasonable administrative burden on hospitals. **The THA recommends that this function remain a responsibility of the FIs, who are in a better position to monitor these circumstances. If CMS requires hospitals to report changes in circumstances, then the specific types of situations should be noted and should only include aspects of their operation that are within their control (e.g., number of beds).**

CMS' proposal to retroactively withdraw SCH or MDH status if a hospital does not appropriately self-report a change in circumstances could be financially devastating. CMS should at minimum give consideration to whether the hospital had knowledge of the disqualifying circumstance. Hospitals should not have to repay CMS based on the difference between the inpatient PPS or outpatient PPS payment and the SCH or MDH payment when they did not know that they no longer qualified for the program. Instead CMS should develop a prospective process for withdrawing the hospitals' SCH or MDH status. We believe that a 30-day timetable for losing SCH/MDH status is unrealistic given the financial implications of such a change and the inability for a hospital to plan for this outcome. **CMS should re-evaluate the proposed timetable for canceling SCH/MDH status when a hospital is found to be disqualified or self-reports disqualification and consider revoking the hospitals' status as of the following cost-reporting period.**

SCH/MDH Volume Decrease Adjustment

An SCH or MDH may apply for special payments if it experiences a decrease of 5 percent or more in its total number of inpatient discharges that was out of its control from one cost-reporting period to another. If the hospital qualifies, it must demonstrate that it took measures to scale back its nursing force commensurately. The adjustment is intended to cover the fixed costs that the hospital is unable to reduce in the year following the volume decrease. CMS believes that only "core staff and services" should be covered by these special payments. To date, CMS has used the AHA's HAS/Monitrend Data Book to compare the hospital's staffing to other similar hospitals in the area to determine if the hospital is staffing its routine and intensive care units appropriately. However, the Data Book has not been updated since 1993. CMS has been using the 1989 publication. Thus, CMS proposes using the occupational mix adjustment data currently being collected for wage index purposes to calculate nursing hours per inpatient day for a hospital in question and local peer hospitals.

The occupational mix adjustment was only partially implemented in its first three years, primarily due to the questionable data and results. The current collection, which is occurring again under rushed circumstances, may also result in questionable data. **We do not believe that it is wise to assume that the occupational mix adjustment data will be appropriate for this use. The THA believes that the data within the AHA annual survey should be sufficient for CMS to determine the nursing levels per patient day.**

Critical Access Hospitals (CAHs)

On November 14, 2005, CMS issued interpretive guidelines on the relocation of CAHs as a follow-up to the FY 2006 inpatient PPS final rule that established the "75% test" – serving 75 percent of the same population, providing 75 percent of the same services and employing 75 percent of the same staff – for necessary provider CAHs. The guidelines not only extended the 75% test to *all* CAHs, but it also altered the definitions of "mountainous terrain" and "secondary road."

We believe that these guidelines go well beyond the regulations included in the FY 2006 rule that provoked numerous critical responses from individual CAHs, associations and congressional representatives. The "mountainous terrain" and "secondary road" definitions are overly prescriptive and the 75% test does not provide reasonable flexibility based on natural variation in demographics, patient needs distribution patterns, normal employee and board attrition, and necessary changes in services to meet community needs. **Rural hospitals that move a few miles are clearly the same providers serving the same communities.**

Many CAHs are planning to rebuild in the near future to improve site safety and quality of care by adding fire and smoke barriers, upgrading infrastructure to support utilities and air handling, modernizing telecommunications to support health information technology, or making other essential upgrades. Facilities expect to relocate when they rebuild for a multitude of reasons: to be closer to a highway, to connect to municipal water and sewer, because of seismic safety concerns, or other similar concerns. **Such improvements will undoubtedly result in higher quality care, better patient outcomes and more efficient service, yet CMS' guidelines discourage these improvements.**

CMS' guidelines will not only impose an unnecessary burden on CAHs, but will preclude many of them from securing financing for needed capital improvements. The hospitals themselves, their hospital districts and their lenders cannot risk investing in a hospital that will be unsure of its status until a year after moving. **CMS should create a preliminary approval process to give assurances to those involved in the project that the CAH relocation will be approved if it meets the assertions made in the attestation submitted to CMS.**

Again this year, almost 60 congressional representatives signed a letter to CMS showing their support for their CAHs and urging changes to these guidelines. We agree with their recommendations and reiterate our suggestion from last year that a safe harbor be established for hospitals relocating within five miles of their existing locations. These providers are not only clearly serving the same communities, but trying to improve the quality of and access to needed health care services. A safe harbor will reduce the administrative burden on not only the hospitals, but CMS and the state survey agencies as well. **We urge CMS to create a safe harbor for CAHs moving a short distance and to make significant changes to these guidelines based on the feedback from CAHs around the nation as detailed in an AHA letter to Thomas Hamilton, director of the survey and certification group.**

Graduate Medical Education (GME) Payments

Exclusion of Didactic Training. The proposed rule states that resident training that occurs at non-hospital sites must be related to patient care if a hospital wishes to count that time for direct medical education (DGME) and indirect medical education (IME) payment purposes. Resident time spent in didactic activities that often occur in associated medical schools – such as educational conferences, journal clubs and

seminars – would specifically be excluded. CMS noted that its statement in a previous letter on this topic "implying that didactic time spent in non-hospital settings could be counted for direct GME and IME ... was inaccurate." CMS also noted that time spent in these activities could be counted for DGME purposes if they occur in a hospital; however, the counting prohibition applies for IME payments regardless of where the educational activity occurs.

We urge CMS to withdraw this change 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.

Emergency Medical Treatment and Active Labor Act (EMTALA)

Definition of "Labor." **The THA supports CMS' proposal to modify the definition of "labor" at 489.24(b) to allow a certified nurse-midwife or other qualified medical personnel operating under their scope of practice, as defined in hospital medical staff bylaws and in state law, to certify that a woman is in false labor**

Hospitals without Dedicated Emergency Departments (ED). Under the proposed rule, a hospital with "specialized capability" is required to accept appropriate transfers under EMTALA regardless of whether it has a dedicated ED. **Guidance is still needed on the definition of specialized capability.**

The THA agrees that a physician-owned, limited-service hospital should be treated as a hospital "with specialized capability or facilities" under EMTALA without regard to whether it has an ED.

THA recommends that every physician-owned, limited-service hospital that relies on the community's emergency services capacity should be obligated to support it.

In addition, physician-owned, limited-service hospitals should be required to have agreements with the community hospitals they plan to rely on in the event that they do not have the capacity to treat a particular patient.

Specifically, the THA recommends the following:

- **A physician-owned, limited-service hospital should be required to have a pre-existing agreement with the community hospital(s) it intends to rely on for emergency back-up services.**

- **The Secretary should establish the terms that must be addressed by an agreement, including:**

- **Procedures for an appropriate transfer for patients not covered under EMTALA**
- **Continuity of care** (e.g., telephone consultation with the receiving hospital and physician, sending the patient's medical records along when transferred, etc.); and
- **Support for maintaining full-time emergency capacity at the community hospital, including on-call coverage**

New Technology

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

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

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

The THA strongly recommends that the Secretary undertake the regulatory process to replace ICD-9-CM with ICD-10-CM and ICD-10-PCS expeditiously.

Other Future Concepts

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. HHS intends to identify several regions in the United States with high health care costs where there is significant interest in reducing those costs and improving health care quality.

While progress has been made regarding quality transparency, similar information on hospital pricing is less accessible. In the proposed rule, CMS details four options for providing pricing information to health care consumers.
THA recommends the following:

1) Hospital charge information should be available to the public.

2) A federal requirement for states, working with insurers, to make available in advance of medical visits, information about an enrollee's expected out-of-pocket costs.

3) A federal-led research effort to better understand what type of pricing information consumers want and would use in their health care decision-making.

4) A hospital-led effort to create consumer-friendly pricing "language" – common terms, definitions and explanations to help consumers better understand the information provided.

More can be done to explain pricing information to consumers clearly and consistently. Hospitals should lead an effort to create common terms, definitions and explanations of complex pricing information. This will include sharing innovative and understandable ways for displaying pricing information for use by consumers.

Hospital Value-Based Purchasing

The DRA required CMS to develop a plan to implement hospital value-based purchasing (pay for performance) beginning in FY 2009. Hospitals remain committed to providing safe, effective, patient-centered, timely, efficient and equitable care to all patients, and THA recommends CMS work with hospitals on the development of a value-based purchasing system for Medicare. It is critically important that the system be well thought out.

Health Information Technology (IT)

The proposed rule states that it "supports the adoption of health IT as a normal cost of doing business to ensure patients receive high quality care." It also notes that the quality and efficiency benefits of health IT may provide a policy rationale for promoting the use of health IT through the Medicare program. Consequently, CMS asks for comments on:

- Its statutory authority to encourage adoption and use of IT;
- The appropriate role of IT in any value-based purchasing program; and
- The desirability of including use of certified health IT in hospital conditions of participation.

The THA strongly believes that health IT is a very important tool for improving the safety and quality of health care, and our members are committed to adopting IT as part of

their quality improvement strategies. They also view IT as a public good that requires a shared investment between the providers and purchasers of care.

Health IT is a very costly tool, requiring both upfront and ongoing spending. A 2005 industry survey of hospitals and health systems found that the median amount hospitals invested on health IT in one year was more than $700,000, 15 percent of total capital expenses. Hospitals spent even greater amounts – a median of $1.7 million or 2 percent of all operating expenses – on operating costs. Survey respondents identified the upfront and ongoing costs of IT as the greatest barriers to further adoption. The survey also found that hospitals with negative margins and those with lower revenues use less IT.

Simply put, our members have not seen financial returns greater than the costs of implementing clinical IT systems, particularly in the short term. They adopt clinical IT because it is the right thing to do for improving patient safety and quality of care, not because it saves them money. Thus, while IT may be a "normal cost of doing business," it systematically raises those costs. **Given that they reap many of the financial benefits of IT, the THA believes that the payers and purchasers of care such as CMS should share in the costs of IT on a prospective basis.**

Value-based Purchasing. Health IT can play a role in reducing the burden of quality reporting. Presently, electronic health records (EHRs) and other clinical IT systems do not automatically generate quality measures. Most hospitals still require special calculations – including expensive manual chart abstraction and use of third-party contractors – to submit quality data. CMS could advance the quality agenda by investing in the development of algorithms for the calculation of the quality measures it wants reported from EHRs and encouraging vendors to include them in their products.

Rather than including health IT in a value-based purchasing program, **CMS could support adoption of health IT through a payment adjustment funded with new money.** For example, it could increase payments to hospitals that use health IT that improves the safety and quality of care by 1 percent. This kind of payment adjustment represents Medicare's share of the necessary investment to achieve this goal and would recognize the greater costs of a "wired" health care system.

Conditions of Participation. The THA firmly believes that **CMS should not include health IT in the Medicare conditions of participation (COP) for hospitals.**

Hospital-acquired Infections

In the proposed rule, CMS has asked for ideas about how to effectively implement the DRA provision requiring the agency to identify instances in which the reliable application of science and appropriate processes of care should prevent infections, and to ensure that Medicare does not pay more for the hospital care of patients who becomes infected as a result of their care than it does for patients who are infection free.

It is difficult to identify the confluence of known science and effective care processes to prevent infections. **We believe that until a broad array of expertise is brought together to consider what conditions, procedures and circumstances should be targeted for this change, it is impossible to know how to most effectively implement the provision.**

End of Comments

Submitter : **Dr. Jeff Henney** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

CMS-1488-P-1562-Attach-1.DOC

#1502

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

Someone at CMS will need to explain to me, how the teaching, curriculum development and evaluation process for the six required ACGME physician skill competencies is not related to patient care. Isn't this exactly what the IOM has criticized our training professions for? In fact, our program currently evaluates us in all these competencies as a continuing quality improvement process DURING patient care. Without time to discuss and reflect our experiences and outcomes we will not be serving the needs of our current and future patients.

Should indeed this come to pass, we will have faculty who will be caught in the productivity race with no time for us. We may get pop-up feed back from an Electronic Health Record in sites that have them that we have made an error or we are not following a guideline. No discussion there. What is being proposed is dangerous for our current patients and our future patients. Our patients deserve for us to have a better education than you are proposing.

Why does the American taxpayer support medical students at over $200,000 per student per year and offers the faculty of residencies less than $15,000 for teaching per resident per year? I am getting a lot more from my residency training to protect and serve my patients of the future than all of medical school combined. Please do not cut us any more – rescind the clarification of this dangerous and capricious rule.

Medical Resident

Submitter : **Dr. Rudy Herrera** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME 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.

CMS-1488-P-1563-Attach-1.DOC

#1563

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

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

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attached

#17364

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. Jennifer James** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

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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.

CMS-1488-P-1565-Attach-1.DOC

#1565

Dear CMS policy maker

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being un related to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

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Please help us be better physicians to our patients by supporting a competent and refreshed faculty . Rescind the interpretation of the IME and DME support rule

Sincerely,

Submitter : **Dr. Brian Jenkins** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

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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.

CMS-1488-P-1566-Attach-1.DOC

#1066

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

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Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

Submitter : **Ms. Nancy Galvagni** **Date: 06/12/2006**

Organization : **Kentucky Hospital Association**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1488-P-1567-Attach-1.DOC

#1567

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 Kentucky Hospital Association's (KHA) 127 member hospitals, we 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).

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc). It also proposes refining the DRGs to better account for severity by implementing consolidated severity adjusted DRGs (CS-DRG), in FY 2008 or sooner. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education, among other policies.

While the KHA supports many of the proposed rule's provisions, we have serious concerns about the proposed changes to the DRG weights and classifications.

The hospital field supports meaningful improvements to Medicare's inpatient PPS. We support the goal of refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. 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 methodology 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.

The HRSVcc, which shifts payments to rural hospitals, increases Kentucky's $1.8 billion inpatient payments by $6.3 million in 2007 (0.35%). The implementation of CS-DRG methodology in 2008 has a significant negative impact on the rural hospitals in Kentucky. Even

though most of Kentucky's urban hospitals recoup in 2008 some of what they lost in 2007, they are still down for the two years and years going forward. The change in DRG in 2008 will reduce Kentucky inpatient payments by approximately $25 million compared to 2007. Moving forward requires thoughtful change.

Specifically, the KHA supports the following:

- **One-year Delay:** The KHA supports a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. Why change a methodology which has been in place since 1983 for one year to be replaced by a new system in 2008? CMS considers the 2007 change a first step in a major overhaul of the DRG system in 2008. How is 2007 a first step if it shifts dollars in the opposite direction of what is planned in 2008?

- **Valid Cost-based Weights:** We support moving to a DRG-weighting methodology based on hospital costs rather than charges if the calculations are correct.

- **A New Classification System Only if the Need Can Be Demonstrated:** The KHA does not support a new classification system at this time, 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:** Develop a methodology that would allow for a three-year phase-in which would allow the negatively impacted hospitals time to adjust their operations. CMS has a history of phasing in changes when hospitals are negatively impacted.

The KHA appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me at (502) 426-6220 or ngalvagni@kyha.com or Steve Miller at (502) 426-6220 or smiller@kyha.com.

Sincerely,

Nancy C. Galvagni
Senior Vice President

American Hospital Association
Detailed Comments on the
FY 2007 Inpatient Prospective Payment System Proposed Rule

Table of Contents

PROPOSED CHANGES

DRG Changes ..... p. 4
New DRG Weights: HSRVcc ..... p. 4
New Patient Classification: Severity of Illness ..... p. 9
DRG Reclassifications ..... p. 12
Long-term Care Hospital DRGs ..... p. 14
Hospital Quality Data ..... p. 15
Outlier Payments ..... p. 17
Core-based Statistical Areas ..... p. 18
Occupational Mix Adjustment ..... p. 18
Hospital Redesignations and Reclassifications ..... p. 20
Geographic Reclassifications ..... p. 21
Wage Index Budget Neutrality ..... p. 23
Low-volume Hospital Payment Adjustment ..... p. 23
SCH/MDH Changes in Qualification Status ..... p. 24
SCH/MDH Volume Decrease Adjustment ..... p. 24
Rural Referral Centers ..... p. 25
Critical Access Hospitals ..... p. 25
Graduate Medical Education Payments ..... p. 26
Emergency Medical Treatment and Active Labor Act ..... p. 27
New Technology ..... p. 29

OTHER FUTURE CONCEPTS

Transparency of Health Care Information ..... p. 30
Hospital Value-based Purchasing ..... p. 34
Health Information Technology ..... p. 36
Hospital-acquired Infections ..... p. 38

PROPOSED CHANGES

DRG CHANGES

In response to payment recommendations from the Medicare Payment Advisory Commission (MedPAC) to address the proliferation of physician-owned, limited service hospitals, the Centers for Medicare & Medicaid Services (CMS) proposed the biggest changes to the calculation of diagnosis-related group (DRG) relative weights since the creation of the prospective payment system (PPS). These changes would significantly redistribute payments among the DRGs and among hospitals. Specifically, CMS proposes 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. CMS also proposes an alternative patient classification system called consolidated severity adjusted DRGs (CS-DRGs), with implementation likely in FY 2008.

The hospital field supports meaningful improvements to Medicare's inpatient PPS. We believe the AHA and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs which will provide an equal incentive to treat all types of patients and conditions. We also believe the system should be simple, predictable, and stable over time. One of the fundamental values of a *prospective* payment system is the ability of providers to reasonably estimate payments in advance to inform their budgeting, marketing, staffing and other key management decisions. Another core feature of the PPS is clinically cohesive and meaningful DRGs that are 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 AHA believes that these are essential characteristics of a well-functioning PPS and it is within these policy goals that we evaluate CMS' proposal.

While we are providing CMS with comments under separate cover on its interim report to Congress regarding the development of a strategic implementation plan on physician-owned, limited service hospitals as required under the *Deficit Reduction Act of 2005* (DRA), we would like to emphasize here that payment changes alone will not remove the inappropriate incentives created by physician self-referral to limited-service hospitals. Physicians will still have the ability and incentive to steer financially attractive patients to facilities they own, avoid serving low-income patients, practice similar forms of selection for outpatient services and drive up utilization for services. We strongly urge CMS to rigorously examine the investment structures of physician-owned, limited-service hospitals and consider our comments on the interim report on the strategic plan. It is imperative that CMS continue the suspension of issuing new provider numbers to physician-owned, limited-service hospitals until the strategic plan developed has been fully implemented and Congress has had an opportunity to consider CMS' final report.

NEW DRG WEIGHTS: HSRVCC

CMS proposes an alternative to MedPAC's approach to HSRVs and cost-based weights that could be characterized as a short cut. CMS asserts that this combined methodology, known as the HSRV cost center methodology (HSRVcc), achieves similar results in a more administratively feasible manner. But that is not the case. Specifically, the CMS proposal involves two major steps.

1. Develop, on a charge-basis, hospital-specific relative weights for each DRG. CMS established 10 cost center categories based on broad hospital accounting definitions: routine day costs; intensive care day costs; and eight ancillary cost centers. CMS calculated DRG relative weights for each of the 10 cost centers by DRG for each hospital and then used those hospital-specific weights for calculating national DRG weights. CMS' current process aggregates charges for all hospitals at the DRG level to calculate weights. CMS believes the new approach removes the variation introduced by hospital characteristics such as teaching, disproportionate share, location and size, among others.

2. "Scale" the charge-based DRG weights to "costs" using the national cost center cost-to-charge ratios (CCRs) developed from the cost report data (as opposed to using hospital-specific CCRs at the claim level). CMS believes this approach will remove the effect of different CCRs across departments within hospitals. CMS chose this methodology because the use of national average rather than hospital-specific departmental CCRs is administratively easier.

The AHA supports the move to cost-based weights but believes CMS' proposed method is flawed. More work is needed to determine the best way to create cost-based weights. Hospitals are willing to work with CMS in a process to develop consensus around the right way to make this change. Below we discuss our detailed concerns and questions regarding the proposed HSRVcc methodology.

HSRVcc METHOD CONCERNS

The AHA believes that more time is needed to develop a sound methodological approach to create cost-based weights and to understand their potential impact.

1. **Errors:** While analyzing CMS' proposed rule, the AHA uncovered a series of data errors, inconsistencies across databases and questionable methodological choices. Further analyses commissioned by the AHA, the Association of American Medical Colleges and the Federation of American Hospitals and conducted by The Moran Company, Inc. to investigate these questions showed that small changes in method lead to large changes in DRG weights, signaling that the proposed changes are highly unstable (see attached technical appendix).

   For instance, the following, more minor, inconsistencies were identified:

   - CMS inadvertently included organ acquisition costs in the data used to set weights for DRGs. These costs should be excluded. This error has a material effect on the resulting weight calculation for transplants. For example, CMS publishes a weight of 5.5466 for DRG 302 (Kidney Transplant), but with this correction The Moran Company calculates a weight of 3.0102.

   - CMS was inconsistent in its treatment of certain categories of hospitals between their calculation of the FY 2007 HSRVcc weights and the proposed CS-DRG weights, making it hard to directly compare the results. For example, hospitals in Maryland were included in the FY 2007 MedPAR data used for the HSRVcc weight calculation and excluded from the CS-DRG calculation.

- The Moran Company used transfer-adjusted charges prior to calculating weights. It was CMS' policy to do this. However, it is unclear whether the weights published for CS-DRGs included this step.

- Data cleaning steps used were not always consistent with standard CMS practices (e.g., removal of cases with 0 charges, low volume DRGs, etc.).

- The cleaning steps applied to the cost report data were not consistent with the cleaning steps applied to the MedPAR claims data, which resulted in different hospitals being included in data sets used for the calculation of the weights and the calculation of the scalers to the weights. For example, hospitals in Maryland and hospitals without cost reports for FY 2003 were excluded from the cost report data used to calculate the scalers and included in the MedPAR file used to calculate the weights.

2. **Trimming:** CMS trimmed the cost center CCRs at 1.96 standard deviations from the geometric mean. We believe that this skews the CCRs, as the hospitals with high routine charge mark-ups are systematically removed from the calculation. This results in the exclusion of 198 hospitals' routine CCRs, accounting for over 26 percent of total routine charges. It also creates a mismatch between the CCRs used and the charges they are applied to, as the hospitals that are trimmed out of the CCRs are still included in the charges that are then reduced to costs and determine the cost shares.

3. **Weighting:** CMS also hospital-weighted rather than charge-weighted the calculation of the CCRs which in turn are used to calculate the scaling factors used to convert the charge-based relative weights to "cost." There are several issues with this approach:

   - This approach gives an equal weight to each hospital in the national cost-to-charge ratio calculation even though hospitals can range in size from fewer than 25 to more than 1,000 beds.
   - This method is inconsistent with the method of averaging used to develop the cost center-specific DRG weights to which the scaling factors are applied. For this part of the analysis, CMS calculated hospital-specific DRG relative weights, but then used a case-weighted average to develop the national value.

   - The hospital-weighted approach results in a 1 percent to 54 percent difference versus a charge-weighted approach in the resulting scaling factors used for the conversion to cost.

The above errors in the calculations over-weight CMS' routine cost shares and under-weight the ancillary cost shares, creating erroneously large swings in DRG weights. Table 1 illustrates how these methodological problems affect the factors used to scale the cost center-specific relative weights. This table shows the impact of trimming the cost center CCRs at 3.0 rather than 1.96 standard deviations from the geometric mean and charge-weighting rather than hospital-weighting the calculation of the national average CCRs that are used in developing the scalers.

Table 1
Impact of Methodological Changes on "Scalers"
Published versus Revised with Methodological Changes

Scaler	CMS Published	Methodological Changes: Trimming Only	Weighting Only	Weighting/ Trimming	Percent Change vs. Published
Routine days	0.2881	0.2882	0.2646	0.2490	-14%
Intensive days	0.1919	0.1933	0.1668	0.1636	-15%
Drugs	0.0877	0.0884	0.0939	0.0970	11%
Supplies	0.1150	0.1142	0.1325	0.1383	20%
Therapeutic	0.0384	0.0381	0.0390	0.0388	1%
Operating room	0.0812	0.0838	0.0861	0.0888	9%
Cardiology	0.0241	0.0246	0.0351	0.0371	54%
Laboratory	0.0670	0.0659	0.0681	0.0687	3%
Radiology	0.0427	0.0437	0.0460	0.0474	11%
Other services	0.0639	0.0600	0.0677	0.0712	12%

Source: Moran Company analysis.

These methodological problems have a large impact on the relative weight calculations at the DRG level. Table 2 shows, for key DRGs, how these methodological problems affect the DRG weights and, therefore, hospital payments.

Table 2
DRG Weights with Current Methodology vs. HSRVcc with Various Corrections
High Volume DRGs with Largest Changes in Weights Due to Corrections

				New DRG Weights: Published vs. Corrected			Change vs. Old Weights		
DRG (v24)	DRG Title	Number of discharges	Current Charged-based Weights w/v24 Grouper	CMS Published HSRVcc Weight	HSRVcc w/ Technical Corrections Only	Corrected, Weighted and Trimmed CCRs	DRG Weight Change Current Method vs. Published	DRG Weight Change Current vs. Corrected, Weighted, and Trimmed	Published vs. Corrected, Weighted, and Trimmed
430	PSYCHOSES	74,871	0.6581	1.2316	1.2416	1.1110	87.7%	69.3%	-9.8%
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	56,042	0.8983	1.0105	1.0099	0.9635	12.5%	7.3%	-4.7%
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	119,513	3.4630	3.8279	3.8366	3.6573	10.5%	5.6%	-4.5%
277	CELLULITIS AGE >17 W CC	118,691	0.8676	1.0015	1.0026	0.9578	15.4%	10.4%	-4.4%
87	PULMONARY EDEMA & RESPIRATORY FAILURE	96,506	1.3854	1.5310	1.5324	1.4699	10.5%	6.1%	-4.0%
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	224,491	0.8611	0.9538	0.9544	0.9162	10.8%	6.4%	-3.9%
294	DIABETES AGE >35	97,122	0.7750	0.8642	0.8636	0.8307	11.5%	7.2%	-3.9%
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	246,948	0.8213	0.9041	0.9042	0.8701	10.1%	5.9%	-3.8%
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	159,894	1.5939	1.7331	1.7359	1.6680	8.7%	4.6%	-3.8%
243	MEDICAL BACK PROBLEMS	100,498	0.7888	0.8680	0.8693	0.8363	10.0%	6.0%	-3.7%
554	OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX	77,003	2.0890	1.9483	1.9560	2.0085	-6.7%	-3.9%	3.1%
110	MAJOR CARDIOVASCULAR PROCEDURES W CC	57,436	3.8616	3.6419	3.6558	3.7563	-5.7%	-2.7%	3.1%
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	119,991	1.4508	1.1670	1.1732	1.2380	-19.6%	-14.7%	6.1%
544	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	444,118	1.9514	1.8941	1.9047	2.0147	-2.9%	3.2%	6.4%
551	PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR	53,717	3.0391	2.6339	2.6481	2.8453	-13.3%	-6.4%	8.0%
552	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX	81,744	2.0837	1.7670	1.7771	1.9468	-15.2%	-6.6%	10.2%
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	91,848	1.1117	0.7862	0.7913	0.8717	-29.3%	-21.6%	10.9%
557	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV DX	123,550	2.8755	2.1323	2.1499	2.4236	-25.8%	-15.7%	13.7%
515	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	58,009	5.2591	4.1471	4.1795	4.7999	-21.1%	-8.7%	15.7%
558	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX	191,677	2.1920	1.4299	1.4456	1.7238	-34.8%	-21.4%	20.6%

Source: Moran Company analysis of FY 2007 proposed inpatient PPS rule. Uses FY 2005 MedPAR.
Notes: High volume DRGs defined as over 50,000 cases. Those included in the table were those with the greatest absolute change in weight moving from the CMS published DRG weight to the DRG weight calculated by trimming CCRs at 3.0 standard deviations, using weighted CCRs, and correcting for technical errors.

These changes have a material impact on hospital payment. CMS' method for weighting and trimming redistributes $1.4 billion dollars among hospitals. Charge-weighting the CCRs and trimming them at three standard deviations would reduce the shift in dollars to $900 million – a reduction of ***half a billion dollars***, or 33 percent. This highlights the need for more work to validate each methodological step to understand how it affects payment and ensure it adds to "accuracy."

4. **Failure to Calculate Costs at the Claim Level:** CMS chose to use *charges* to initially calculate the relative weights at the DRG level and then a national scaler to make the conversion to "cost-based" weights. The national scaler converts the 10 cost center charge-based weights to one national weight using the actual share of costs across departments. CMS maintains that this adjusts for differential mark-ups across hospital departments. In contrast, MedPAC estimated *costs* at the claim level to calculate relative weights. CMS provided no validation of the methodological shortcut they propose.

5. **Cost Centers:** CMS aggregates charges into 10 cost centers for each DRG, then applies a cost-center level CCR (derived from the cost reports) to charge figures (from claims data). But because hospitals often report charges on the cost reports differently than charges on the claims, the cost-center level CCRs are calculated based on a different set of charges than the charges to which the CCRs are later applied. We believe this may materially distort the DRG weights and needs to be thoughtfully considered and accounted for in any methodology. If CMS is going to move to cost-based weights, regardless of the methodology, hospitals will need time to align their mapping of cost centers into departments or cost categories for purposes of cost reporting with that of claims reporting.

6. **Validation:** As mentioned above, CMS provided no analysis to validate that the proposed changes result in better payment policy. While measuring improved payment accuracy is difficult, the large degree to which the weights fluctuate given methodological changes alone indicates the need for further analysis and study. CMS should construct a process to test the sensitivity of weights to various methodological assumptions and publicly share the result, including:

   - Compare CMS weights to MedPAC's HSRV-cost approach;
   - Compare CMS weights to an approach using standardized costs (as opposed to HSRV);
   - Compare CMS weights to weights calculated by estimating costs at the claims level using the 10 cost center approach;
   - Evaluate alternative methodologies for estimating costs (e.g., method used by New York state's Medicaid program);
   - Compare stability of weights over time; and
   - Determine whether payment policy is improved.

Assessment of "payment accuracy" conducted by The Moran Company as well as The Health Economics and Outcomes Research Institute (THEORI), a division of the Greater New York Hospital Association, finds the CMS HSRVcc approach to be not at all to marginally better than the current system. Fixing the major methodological flaws yields minimal improvement, according to THEORI. CMS' HSRVcc approach actually creates new areas of care where systematic incentives for specialization could occur. This analysis raises significant questions about CMS' approach and further analysis should be conducted before any changes to the current charge-based methodology are made. These analyses will help determine the most effective and administratively feasible approach for a shift to cost-based weights in FY 2008.

NEW PATIENT CLASSIFICATION: SEVERITY OF ILLNESS

CMS also proposes moving to an entirely new patient classification system beginning in FY 2008 *or earlier*. Currently, Medicare uses 526 DRGs to classify all Medicare patients. CMS considered use of 3M's all-patient refined DRGs (APR-DRGs) as an alternative to its current DRGs, which would increase the number of categories to 1,258. However, CMS ultimately proposed refining the APR-DRG system by consolidating APR-DRGs into fewer categories. This would result in a new DRG system with 861 consolidated severity-adjusted DRGs, or CS-DRGs.

The AHA believes that the need for and best approach to changing the patient classification system has not been concretely and objectively demonstrated. More careful analysis is needed, along with greater access to the specifics of CMS's methodology and the new GROUPER. Below we discuss our detailed concerns and questions about this proposal.

CS-DRG METHOD CONCERNS

1. **Validation:** It is unclear whether there is a need for a new patient classification system. More work is needed to assess the proposed system and others that might be considered. As with the HSRVcc proposal, CMS provided no analysis that shows that the proposed changes result in an improved hospital payment system compared to the existing DRG system or APR-DRGs.

   CMS must test the degree to which the variation in costs within cases at the DRG level is reduced under both CS-DRGs and APR-DRGs. Payment classifications that still exhibit a high degree of cost variation should be identified and potentially revised. We suggest comparing the distribution of the coefficient of variation at the DRG level for various grouping approaches.

   For instance, CMS chooses to collapse the tier-four cases within major diagnostic categories (MDCs). It is unclear whether all of the tier-four cases are clinically cohesive enough to be combined and whether consolidation adequately considers variations in resource requirements. CMS also aggressively collapses the DRGs with low Medicare volume such as obstetrics, psychiatric and substance use services without any discussion of the potential ramifications for other payment systems, such as other Medicare PPSs, Medicaid and the

private sector that often bases payment off the Medicare inpatient DRG system. CMS believes that a new patient classification system that distinguishes more-sick from less-sick patients will reduce the "cherry picking" of healthy patients, but there may be other, easier ways to accomplish this. For example, CMS embarked on a new way to differentiate patients last year based on the absence or existence of a major cardiovascular diagnosis but did not discuss the possibility of other similar, less disruptive changes to the system as an option in this year's rule.

Even more fundamentally, today's DRG system was created to distinguish the resource use required among patients. It has been modified over time to reflect changes in clinical practice and technology. The APR-DRG system is based on severity of illness, not necessarily the resource use required. The impact of a move to CS-DRGs – an APR-DRG hybrid – is unclear. But the implications of moving from a resource-based system to a severity-based payment system must be more fully explored and understood.

2. **Budget Neutrality Adjustment:** CMS suggests in the proposed rule that it would reduce payments to hospitals by instituting a budget neutrality adjustment to offset the fact that case mix may increase because of improved coding rather than actual changes in acuity. However, CMS did not propose an adjustment or even a methodology for determining an adjustment. CMS often institutes such adjustments that are based on assumptions but never checked or later corrected. We recommend that CMS hold off on such an adjustment until there is evidence that one is needed.

3. **Availability of the GROUPER:** The proprietary nature of the proposed CS-DRG GROUPER is of concern. The current DRG GROUPER logic has been in the public domain since the inception of the PPS. Without the new GROUPER logic, it is virtually impossible for AHA or anyone else to thoroughly analyze the system and comment – without access to the new GROUPER, we have no understanding of how and why patients fall into certain CS-DRGs and cannot evaluate whether it represents policy improvement. If CS-DRGs are adopted and the GROUPER remains proprietary, the AHA would be limited in our ability to educate and assist our member hospitals. Moreover, a single company's monopoly would be both more expensive and more difficult to integrate into our hospitals' existing systems. Maryland hospitals report a GROUPER price of $20,000 per hospital with the ultimate price varying based on criteria such as whether it is used on a mainframe or PC. We urge CMS to make any new classification system widely available to the public.

4. **Too Few Diagnoses and Procedures Considered:** We are concerned that CMS' GROUPER does not use all diagnoses and procedures that affect a patient's severity of illness and/or the resources utilized. The current DRG GROUPER only considers nine diagnoses and up to six procedures. Hospitals submit claims to CMS in an electronic format. The HIPAA compliant electronic transaction 837i standard allows up to 25 diagnoses and 25 procedures. Many fiscal intermediaries are ignoring or omitting the additional codes submitted by hospital providers since these additional diagnoses and procedures are not needed by the GROUPER to assign a DRG.

   Capturing all diagnoses and procedures meeting the definitions of reportable secondary diagnoses and procedures will provide a more complete picture of patient complexity. As

CMS considers methodologies for refining the patient classification system, the number of secondary diagnoses may be an important factor in determining differences in patient characteristics. This is particularly true of patients with many chronic illnesses that add to the complexity of treating them.

AHA RECOMMENDATIONS

The hospital field supports meaningful improvements to Medicare's inpatient PPS. We believe the AHA and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs which will provide an equal incentive to treat all types of patients and conditions. 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. Moving forward requires thoughtful change. Specifically, the AHA supports the following:

- **One-year Delay:** The AHA supports a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. The AHA and the hospital field are committed to working with CMS over the next year to address these concerns.

- **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:** The AHA does not support a new classification system at this time, 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. For example, of the 2,566 hospitals that would experience an increase in payment using the HSRVcc[1] methodology alone, 48 percent would experience a net loss when CS-DRGs and HSRVcc are done together. Of the 859 hospitals that have a decrease in payment under the HSRVcc methodology alone, 33.9 percent would become overall winners when CS-DRGs and HSRVcc are done together.

- **Three-year Transition:** Any changes should be implemented with a three-year transition, given the magnitude of payment redistribution across DRGs and hospitals. We recommend that CMS provide a three-year transition with a blend of the old DRG

[1] Source: Moran Company analysis of 2004 MedPAR under FY 2007 payment policies using weighted CCRs and trimming CCRs at 3.0 standard deviations.

weights and the new DRG weights. In the first year, hospitals would be paid based on an average of DRG weights: 75 percent of the old weights; 25 percent of the new weights. The second year would be 50 percent of each, and the third year would be 25 percent of the old weights and 75 percent of the new weights. Another method of transition is dampening the reduction for DRGs with significant decrease in relative weights similar to the dampening of APC weights in the outpatient PPS. Dampening could be more feasible – especially if a significant change to the classification system is made – because it does not require CMS to calculate payments using two different systems.

We further believe that a stop loss should be instituted as part of this transition. This would be similar to the approach currently used under the inpatient psychiatric PPS whereby no hospital can receive less than 70 percent of what they would otherwise have been paid under the old system. In combination with the DRG blend or dampening, this would result in less significant losses in the first year than in the last year of the transition. To avoid having to run all claims under both DRG weights, CMS could establish a payment-to-cost ratio for each hospital in FY 2006 and use that as a base against which to compare payments under the new system.

- **Collaborative Approach to Moving Forward**: The AHA commits to working with CMS to develop and evaluate alternatives for new weights and classifications.

DRG RECLASSIFICATIONS

DRGs: Pancreas Transplant. We agree with the proposed coding changes for DRG 513 (Pancreas Transplant), which removes the requirement that pancreas transplant patients also have kidney disease. This change is consistent with the newly approved National Coverage Determination (NCD) to cover pancreas transplants alone as reasonable and necessary under limited circumstances for patients with Type I diabetes.

DRGs: Dual Array Implantable Neurostimulators for Deep Brain Stimulation. We oppose CMS' recommendation to keep the implantation of dual array implantable neurostimulators for deep brain stimulation in DRG 1 (Craniotomy Age >17 with CC) and DRG 2 (Craniotomy Age >17 without CC). CMS should recognize the higher resources associated with this technology.

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.

DRGs: Cardiac Resynchronization Therapy, Defibrillators (CRT-D). We agree with the proposal to add code 37.74 (Insertion or Replacement of Epicardial Lead [Electrode] into Atrium) to the DRG logic so that all types of defibrillator devices and lead combinations would be included in the following DRGs:

- DRG 515 (Cardiac Defibrillator Implant without Cardiac Catheter);
- DRG 535 (Cardiac Defibrillator Implant with Cardiac Catheter with AMI/Heart Failure/Shock); and

- DRG 536 (Cardiac Defibrillator Implant with Cardiac Catheter without AMI/Heart Failure/Shock).

This change would bring the DRGs into alignment with the change in coding advice to assign code 37.74 in conjunction with implantation of CRT-D defibrillators.

Application of Major Cardiovascular Diagnoses (MCVs) List to Defibrillator DRGs. We oppose the proposal to delay refining defibrillator DRGs based on MCVs. We believe it is appropriate for CMS to apply a clinical severity concept similar to the approach used in FY 2006 to refine cardiac DRGs to an expanded set of DRGs (e.g., defibrillator DRGs) based on the presence or absence of an MCV.

DRGs: Hip and Knee Replacements. For FY 2006, new codes were created to differentiate between new and revised hip and knee replacements. In addition, more specific codes were created to identify the joint components replaced. After publication of the FY 2006 inpatient PPS final rule, a number of commenters advised CMS that the DRG logic for DRG 471 (Bilateral or Multiple Major Joint Procedures of Lower Extremity) included knee and hip procedures that are not bilateral or do not involve multiple major joints. We agree with CMS' proposal to remove the codes from DRG 471 that do not capture bilateral and multiple joint revisions or replacements.

DRGs: Severe Sepsis. We agree that providers have found the coding of systemic inflammatory response syndrome (SIRS), sepsis and severe sepsis confusing in the last few years. The classification of these conditions has changed several times during this period. We concur that data have not been consistent and that a new DRG for severe sepsis would be inappropriate. However, we recommend that a change be made so patients with severe sepsis associated with respiratory failure requiring mechanical ventilation may be properly recognized. The ICD-9-CM classification instructions require that these patients be coded with the systemic infection as the principal diagnosis. The infection codes do not group to DRG 475 (Respiratory System Diagnosis with Ventilator Support) despite the use of resource-intensive mechanical ventilation (procedure code 96.7). This results in a significant loss of reimbursement for these patients.

Since the change in coding sequencing of these patients, the Coding Clinic Editorial Advisory Board has discussed this issue several times. In addition, several proposals have been submitted to the ICD-9-CM Coordination and Maintenance Committee to allow the sequencing of respiratory failure as the principal diagnosis. To date, no changes have been made. At this point, reverting the sequencing instructions would be confusing to coders and would once again disrupt trend data.

Instead, we recommend considering mechanical ventilation as a pre-MDC DRG on the basis of the procedure code. If this is not possible, we recommend that CMS add systemic infections (038.xx,) as acceptable principal diagnoses for DRG 475 when reported in conjunction with mechanical ventilation or tracheostomy.

DRGs: Complications/Comorbidities (CC) Categories 403-404. Effective October 1, changes have once again been made to the definition of the fifth-digits for categories 403 (Hypertensive Chronic Kidney Disease) and 404 (Hypertensive Heart and Chronic Kidney Disease). Prior to October 1, 2005, a fifth digit of "0" indicated "without chronic renal failure," while a fifth digit of "1" indicated "with chronic renal failure." While all patients in categories 403 and 404 had chronic kidney disease linked to hypertension, only those with a fifth digit of "1" had progressed to the point of kidney failure. Effective October 1, 2005, the definition of the fifth digits changed to "with or without chronic kidney disease." This was confusing since all patients in categories 403 and 404 by definition were supposed to have a chronic kidney condition. The change also blurred the distinction between the patients with more severe kidney failure and those with less kidney damage. The most recent change for this year once again changes the meaning of fifth digit "0" 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. More importantly, 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 codes 403.10, 403.90, 404.10 and 404.90, we recommend that CMS instead rely on the supplemental code from category 585 (Chronic Kidney Disease) to recognize the CC.

Implementing a Modern Clinical Classification System. We continue to agree with CMS' assessment in the May 9, 2002 hospital inpatient PPS notice of proposed rulemaking that ICD-10 is an improvement over ICD-9-CM and will provide greater specificity and detail. We believe that CMS should continue with plans to implement ICD-10. Implementing the significant DRG changes is a temporary fix, and a more refined DRG system can only be accomplished with more specific clinical classification systems, capable of painting a more complete picture of a patient's condition and the services provided to treat that condition – namely ICD-10-CM and ICD-10-PCS.

LONG-TERM CARE HOSPITAL (LTCH) DRGS

The AHA is very concerned about the proposed reweighting of the long-term care hospital (LTCH) DRGs for FY 2007. The projected payment cut resulting from the reweighting – 1.4 percent – in combination with the payment cut resulting from the recent LTCH PPS final rule for 2007 – 7.1 percent – will cause substantial volatility for LTCH providers, and ultimately restrict access for patients needing long-term acute care services. It would be extremely difficult for any provider group to withstand an 8.5 percent cut in one year. By pursuing these changes, CMS is misinterpreting MedPAC's estimate of 2006 Medicare margins for LTCHs and creating an extremely unstable regulatory environment for LTCHs. MedPAC projected a 7.8 percent Medicare margin for LTCHs in 2006 and recommended no market basket update for FY 2007.

However, this MedPAC projection does not include two major policy changes that also decrease Medicare margins for LTCHs: the projection excludes the impact of the "25% Rule" limiting payments to co-located LTCHs and the new reductions associated with the LTCH short-stay outlier policy. Therefore, CMS goes too far with this proposal to reduce Medicare payments even further.

Given these considerations, we urge the agency to forgo the proposed 1.4 percent cut and instead implement the reweighting in a budget-neutral manner.

This would appropriately redistribute allocated funds among the payment categories to reflect current costs and omit the inappropriate modification of total payments due to unrelated considerations. **It is irrational to treat the LTCH PPS differently than other Medicare payment systems by failing to reweight the LTCH PPS in a budget-neutral manner.**

At this time, CMS should focus on developing further patient and facility criteria for LTCHs to ensure that patients who are clinically suitable continue to have access to the LTCH setting. We strongly support CMS' pursuit of a scientific foundation for these expanded criteria and are eager to review the recommendations currently under development by CMS' contractor the Research Triangle Institute.

HOSPITAL QUALITY DATA

The Deficit Reduction Act of 2005 (DRA) expands quality reporting requirements for hospitals to be eligible to receive a full market basket update. The proposed rule states that to qualify for their full market basket update, hospitals would have to pledge to submit data on all 21 measures currently part of the Hospital Quality Alliance's (HQA) public reporting on www.HospitalCompare.hhs.gov for patients discharged on or after January 1. Hospitals failing to submit data for the first calendar quarter of 2006 by August 15 would receive an inpatient update equal to the market basket minus two percentage points. Hospitals that fail data validation tests for data submitted for the first three calendar quarters of 2005 would also lose the two percentage points from the market basket update.

As a partner in the HQA, the AHA and its member hospitals fully support the HQA's effort to make more information on hospital quality available to the public, and we join with CMS in wanting to make it happen quickly and accurately. However, as written, the proposed rule 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.**

The DRA gave the Secretary of the Department of Health and Human Services (HHS) the authority to further expand the measures that must be reported to qualify for full market basket update in future years. **We strongly urge CMS to select measures only from those used by**

the HQA for public reporting. To choose different measures would thwart efforts to streamline quality reporting, add to the "babble" of quality measurement that currently exists in health care and dilute efforts to create a single source to share solid reliable information with the public. In addition, whenever the Secretary intends to expand the set of measures linked to payment, **CMS should consider publishing the proposal at least one full year prior to the start of the fiscal year.** This will enable hospitals and their vendors to put the needed data collection processes in place to be able to provide the requested data.

Further, we agree with CMS that it is critical that the collected data be validated. The process used to validate the HQA data was reviewed by the Government Accountability Office, which concluded that there was "a high overall baseline of accuracy," but recommended several changes to improve the validation process. CMS proposes to look at the validation results for data submitted on patients who were discharged during the first three calendar quarters of 2005. CMS has hired a contractor to randomly select five patient records per quarter. That contractor selects the patients, asks the hospital to send a copy of the medical record for the hospitalization of the patients that occurred during that period, and then reabstracts the same data that the hospital abstracted from the medical record. A comparison is made between the data the hospital submitted and the data the contractor abstracted, and if there is at least an 80 percent agreement, the hospital is said to have passed validation. In the proposed rule, the hospital would have to have at least 80 percent agreement across the 15 medical records that the contractor reabstracted. This methodology assumes that the contractor has correctly reabstracted the data and that discrepancies must mean erroneous data submission on the part of the hospital. However, that is not always the case. This validation process is still in its infancy and seems to be working to correctly validate the information submitted by many, but unfortunately not all, hospitals. Significant problems have occurred for some hospitals of which we are aware.

Some data validation problems have actually begun with the data submission process. Hospitals and their data collection vendors submit data to the Quality Improvement Organization (QIO) data warehouse in a good-faith effort to get the information submitted in the right format, with all of the right labels and coding. An "error report" is generated that is supposed to alert the hospital if it appears data were received in a way that is not consistent with the requirements. The hospital is supposed to receive this report in time to make any necessary corrections. However, the report can be hundreds of pages long with a multitude of meaningless notations. A significant problem in data transmission might have occurred, but the indications of it are buried in this voluminous report and may not be discovered until it is too late for the hospital to make a correction. In addition, the data collection vendors on whom the hospitals rely to format and submit the data correctly do not have access to these error reports, nor do they have any other mechanisms for checking to make sure that the data they sent was received correctly. This has inevitably led to errors not being caught in time. When these errors are then left in the database, the CMS contractors' reabstraction of the data does not match up with what is recorded for the hospital in the database, leading to the hospital failing validation.

Another common problem results when the contractor has asked for the medical record pertaining to a particular patient, but has not specified which admission it wanted. Since it is not uncommon for heart failure patients to be readmitted for care, the omission of the specifics on which admission was being reabstracted has inevitably led to the hospital copying and

submitting data on one admission, and the contractor trying to make that match up with the data for a different admission – and the data simply will not match up.

There also have been many reported instances in which the contractor conducting the reabstraction of the data failed to find information that was clearly in the medical record – a simple human error, but one that should not be used to penalize the hospital.

CMS was made aware of these problems with the validation process and it has begun to work to improve the process reliability so it can be used to support payment decisions. However, in the first three calendar quarters of 2005, the validation process did not have sufficient integrity to warrant hospital payments being withheld based on the validation results. At this juncture, we firmly believe that the problems with the validation process itself need to be resolved before any payment decisions are made solely on the basis of the contractor's work. **We strongly urge CMS to review, on a case-by-case basis, any incidence where a hospital's payment would be put in jeopardy as a result of the validation process. It should allow the hospital to submit information showing that it made a good-faith effort to supply the data warehouse with accurate information so that the public could be informed about the quality of its care. If the hospital has made a good-faith effort, it should receive full payment regardless of whether the data are deemed accurate enough for public display.** In addition, CMS should instruct its QIO data warehouse to accept any significant corrections so that the public can have a full and accurate picture of hospital quality.

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 remain very concerned that the threshold is too high. According to our analyses, 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.

The AHA appreciates 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. The AHA strongly opposes using this methodology to estimate the outlier threshold.** The AHA conducted a series of analyses to identify a more appropriate methodology. Below we put forth for CMS' consideration a methodology that incorporates both *cost* inflation and *charge* inflation. We believe the use of more than one indicator will make the threshold calculation more accurate and reliable.

First, we inflated 2005 charges by 15.71 percent (the inflation factor used by CMS in the proposed rule) and then reduced the charges to costs. Instead of using the cost-to-charge ratios (CCRs) from the CMS Impact File, we used the CCRs from the March 31, 2006 HCRIS release. In addition, we accounted for the nine-month lag from the end of a cost-reporting period until the FI is able to update the CCR. We accomplished this by projecting forward from the most recent fiscal period in the March 31 HCRIS update to the fiscal period(s) expected to be used for the calculation of the CCR(s) determining federal FY 2007 outlier payments.

The cost inflation factor for projecting CCRs was determined from the cost reports of a cohort of 3,253 matched hospitals for periods beginning in federal FYs 2002, 2003 and 2004. All three cost reports were available for each hospital from the recent update of HCRIS. The 2002-2004 aggregate annual rate of increase in the cost per discharge for these hospitals was 5.69 percent[2]. This cost inflation factor and the CMS charge inflation factor of 7.57 percent were used to project CCRs over the time periods described above. The projected CCRs were applied to projected federal FY 2006 charges to simulate the determination of costs for FY 2007 outlier payments. **The estimated fixed-loss amount that would result in 5.1 percent outlier payments under this methodology is $24,000.**

The AHA strongly urges CMS to adopt this methodology, which is applicable regardless of what DRG changes are made or not made in FY 2007. We estimate that the fixed-loss threshold necessary to achieve 5.1 percent in FY 2006 should have been set at $21,275 as compared to the $23,600 actually utilized. We believe CMS underspent the funds set aside for outliers by an estimated $3 billion over FYs 2004, 2005 and 2006. **This is a real cut in payments to hospitals that cannot be recouped. If CMS leaves the threshold at $25,530, rather than dropping it to $24,000, we believe that CMS will again significantly underspend by over $300 million.** We urge CMS to adopt our recommended methodology to lower the outlier threshold. Attached is the full analysis, conducted by Vaida Health Data Consulting.

CORE-BASED STATISTICAL AREAS (CBSAS)

In adopting the Core-based Statistical Areas (CBSAs) in FY 2005, a small number of hospitals that were classified as urban in FY 2004 became classified as rural in FY 2005. Because moving from a Metropolitan Statistical Area (MSA) to the rural statewide average would have resulted in a significant decline in these hospitals' wage indexes, CMS implemented a three-year transition period (FYs 2005-2007). The AHA supports the continued transition for these hospitals to give them the opportunity and time to reclassify.

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

[2] An audit adjustment was applied to costs from "as submitted" cost reports. The audit adjustment was determined by comparing 2,729 "as submitted" cost reports from the December 31, 2003 HCRIS database with the settled reports of the same hospitals in the March 31, 2006 HCRIS update.

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.

Definitions and Covered Employees. In filling out the interim-survey, our members found that the placement of certain employees caused confusion. Examples include surgical technicians, paramedics who are employed by the hospital and usually work in the emergency department, and unit secretaries who are also known as ward clerks. CMS clarified after the proposed rule was released that these employees should be placed in the "all other" category for the interim-collection. Moving forward, CMS should re-evaluate where these employees belong. **However, such changes should not be made to the ongoing collection, as it would necessitate the resubmission of the first calendar quarter's data to ensure that both quarters could be used for FYs 2008 and 2009.** If CMS believes that such changes are warranted, then the hospitals will need notification prior to the release of the final inpatient PPS rule in order to meet the August 31 deadline for submissions.

Cost Centers. We agree with CMS' "bright line" clarification for this collection that only nursing personnel within the cost centers listed should be included in that category for the purposes of consistency. It is significantly less work for hospitals to focus on certain cost centers, and we continue to support this methodology. **We believe that the vast majority of nursing personnel within a hospital fall within these cost centers and do not believe that CMS should include every cost center that may have a few nursing personnel included in it.**

However, CMS should consider refining the list for future collections. Every hospital has a different method for attributing costs to the cost centers, thus there are probably a few cost centers that contain a significant number of nursing personnel for certain hospitals that were not captured for this collection. Given the shortened comment period in combination with the magnitude of the other changes proposed by CMS in the inpatient PPS rule this year, we were unable to extensively research which cost centers CMS should add. We suggest that CMS accept comments on any potential changes to the cost center list before making such changes. **In addition, we believe that additional cost centers should *not* be added to the ongoing collection as it would necessitate the resubmission on the first calendar quarter's data to ensure that both quarters could be used for FYs 2008 and 2009.** If CMS believes that such

changes are necessary for the current collection, then hospitals would need notification prior to the release of the final inpatient PPS rule in order to meet the August 31 deadline for submissions.

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.**

However, hospitals will 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 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, 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. **The AHA 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. 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.**

HOSPITAL REDESIGNATIONS AND CLASSIFICATIONS

Section 508 Reclassifications. Section 508 of the *Medicare Modernization Act* (MMA) provided $900 million over three years for a one-time geographic reclassification opportunity, which expires March 31, 2007. Because the 508 reclassifications expire mid-year and hospitals may

not receive Section 508 funding at the same time as any other form of reclassification, CMS has proposed special provisions for accepting or denying partial-year reclassifications for FY 2007.

In FY 2006, CMS stated that individual hospitals reclassified under Section 508 would be allowed to request regular reclassification for the portion of the three-year period that the hospital is not receiving Section 508 funding, or to turn down the Section 508 reclassification for the first half of FY 2007 and receive regular individual reclassification for the full three years.

CMS also stated that Section 508 hospitals that would like to be part of a group reclassification could turn down their 508 reclassification for the first half of FY 2007 and join a group for the full three-year period. Or the hospitals could maintain Section 508 reclassification while the rest of the group gets their "home wage index" for the first half of the year. The entire group then could reclassify together for the rest of the three-year period.

In the proposed rule, CMS clarifies that "home wage index" means that hospitals could receive the wage index they otherwise would have, absent the group reclassification. For some hospitals, this might literally be the wage index for the area in which they are located. For others, this may mean an individual reclassification to another area.

Section 508 hospitals, and those involved in a group reclassification with a Section 508 hospital, would normally have been required to accept or reject reclassification within 45 days of the publication of the proposed rule; however, the complications with the occupational mix adjustment will prevent this. **We appreciate and support CMS' flexibility around the expiration of Section 508 and the reclassification deadlines given the unusual circumstances this year.**

GEOGRAPHIC RECLASSIFICATIONS

Multi-campus Hospitals. Payment is determined using the wage index value for the MSA in which a campus is located, even though the organization may have other campuses located in different labor market areas. Because multi-campus hospitals submit a single cost report that does not break down wage data by campus, an individual campus historically has been unable to seek reclassification. For FYs 2006-2008, CMS authorized individual campuses to use the average hourly wage data of the entire multi-campus hospital system to seek geographic reclassification to the labor market area in which the other campus(es) are located. CMS also stated in the FY 2006 rule that, in the future, it would continue to consider mechanisms to collect the data necessary for geographic reclassifications that are not unduly burdensome for providers. However, CMS now proposes rescinding this option, as there was only one hospital in the country that was affected by this situation and, after the change in labor market areas in FY 2005, it has subsequently joined an urban county group that is reclassified to the area in which it was previously reclassified using the multi-campus hospital rule.

The AHA opposes CMS' proposal to remove this option. While CMS may know of only one hospital at this point, there may be others, and additional hospitals may be affected after the next census collection and subsequent changes in labor market definitions. In addition, the need for this provision has not subsided as CMS suggests. This hospital will need to use either campus-

specific or hospital-wide data for its next reclassification, whether group or individual, and lack a method to do so.

CMS suggests that each campus should disaggregate and receive its own provider number. A multi-campus hospital with a single provider number provides certain health and treatment benefits to patients, such as the ability to move among campuses for various aspects of treatment. Each campus may specialize in a particular service (oncology, cardiology, etc.) and patients can move among the campuses with one medical records system, one billing system and a unified medical staff. Economies of scale reduce costs for the whole system. **Thus, we do not believe it is a realistic or appropriate option to force these campuses to apply for individual provider numbers.**

We recommend that CMS continue to allow multi-campus hospital systems to use the data from all campuses as a proxy for individual campuses to reclassify to an area where another one of the campuses is located given how few hospitals are expected to use this option. This is a reasonable request as most multi-campus hospital systems likely pay equal or similar wages at each campus. If CMS finds that the situation becomes more prevalent, it could require the manual completion of the campus-specific Schedule S-3 for those hospitals that do not have the appropriate individual campus data. However, if CMS moves to a campus-specific S-3, CMS still needs to extend the current special rule for five years until the new campus-specific data is useable for an application.

Urban Group Reclassifications. The AHA supports CMS' proposal to allow hospitals located in counties that are in the same CBSA as the county in which they seek redesignation to be considered to have met the proximity requirement. By failing to include CBSAs in the proximity criteria, CMS has excluded one group of hospitals, those located in Palm Beach County, FL, from being able to reclassify to the Fort Lauderdale-Pompano Beach-Deerfield Beach division of the Miami CBSA. **Given that CBSAs are actually more refined classifications than Combined-statistical Areas, we believe that the inclusion of CBSAs in the proximity criteria would be consistent with CMS' policy goals and protect hospitals from unintended consequences.**

Critical Access Hospitals in Lugar Counties. As a result of changes in the labor market area definitions made in response to the results of the 2000 census, counties in which a number of Critical Access Hospitals (CAHs) are located became "treated" as urban instead of rural under the inpatient PPS because of a statutory provision modifying the status of rural counties with certain commuting patterns to metropolitan areas. In its FY 2005 final rule, CMS interpreted this provision as applying to CAHs located in these counties (known as "Lugar counties" after the Senate sponsor of the provision) and allowed these facilities a grace period to seek reclassification as rural in order to retain their CAH status.

While accommodating CAHs in this manner, the agency also took the position that any CAH being reclassified would no longer be eligible for pass-through payments for the services of certified registered nurse anesthetists (CRNAs). Its reasoning was that the facility was no longer "located in a rural area (as defined for purposes of section 1886(d) of the Social Security Act)" as the pass-through statute requires, but were only reclassified as rural.

In response to comments received on the FY 2006 proposed rule, CMS announced a policy change in the final rule for FY 2006 stating that Lugar county designation would not affect a CAH's rural status because the statutory provision creating such counties only applies to hospitals paid under the inpatient PPS (CAHs are paid under a separate, cost-based system). This policy change had the effect of eliminating the need for these CAHs to seek either geographic reclassification or a waiver of the Lugar statute (which CMS has maintained it has no authority to do). **In effect, under this new reading of the law, the provision creating Lugar counties does not apply *at all* for purposes of CAH eligibility.**

Despite this policy change, CMS continues to maintain that a CAH located in a newly-designated Lugar county cannot qualify for CRNA pass-through payments. This position is at odds with the agency's view that *it is geographic reclassification that renders a CAH ineligible for such payments* – since, under CMS' revised policy, a CAH located in such a county need not seek geographic reclassification to be a CAH. Apparently, it is CMS' view that these CAHs can never qualify for CRNA pass-through payments, whether they have sought reclassification (under the old policy) or not (under the new policy). **We believe that all CAHs located in a newly-designated Lugar county should receive pass-through payments, regardless of whether they sought reclassification, and urge CMS to revise its regulations accordingly.**

Wage Index Budget Neutrality

CMS eliminates the CAH data from the wage index file it uses to compute the national average hourly wage (NAHW). For FY 2007, 1,191 CAHs representing approximately 24 percent of all inpatient PPS hospitals (as of FY 2000) – 55 percent of all rural hospitals in FY 2000 – have been eliminated from the file. Because CAHs have lower average hourly wages (AHWs) than the average PPS hospital, the elimination of this data results in an overstated NAHW. While the NAHW has been increasing, the systematic withdrawal of low-wage hospitals has artificially inflated the NAHW to some extent. This artificial increase is included in the negative budget neutrality adjustment that consequently reduces payment, resulting in the national inpatient PPS operating payments being understated by an estimated $1.52 billion over five years (2003-2007). **Thus, we believe that CMS should apply a positive budget neutrality adjustment in FY 2007 to compensate for the underpayments.** The understatement increases each year as more hospitals become CAHs and more data are eliminated from the wage index data. However, we believe that this could be a one-time adjustment as we expect very few hospitals to convert to CAH status now that the necessary provider designation is no longer an option.

Low-Volume Hospital Payment Adjustment

Section 406 of the MMA created a payment adjustment under the inpatient PPS to account for the higher costs per case of low-volume hospitals. The law defined eligible hospitals as those located more than 25 miles from another facility with fewer than 800 total discharges annually. The rule proposes to maintain a 25 percent increase, the maximum allowable, in payments to hospitals with fewer than 200 discharges. For those hospitals that have between 200 and 800 discharges, CMS proposes to maintain its current policy, applying no payment increase. Only two hospitals will receive this adjustment in FY 2007 according to CMS estimates. **The AHA is concerned that CMS is ignoring congressional intent and denying a group of hospitals –**

those with more than 200 discharges but fewer than 800 discharges – access to this necessary payment increase.

SCH/MDH Changes in Qualification Status

The proposed rule would require an approved sole community hospital (SCH) or Medicare dependent hospital (MDH) to notify the appropriate CMS Regional Office of any change affecting its classification as such. To date, it has been the FIs responsibility to evaluate hospitals' continuing qualification for SCH or MDH status. CMS expects the hospital to now self-disclose any material changes in circumstances or potentially face a retroactive cancellation of their designation once an FI discovers its ineligibility.

This appears to be an inappropriate shift of the burden from the FIs to hospitals. For instance, hospitals are neither involved in, nor have any control over, the building of new roads or new hospitals and thus should not be accountable to report such changes. It also would be very difficult for hospitals to know when and for how long there were prolonged severe weather conditions that closed area roads, or to note changes to posted speed limits and traffic patterns. In addition, some of the qualifying criteria, such as inpatient admissions at other regional hospitals, would be hard to monitor as the hospitals do not have this sort of data on their competitors. Requiring hospitals to constantly monitor whether they continue to meet these requirements would impose a tremendous and unreasonable administrative burden on hospitals. **The AHA recommends that this function remain a responsibility of the FIs, who are in a better position to monitor these circumstances. If CMS requires hospitals to report changes in circumstances, then the specific types of situations should be noted and should only include aspects of their operation that are within their control (e.g., number of beds).**

CMS' proposal to retroactively withdraw SCH or MDH status if a hospital does not appropriately self-report a change in circumstances could be financially devastating. CMS should at minimum give consideration to whether the hospital had knowledge of the disqualifying circumstance. Hospitals should not have to repay CMS based on the difference between the inpatient PPS or outpatient PPS payment and the SCH or MDH payment when they did not know that they no longer qualified for the program. Instead CMS should develop a prospective process for withdrawing the hospitals' SCH or MDH status. We believe that a 30-day timetable for losing SCH/MDH status is unrealistic given the financial implications of such a change and the inability for a hospital to plan for this outcome. **CMS should re-evaluate the proposed timetable for canceling SCH/MDH status when a hospital is found to be disqualified or self-reports disqualification and consider revoking the hospitals' status as of the following cost-reporting period.**

SCH/MDH Volume Decrease Adjustment

An SCH or MDH may apply for special payments if it experiences a decrease of 5 percent or more in its total number of inpatient discharges that was out of its control from one cost-reporting period to another. If the hospital qualifies, it must demonstrate that it took measures to scale back its nursing force commensurately. The adjustment is intended to cover the fixed costs that the hospital is unable to reduce in the year following the volume decrease. CMS believes

that only "core staff and services" should be covered by these special payments. To date, CMS has used the AHA's HAS/Monitrend Data Book to compare the hospital's staffing to other similar hospitals in the area to determine if the hospital is staffing its routine and intensive care units appropriately. However, the Data Book has not been updated since 1993. CMS has been using the 1989 publication. Thus, CMS proposes using the occupational mix adjustment data currently being collected for wage index purposes to calculate nursing hours per inpatient day for a hospital in question and local peer hospitals.

The occupational mix adjustment was only partially implemented in its first three years, primarily due to the questionable data and results. The current collection, which is occurring again under rushed circumstances, may also result in questionable data. **We do not believe that it is wise to assume that the occupational mix adjustment data will be appropriate for this use. The AHA believes that the data within the AHA annual survey should be sufficient for CMS to determine the nursing levels per patient day.**

RURAL REFERRAL CENTERS

If a hospital wants to become a Rural Referral Center (RRC) but does not have 275 or more beds, it must meet two mandatory alternative criteria plus one of three additional criteria. The proposed rule would update the alternative criteria for RRC designation in FY 2007.

Until recently, the median case-mix index values were very stable. The chart below illustrates the volatility over the past few years in the values for two regions:

Region 7 West South Central	
FY 2005	1.1371
FY 2006	1.3532
FY 2007	1.2445
Region 6 West North Central	
FY 2005	1.0855
FY 2006	1.2252
FY 2007	1.2856

While it is not clear why this is occurring, it does suggest a possible methodological problem. **Thus, we recommend that CMS undertake additional analyses to determine the cause of the recent fluctuations.** This is particularly important given the possible disruption to case-mix patterns as a result of a new patient classification system such as the CS-DRG proposal.

CRITICAL ACCESS HOSPITALS (CAHS)

On November 14, 2005, CMS issued interpretive guidelines on the relocation of CAHs as a follow-up to the FY 2006 inpatient PPS final rule that established the "75% test" – serving 75 percent of the same population, providing 75 percent of the same services and employing 75 percent of the same staff – for necessary provider CAHs. The guidelines not only extended the 75% test to *all* CAHs, but it also altered the definitions of "mountainous terrain" and "secondary road."

We believe that these guidelines go well beyond the regulations included in the FY 2006 rule that provoked numerous critical responses from individual CAHs, associations and congressional representatives. The "mountainous terrain" and "secondary road" definitions are overly prescriptive and the 75% test does not provide reasonable flexibility based on natural variation in demographics, patient needs distribution patterns, normal employee and board attrition, and necessary changes in services to meet community needs. **Rural hospitals that move a few miles are clearly the same providers serving the same communities.**

Many CAHs are planning to rebuild in the near future to improve site safety and quality of care by adding fire and smoke barriers, upgrading infrastructure to support utilities and air handling, modernizing telecommunications to support health information technology, or making other essential upgrades. Facilities expect to relocate when they rebuild for a multitude of reasons: to be closer to a highway, to connect to municipal water and sewer, because of seismic safety concerns, or other similar concerns. **Such improvements will undoubtedly result in higher quality care, better patient outcomes and more efficient service, yet CMS' guidelines discourage these improvements.**

CMS' guidelines will not only impose an unnecessary burden on CAHs, but will preclude many of them from securing financing for needed capital improvements. The hospitals themselves, their hospital districts and their lenders cannot risk investing in a hospital that will be unsure of its status until a year after moving. **CMS should create a preliminary approval process to give assurances to those involved in the project that the CAH relocation will be approved if it meets the assertions made in the attestation submitted to CMS.**

Again this year, almost 60 congressional representatives signed a letter to CMS showing their support for their CAHs and urging changes to these guidelines. We agree with their recommendations and reiterate our suggestion from last year that a safe harbor be established for hospitals relocating within five miles of their existing locations. These providers are not only clearly serving the same communities, but trying to improve the quality of and access to needed health care services. A safe harbor will reduce the administrative burden on not only the hospitals, but CMS and the state survey agencies as well. **We urge CMS to create a safe harbor for CAHs moving a short distance and to make significant changes to these guidelines based on the feedback from CAHs around the nation as detailed in our letter under separate cover to Thomas Hamilton, director of the survey and certification group.**

GRADUATE MEDICAL EDUCATION (GME) PAYMENTS

Exclusion of Didactic Training. The proposed rule states that resident training that occurs at non-hospital sites must be related to patient care if a hospital wishes to count that time for direct medical education (DGME) and indirect medical education (IME) payment purposes. Resident time spent in didactic activities that often occur in associated medical schools – such as educational conferences, journal clubs and seminars – would specifically be excluded. CMS noted that its statement in a previous letter on this topic "implying that didactic time spent in non-hospital settings could be counted for direct GME and IME ... was inaccurate." CMS also noted that time spent in these activities could be counted for DGME purposes if they occur in a

hospital; however, the counting prohibition applies for IME payments regardless of where the educational activity occurs.

We strongly urge CMS to rescind the purported "clarification" in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare DGME and IME payments. The stated rationale for the exclusion of this time is that it not "related to patient care." This position is in stark contrast to CMS' 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."[3]

We strongly agree with CMS' 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. In addition, it would be very difficult to separate out time spent at these activities. **We urge CMS to withdraw this change 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.**

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

Definition of "Labor." **The AHA supports CMS' proposal to modify the definition of "labor" at 489.24(b) to allow a certified nurse-midwife or other qualified medical personnel operating under their scope of practice, as defined in hospital medical staff bylaws and in state law, to certify that a woman is in false labor.** This change recognizes that licensure and scope of practice should remain under the purview of state law and regulation. Further, this change provides hospitals with the staffing flexibility needed to maintain access to and the efficiency of vital obstetrical services, particularly in hospitals located in areas of the country that may find it difficult to attract and retain physicians, such as rural areas.

Hospitals without Dedicated Emergency Departments (ED). Under the proposed rule, a hospital with "specialized capability" is required to accept appropriate transfers under EMTALA regardless of whether it has a dedicated ED. **Guidance is still needed on the definition of specialized capability.** The EMTALA technical advisory group (TAG) has the ability to make recommendations for clarifying guidance, and we look forward to working with its members on this topic. In addition to questions related to the availability of on-call physicians and inpatient psychiatric resources, this proposed regulation calls into question application to inpatient rehabilitation facilities and long-term acute care hospitals.

The AHA agrees that a physician-owned, limited-service hospital should be treated as a hospital "with specialized capability or facilities" under EMTALA without regard to whether it has an ED. However, in the DRA-mandated HHS interim report to Congress on its development of a strategic plan regarding physician investment in specialty hospitals, the Secretary suggested that this interpretation of EMTALA "may result in an increase in the number of specialty hospitals accepting transfers of emergency patients on nights and weekends." (CMS

[3] September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins.

uses "specialty" to mean the hospitals covered under Congress's moratorium, i.e., physician-owned, limited-service hospitals providing primarily cardiac, surgical or orthopedic services.) **As presented in our statement to the EMTALA TAG when this question was considered, we believe it is unlikely this will result in improved access for patients to the specialty care they need.**

It is important to separate the capabilities of the practicing physicians from the capabilities of the facility in which they are practicing. While the physician expertise housed in the physician-owned, limited-service facility could be capable of meeting the needs of community hospital patients, the facility is seldom designed or operated in a manner to support this level of practice. Although physician-owned, limited-service hospitals hold themselves out as "hospitals," many of these facilities actually have a range of capabilities more similar to a hospital department or ambulatory surgical center. These hospitals often do not have emergency capabilities, as they are geared toward elective cases of minor severity. Their capabilities are typically limited to a single major diagnostic category, and they staff for minimal inpatient capacity. Many of these facilities minimize resource consumption by being almost a Monday through Friday operation. For these reasons, it generally would not be in the best interests of community hospital patients to be transferred to these facilities.

At the same time, many physician-owned, limited-service hospitals have withdrawn specialist services from the community at-large. As their physicians maintain an increasing amount of their practice at these hospitals or other sites outside the community hospital (e.g., ambulatory surgical centers), they are much less willing to accept on-call responsibility for the broader community's emergency needs. While withdrawing specialist services from on-call coverage, these same physician-owned, limited-service hospitals presume to rely on the community hospital for back-up in the event of complications requiring around-the-clock access to emergency care and inpatient admission to the community hospital. With the change in physician practice patterns and the increased number of physicians requesting only courtesy admitting privileges at community hospitals, relying only on the professional obligations attached to admitting privileges is not sufficient to assure appropriate transfer arrangements and the availability of physicians to provide emergency specialty capacity. **Every physician-owned, limited-service hospital that relies on the community's emergency services capacity should be obligated to support it.**

In addition, this policy does not address the problem of patients at physician-owned, limited service hospitals who suffer from complications appearing in a hospital ED with no warning call, no medical history, no operative report, no information on the anesthesia used and, often, no ability to reach the treating surgeon for consultation. **Physician-owned, limited-service hospitals should be required to have agreements with the community hospitals they plan to rely on in the event that they do not have the capacity to treat a particular patient.**

Specifically, the AHA recommends the following:

- **A physician-owned, limited-service hospital should be required to have a pre-existing agreement with the community hospital(s) it intends to rely on for emergency back-up services.**

- **The Secretary should establish the terms that must be addressed by an agreement, including:**
  - **Procedures for an appropriate transfer for patients not covered under EMTALA** (e.g., inpatient or outpatient whose condition develops into an emergency beyond the capability of the limited-service hospital and consequently needs to be transferred to a full-service hospital);
  - **Continuity of care** (e.g., telephone consultation with the receiving hospital and physician, sending the patient's medical records along when transferred, etc.); and
  - **Support for maintaining full-time emergency capacity at the community hospital, including on-call coverage** (e.g., physician-owned, limited-service hospital physicians serve in on-call panels at the community hospital, or the physician-owned, limited-service hospital provides financial support to the community hospital to maintain on-call coverage).

NEW TECHNOLOGY

Section 503 of the MMA provided new funding for add-on payments for new medical services and technologies and relaxed the approval criteria under the inpatient PPS. This important provision was enacted to ensure that the inpatient PPS would better account for expensive new drugs, devices and services. However, CMS continues to resist approval of new technologies and considers only a few technologies a year for add-on payments. **The AHA also is disappointed that CMS has not increased the marginal payment rate to 80 percent rather than 50 percent, consistent with the outlier payment methodology, as previously requested by the AHA.**

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

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

The National Committee on Vital and Health Statistics (NCVHS) and Congress, in committee language for the MMA, recommended that the Secretary undertake the regulatory process to upgrade ICD-9-CM to ICD-10-CM and ICD-10-PCS. Congress' call for action recognized that procedure classification codes serve to identify and support research and potential reimbursement policies for inpatient services, including new health technology, as required under the *Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.*

To date, despite these recommendations, as well as the recommendations of several federal health care agencies and offices and health care trade and professional associations, HHS has not yet moved forward to adopt the ICD-10 classification upgrades. We believe that absent a switch

to ICD-10 soon, there will be a significant data crisis in the U.S. This coding crisis will affect the efficiency of the current coding process, adding significant operational costs. In addition, failure to recognize this looming problem will only impede the efforts to achieve President Bush's goal for an electronic health record by 2014.

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

Category 00 is now full, and the C&M committee is entertaining proposals for codes in category 17. At the April C&M meeting a proposal was presented that would in effect leave only 80 codes available in this category. Many of the specific body system chapters are already filled (e.g., cardiac and orthopedic procedures). In recent years, as many as 50 new procedure codes have been created in a single year. This means that it is possible for ICD-9-CM to completely run out of space in one-and-a-half years. We concur with the NCVHS recommendation to issue a proposed rule for adoption of ICD-10. We also would support an implementation period of at least two years following issuance of a final rule.

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

OTHER FUTURE CONCEPTS

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. HHS intends to identify several regions in the United States with high health care costs where there is significant interest in reducing those costs and improving health care quality.

Significant progress has been made in making quality information more transparent. The AHA, the Federation of American Hospitals and the Association of American Medical Colleges partnered with CMS and others to form the Hospital Quality Alliance (HQA). The work of the HQA has led to the voluntary reporting and sharing with the public of 21 quality measures on the *Hospital Compare* Web site, and more measures of hospital quality and patient satisfaction are planned for the future. This effort has been tremendously successful, with nearly all inpatient

PPS hospitals voluntarily reporting quality information. **Efforts to further expand public availability of hospital quality information must continue to be pursued through the HQA.**

While progress has been made regarding quality transparency, similar information on hospital pricing is less accessible. 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).

People deserve meaningful information about the price of their hospital care. Hospitals are committed to sharing information that will help people make important decisions about their health care. Sharing pricing information, however, is more challenging because hospital care is unique. Hospital prices can vary based on patient needs and the services they use; prices reflect the added costs of hospitals' public service role – like fire houses and police stations – serving the essential health care needs of a community 24 hours a day, seven days a week; and most hospitals cannot yet provide prices that reflect important information from other key players like the price of physician care while in the hospital or how much of the bill a patient's insurance company may cover. But more can, and should, be done to share hospital pricing information with consumers.

Providing *meaningful* information to consumers about the price of their hospital care is the most significant challenge hospitals, and CMS, face in increasing transparency of hospital pricing information. Objectives for improving pricing transparency should include:

- Presenting information in a way that is easy for consumers to understand and use;
- Making information easy for consumers to access;
- Using common definitions and language to describe pricing information for consumers;
- Explaining to consumers how and why the price of their care can vary; and

- Encouraging consumers to include price information as just one of several considerations in making health care decisions.

The AHA recently released a position statement on hospital pricing transparency outlining steps to be taken to improve the pricing information available to health care consumers. The following four steps represent the AHA's roadmap for pricing transparency.

1) A federal requirement for states, working with state hospital associations, to expand existing efforts to make hospital charge information available to consumers.

- Thirty-two states already have statutes requiring hospitals to report pricing information that is made available to the public either by posting to a hospital, hospital association or government Web site, issued in a government or hospital association report, or made available to consumers upon request; five additional states voluntarily do so.

- State efforts on price transparency vary, from making individual hospitals' master list of charges available to the public (e.g., California), to making pricing information on frequent hospital services available to the public (e.g., Missouri, Florida, Nevada, North Carolina), to making information on all inpatient services available to the public (e.g., Colorado, Kentucky, Oregon, Pennsylvania, Wisconsin).

2) A federal requirement for states, working with insurers, to make available in advance of medical visits, information about an enrollee's expected out-of-pocket costs.

- This information is especially important to the majority of consumers who already have some type of health insurance coverage. Their likely interest is in knowing the amount for which they personally are financially responsible. This information is provided today to consumers by their insurance company – it is called an "explanation of benefits, or EOB – but is only given after care is provided. To help inform consumers in advance of their out-of-pocket obligations, insurers could provide an "advance EOB." This information could be shared with an insured individual by phone or electronically through an insurer's Web site. Aetna is currently piloting a project like this for physician services in Cincinnati.

3) A federal-led research effort to better understand what type of pricing information consumers want and would use in their health care decision-making.

We have learned much based on research about what kind of information consumers want about the quality of their health care. But we know less about what consumers may want to know about pricing information. Consumers need different types of price information, depending on whether and how they are insured. The following illustrates different consumer needs:

- **Traditional Insurance.** Because traditional insurance typically covers nearly all of the cost of hospital care, people with this type of coverage are likely to want information

about what their personal out-of-pocket cost would be if they receive care at one hospital versus another.

- **Health Maintenance Organization (HMO) Insurance.** People who have HMO coverage will have even more specific price information needs. They have agreed, in advance, to adhere to certain limits on their choice of physician or hospital in exchange for broad-based coverage of their health care needs. A person with HMO coverage typically faces no additional cost for care beyond their premium and applicable deductibles and copayments, but must agree to use physicians and hospitals that are participating in that HMO plan. These individuals likely have little, if any need for specific price information.

- **High-Deductible or Health Savings Account (HSA) Insurance.** People with HSAs have more interest than a typically insured person in price information. These types of plans are designed to make consumers more price-sensitive and to encourage consumers to be prudent "shoppers" for the care they need. A typical plan of this type has a deductible of $2,500. But consumers with HSA coverage are likely to be more interested in price information for physician and ambulatory care than for inpatient hospital care for several reasons:

    - Many patients admitted to the hospital were first seen on an emergency basis in the hospital emergency department. These are not price-shopping patients, but patients who found themselves in need of emergent care and either came or were brought to the nearest hospital emergency department.
    - For patients admitted to the hospital for a scheduled or elective procedure, inpatient hospital price information may be less important because most, if not all, hospital admissions result in a cost that exceeds the typical HSA deductible of $2,500, and therefore, are covered by most HSA plans.
    - People with HSA coverage may be most interested in comparing prices and shopping for care to be delivered that leads up to meeting their deductible (typically $2,500). People with this type of coverage may be most interested in prices for physician office visits and other ambulatory care for which they are likely to be responsible for paying the full cost.

- **Uninsured Individuals of Limited Means.** People without insurance who have limited means for paying for the health care services they have received need to know how much of their hospital or physician bill they may be responsible for. In the case of hospital care, the information they need must be provided directly by the hospital, after the hospital can ascertain whether a patient may qualify for state insurance programs of which they were unaware, free care provided by the hospital, or other financial assistance.

4) A hospital-led effort to create consumer-friendly pricing "language" – common terms, definitions and explanations to help consumers better understand the information provided.

More can be done to explain pricing information to consumers clearly and consistently. Hospitals will lead an effort to create common terms, definitions and explanations of complex pricing information. This will include sharing innovative and understandable ways for displaying pricing information for use by consumers.

The four points of this roadmap include an appropriate role for HHS, which should provide incentives to the states to improve transparency at the state and local level. HHS, through the Agency for Healthcare Research and Quality (AHRQ), is in the best position to complete research on what consumers want and would use in purchasing health care services.

HOSPITAL VALUE-BASED PURCHASING

The DRA required CMS to develop a plan to implement hospital value-based purchasing (pay for performance) beginning in FY 2009. The plan must consider the following issues:

- Measure development – the ongoing development, selection and modification process for measures of quality and efficiency in hospital inpatient settings;
- Data infrastructure and refinement – reporting, collecting and validating of quality data;
- Public reporting – disclosure of information on hospital performance; and
- Incentives – the structure of payment adjustments, including the determination of thresholds for quality improvements that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the payments.

Hospitals remain committed to providing safe, effective, patient-centered, timely, efficient and equitable care to all patients, and the AHA is committed to working with CMS on the development of a value-based purchasing system for Medicare. It is critically important that the system be well thought out.

The HQA is not only accomplishing its goal of making standardized, easy-to-understand information available to the public, but also is reducing the measurement "babble" that had been generated by a large variety of separate organizations asking hospitals to produce quality information. These disparate data requests impede rather than support quality improvement. Conversely, the HQA has brought focus to hospitals' improvement efforts.

Significant resources already have been invested in the HQA effort and the *Hospital Compare* Web site by all of the participants. Nearly 4,200 hospitals – representing more than 99 percent of all eligible Medicare PPS hospitals and over 600 CAHs – have committed to this process, leading the way by sharing data with their communities and the public. **This is a solid foundation on which we must continue to build, and it should be the foundation for any pay-for-performance program included in legislation. To base the pay-for-performance initiative on the work of a group other than the HQA would be duplicative, wasting significant knowledge and expertise.**

Smaller hospitals will face challenges, regardless of the measures chosen for use in a pay-for-performance system. The limited number of patients in small hospitals means that their performance rates can be volatile. In designing a system that rewards excellence, this type of volatility can lead to inappropriate conclusions about the quality of care at these hospitals and affect whether they qualify for a reward under an incentive program. At the same time, omitting small hospitals from a program may suggest to some patients that they do not provide care that is comparable in quality to that of larger organizations. The implications of this volatility in their data must be carefully considered so that hospitals with small sample sizes can participate and receive appropriate recognition for the excellence they achieve.

Payment rewards should be based on evidence-based measures of adherence to quality improving "processes." By using evidence-based *process* measures (e.g., aspirin provided at arrival to patients with acute myocardial infarction; antibiotics provided one hour prior to surgery), *every* provider has the opportunity to succeed, thereby improving the overall quality of the system. Incentive approaches should incorporate rewards for both attainment of a certain threshold of performance and improvement in performance.

We are concerned about premature efforts to tie payments to issues that could change incentives, such as efficiency. We believe that, for now, pay-for-performance initiatives should focus solely on quality improvement. There is no common definition of efficiency of care for hospitals. Efficient over what period of time: the course of a hospitalization or a stated period? Also, efficient for whom: the hospital ... the patient ... the government ... other payers? Each answer would lead to the development of different measures of efficiency and very different conclusions about whether care was efficient.

In addition, measuring and rewarding performance based on a particular definition of efficiency may have considerable consequences for patients. For example, just a few years ago, HMOs developed criteria for efficient care that their physicians and other providers were told to follow. But the resulting headlines referencing denials of tests and treatments, and the accompanying public outcry, led to a fall out in traditional, staff-model HMOs.

Much more work needs to be done to define what should be encouraged in terms of efficient care before it is incorporated into payment policy.

Incentive approaches to payment should use a system of rewards to increase payments or reduce regulatory burden for successful providers. Because the Medicare inpatient PPS already pays less than the cost of care for more than one-third of hospitals, incentives involving penalties should not be used. Additionally, rewards should be sizeable enough to cover the costs of implementing process changes and allow for reinvestment in quality improvement efforts.

To be effective, incentive approaches must align hospital and physician incentives, encouraging all to work toward the same goal of improving quality and providing effective, appropriate care. This is imperative. Incentive approaches rewarding improvement can be successful only if physician and hospital performance can be successfully aligned, in terms of both performance and finances.

HEALTH INFORMATION TECHNOLOGY (IT)

The proposed rule states that it "supports the adoption of health IT as a normal cost of doing business to ensure patients receive high quality care." It also notes that the quality and efficiency benefits of health IT may provide a policy rationale for promoting the use of health IT through the Medicare program. Consequently, CMS asks for comments on:

- Its statutory authority to encourage adoption and use of IT;
- The appropriate role of IT in any value-based purchasing program; and
- The desirability of including use of certified health IT in hospital conditions of participation.

The AHA strongly believes that health IT is a very important tool for improving the safety and quality of health care, and our members are committed to adopting IT as part of their quality improvement strategies. They also view IT as a public good that requires a shared investment between the providers and purchasers of care.

Health IT is a very costly tool, requiring both upfront and ongoing spending. A 2005 AHA survey of hospitals and health systems found that the median amount hospitals invested on health IT in one year was more than $700,000, 15 percent of total capital expenses. Hospitals spent even greater amounts – a median of $1.7 million or 2 percent of all operating expenses – on operating costs. Survey respondents identified the upfront and ongoing costs of IT as the greatest barriers to further adoption. The survey also found that hospitals with negative margins and those with lower revenues use less IT.[4]

The proposed rule highlights the anticipated benefits of health IT as laid out by the RAND Corporation. However, it overlooks another of the study's major findings – that the financial benefits of IT investments accrue more to the payers and purchasers of care than the hospitals and health systems that pay for them.[5]

Simply put, our members have not seen financial returns greater than the costs of implementing clinical IT systems, particularly in the short term. They adopt clinical IT because it is the right thing to do for improving patient safety and quality of care, not because it saves them money. Thus, while IT may be a "normal cost of doing business," it systematically raises those costs. **Given that they reap many of the financial benefits of IT, the AHA believes that the payers and purchasers of care should share in the costs of IT.**

Finally, we learned through the HIPAA process that efficient health information exchange requires all parties to upgrade their systems and work from a common set of standards. As we

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[4] "Forward Momentum: Hospital Use of Information Technology." Washington, DC: AHA (2005).
[5] R. Hillestad, J. Bigelow, A. Bower, F. Girosi, R. Meili, R. Scoville, and R. Taylor. "Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, and Costs," *Health Affairs*, September 1, 2005; 24(5): 1103 - 1117.

moved toward implementation of health IT in hospitals, payers – including the federal government – must modify their own systems to accept electronic data.

Statutory Authority. The broad question of whether CMS has statutory authority to encourage adoption and use of health IT will depend on the specific mechanisms it selects. For example, CMS has some authority to pursue demonstration projects. However, more systematic approaches, such as value-based purchasing or payment adjustments, would require legislative action.

Value-based Purchasing. As noted elsewhere in this comment letter, the AHA believes that any value-based purchasing program should not be punitive. **With regard to IT, only programs that add funds to the inpatient PPS should be pursued because IT is costly, requiring both upfront and ongoing expenditures.** Decreasing payments to those that have not been able to afford IT further limits their ability to invest. A budget-neutral approach also ignores the reality that health IT systematically increases hospitals' costs.

The AHA also believes that value-based purchasing programs should build off the consensus measures endorsed by the broad spectrum of organizations – including CMS – that participate in the HQA. In general, the HQA favors measures that address quality outcomes, rather than the tools used to get there.

Health IT can play a role in reducing the burden of quality reporting. Presently, electronic health records (EHRs) and other clinical IT systems do not automatically generate quality measures. Most hospitals still require special calculations – including expensive manual chart abstraction and use of third-party contractors – to submit quality data. CMS could advance the quality agenda by investing in the development of algorithms for the calculation of the quality measures it wants reported from EHRs and encouraging vendors to include them in their products.

Rather than including health IT in a value-based purchasing program, **CMS could support adoption of health IT through a payment adjustment funded with new money.** For example, it could increase payments to hospitals that use health IT that improves the safety and quality of care by 1 percent. This kind of payment adjustment represents Medicare's share of the necessary investment to achieve this goal and would recognize the greater costs of a "wired" health care system. The AHA will pursue legislation authorizing such a payment adjustment. Other mechanisms, such as loan guarantees and grant funds, are needed to help hospitals finance the upfront costs of implementing health IT.

Conditions of Participation. The AHA firmly believes that **CMS should not include health IT in the Medicare conditions of participation (COP) for hospitals.** The COPs address the basic, essential infrastructure needed to ensure patient safety and must be clearly understood. Successful implementation of quality-enhancing IT requires careful planning and changes to work processes. The hospital field is still developing its understanding of how to implement these systems correctly. In addition, the commercial health IT applications available do not always meet hospitals' needs. The evidence on health IT does not yet support this level of requirement and would amount to an unfunded mandate. A recent report supported by the AHRQ found that the existing research on the quality benefits of health IT is limited to a handful of leadership institutions that generally developed their own systems. And, while promising, the

results are not yet generalizable to the average community hospital using the vendor systems currently on the market.[6]

While the AHA appreciates the efforts of the Certification Commission on Health Information Technology (CCHIT) to provide the market with better confidence in vendor product, we do not believe those efforts are sufficiently advanced to warrant inclusion in any adoption incentives CMS might pursue. CCHIT is only at the beginning stages of looking into certification of hospital inpatient products. CCHIT's work on ambulatory products is more advanced but, while it shows promise, has not yet proven itself in the marketplace.

HOSPITAL-ACQUIRED INFECTIONS

In the proposed rule, CMS has asked for ideas about how to effectively implement the DRA provision requiring the agency to identify instances in which the reliable application of science and appropriate processes of care should prevent infections, and to ensure that Medicare does not pay more for the hospital care of patients who becomes infected as a result of their care than it does for patients who are infection free.

It is difficult to identify the confluence of known science and effective care processes to prevent infections. **We believe that until a broad array of expertise is brought together to consider what conditions, procedures and circumstances should be targeted for this change, it is impossible to know how to most effectively implement the provision.** As the representative of America's hospitals and health systems, the AHA would be pleased to be part of those discussions.

We believe that the right starting point for this work is to build off CMS' substantial investment in the Surgical Care Improvement Project (SCIP). Surgical wound infections are among the most common and hazardous hospital-acquired infections. There is a readily available community of expertise among the broad group of organizations involved in SCIP, including the American College of Surgeons, the American Society of Anesthesiologists, the Association of periOperative Registered Nurses and the Centers for Disease Control and Prevention, among others. The existing SCIP partners' expertise can help identify a few surgical procedures that might be most appropriate for the change Congress envisioned. We believe these are likely to be relatively "clean" surgeries, meaning surgeries on patients whose conditions or wounds have not already put them at higher risk for infection, and patients who do not already have a variety of complicating conditions that would place them in higher paying DRGs. Additional expertise on coding and the DRG GROUPER also is needed for these discussions to help address questions of what data are helpful and readily available to determine which infections were acquired in the hospital versus the community, and which codes actually lead to enhanced payments.

In addition, there is good evidence to suggest that even when reliable science and appropriate care processes are applied in the treatment of patients, not all infections can be prevented. Therefore, we suggest that by utilizing the SCIP program as the basis for responding to the

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[6] "Costs and Benefits of Health Information Technology." Agency for Healthcare Research and Quality Publication No. 06-E006 (April 2006).

congressional mandate, CMS could choose not to penalize a hospital if, despite their best efforts, an infection occurs. For example, if a hospital's performance on the SCIP surgical wound infection prevention measures show that it reliably performs the necessary infection prevention steps all or nearly all of the time, CMS might not make any change to the current payment system for that hospital.

Submitter : Dr. Matt Lindgren

Date: 06/12/2006

Organization : John Peter Smith Hospital-FMRP

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

GME Payments

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.

CMS-1488-P-1568-Attach-1.DOC

#1568

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

Someone at CMS will need to explain to me, how the teaching, curriculum development and evaluation process for the six required ACGME physician skill competencies is not related to patient care. Isn't this exactly what the IOM has criticized our training professions for? In fact, our program currently evaluates us in all these competencies as a continuing quality improvement process DURING patient care. Without time to discuss and reflect our experiences and outcomes we will not be serving the needs of our current and future patients.

Should indeed this come to pass, we will have faculty who will be caught in the productivity race with no time for us. We may get pop-up feed back from an Electronic Health Record in sites that have them that we have made an error or we are not following a guideline. No discussion there. What is being proposed is dangerous for our current patients and our future patients. Our patients deserve for us to have a better education than you are proposing.

Why does the American taxpayer support medical students at over $200,000 per student per year and offers the faculty of residencies less than $15,000 for teaching per resident per year? I am getting a lot more from my residency training to protect and serve my patients of the future than all of medical school combined. Please do not cut us any more – rescind the clarification of this dangerous and capricious rule.

Medical Resident

Submitter : **Mr. James Grant** **Date: 06/12/2006**

Organization : **American Surgical Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1569-Attach-1.DOC

1569

AMERICAN SURGICAL
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June 12, 2006

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

Re: CMS-1488-P
Proposed Changes to the Hospital Inpatient Prospective Payment System

Dear Administrator McClellan:

The American Surgical Hospital Association (ASHA), representing the nation's physician owned hospitals with specialized capabilities, is pleased to offer comments on the proposed rules for the fiscal year 2007 inpatient prospective payment system.

The key issues for our members are the proposed 2007 changes in weights to make them more hospital specific; the proposed adoption in 2008 of severity adjusted DRGs; and clarification of the application of EMTALA to physician owned specialty hospitals.

ASHA has previously supported the recommendations of the Medicare Payment Advisory Commission (MedPAC) to revise the inpatient payment system to better align payments with true costs of care. ASHA agrees that hospitals providing services to more complex patients should be reimbursed in a manner that reflects the nature of that care. While we do not want to see a payment system that rewards hospital inefficiency, it is a reasonable policy to make sure that services are appropriately compensated.

Over time some DRGs have become more profitable than others. Making adjustments in the rates to restore balance to the entire inpatient payment system is a needed step. We endorse the efforts of CMS to achieve these goals through adoption of hospital specific weights and severity adjusted DRGs.

ASHA recommends that these changes be implemented in one step, not two. As presently constructed, the proposed rule would cause one set of shifts in payment in 2007 and another in 2008, not necessarily all in the same direction. As a result, rates could increase or decrease in both years, a result that we feel is not in the best interests of effective hospital financial planning or management.

We suggest that CMS delay implementation until 2008 when it would be prepared to address all of the issues simultaneously. Thus there would be only one major adjustment to inpatient rates. We also recommend that CMS, to the extent possible, phase in the changes since many hospitals, not just ASHA members, may experience significant variations in payment. We agree that these changes are essential, but CMS should take steps to make sure that their implementation is handled in a way that minimizes the disruption to patient care.

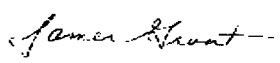
We are aware that some critics of the proposed rule have argued that the statistical methods used by CMS and the data incorporated into the changed payment system are flawed. We have no specific view on those concerns, but are confident that CMS will respond appropriately to legitimate criticism of the statistical methods and the underlying data.

CMS has specifically looked at the relation between EMTALA and the activities of specialty hospitals. ASHA has participated in that public process and believes that the recommended actions in the proposed rule strike the proper balance. Our member hospitals are subject to EMTALA requirements that apply to hospitals that have, or do not have, emergency facilities. We have never disputed our obligations under that law. The clarifying language suggested by CMS is appropriate and will help assure that patients needing medical attention will be able to obtain it at the appropriate facilities, regardless of size or ownership.

ASHA believes that the steps recommended by CMS are essential to increase the rationality of hospital payment. Our only recommendations relate to the timing of their implementation.

We appreciate the opportunity to respond to the proposed rule.

Sincerely,



James Grant
President

Submitter : **Dr. Robert Menzies** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

CMS-1488-P-1570-Attach-1.DOC

#1570

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

Submitter : **Dr. Kent Mitchell** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

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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.

CMS-1488-P-1571-Attach-1.DOC

#1571

Dear CMS policy maker

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being un related to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. That hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

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Please help us be better physicians to our patients by supporting a competent and refreshed faculty . Rescind the interpretation of the IME and DME support rule

Sincerely,

Submitter : **Ms. Jennifer Fennell**

Date: 06/12/2006

Organization : **St. John Oakland Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1488-P-1572-Attach-1.DOC

#572

June 12, 2006

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

SENT VIA e-Rulemaking

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

Dear Administrator McClellan:

St. John Oakland Hospital (SJOH), a member of St. John Health (SJH), that provides resident training for over 60 osteopathic medical school graduates in Southeast Michigan, 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).

SJOH urges CMS 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].

SJOH supports 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,

Jennifer O. Fennell

Jennifer O. Fennell
Vice President of Finance
St. John Oakland Hospital

Submitter : Dr. Nicole Nguyen

Date: 06/12/2006

Organization : John Peter Smith Hospital-FMRP

Category : Health Care Professional or Association

Issue Areas/Comments

GME Payments

GME Payments

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.

CMS-1488-P-1573-Attach-1.DOC

#1573

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

Someone at CMS will need to explain to me, how the teaching, curriculum development and evaluation process for the six required ACGME physician skill competencies is not related to patient care. Isn't this exactly what the IOM has criticized our training professions for? In fact, our program currently evaluates us in all these competencies as a continuing quality improvement process DURING patient care. Without time to discuss and reflect our experiences and outcomes we will not be serving the needs of our current and future patients.

Should indeed this come to pass, we will have faculty who will be caught in the productivity race with no time for us. We may get pop-up feed back from an Electronic Health Record in sites that have them that we have made an error or we are not following a guideline. No discussion there. What is being proposed is dangerous for our current patients and our future patients. Our patients deserve for us to have a better education than you are proposing.

Why does the American taxpayer support medical students at over $200,000 per student per year and offers the faculty of residencies less than $15,000 for teaching per resident per year? I am getting a lot more from my residency training to protect and serve my patients of the future than all of medical school combined. Please do not cut us any more – rescind the clarification of this dangerous and capricious rule.

Medical Resident

Submitter : Dr. Kathleen Bakke **Date:** 06/12/2006

Organization : Dr. Kathleen Bakke

Category : Physician

Issue Areas/Comments

GME Payments

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.

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,

Kathleen M. Bakke MD

Submitter : **Dr. Fidel Ogeda** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

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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.

CMS-1488-P-1575-Attach-1.DOC

#1575

Dear CMS policy maker

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being un related to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. That hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty . Rescind the interpretation of the IME and DME support rule

Sincerely,

Submitter : **Dr. Sonal Patel** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME 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.

CMS-1488-P-1576-Attach-1.DOC

#1576

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

Someone at CMS will need to explain to me, how the teaching, curriculum development and evaluation process for the six required ACGME physician skill competencies is not related to patient care. Isn't this exactly what the IOM has criticized our training professions for? In fact, our program currently evaluates us in all these competencies as a continuing quality improvement process DURING patient care. Without time to discuss and reflect our experiences and outcomes we will not be serving the needs of our current and future patients.

Should indeed this come to pass, we will have faculty who will be caught in the productivity race with no time for us. We may get pop-up feed back from an Electronic Health Record in sites that have them that we have made an error or we are not following a guideline. No discussion there. What is being proposed is dangerous for our current patients and our future patients. Our patients deserve for us to have a better education than you are proposing.

Why does the American taxpayer support medical students at over $200,000 per student per year and offers the faculty of residencies less than $15,000 for teaching per resident per year? I am getting a lot more from my residency training to protect and serve my patients of the future than all of medical school combined. Please do not cut us any more – rescind the clarification of this dangerous and capricious rule.

Medical Resident

Submitter : Dr. Bernard Katz

Date: 06/12/2006

Organization : Santa Monica Bay Physicians

Category : Physician

Issue Areas/Comments

GME Payments

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,

Bernard J. Katz, MD

Submitter : **Dr. Shelle Barber** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital - FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

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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.

CMS-1488-P-1578-Attach-1.DOC

#1578

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

Someone at CMS will need to explain to me, how the teaching, curriculum development and evaluation process for the six required ACGME physician skill competencies is not related to patient care. Isn't this exactly what the IOM has criticized our training professions for? In fact, our program currently evaluates us in all these competencies as a continuing quality improvement process DURING patient care. Without time to discuss and reflect our experiences and outcomes we will not be serving the needs of our current and future patients.

Should indeed this come to pass, we will have faculty who will be caught in the productivity race with no time for us. We may get pop-up feed back from an Electronic Health Record in sites that have them that we have made an error or we are not following a guideline. No discussion there. What is being proposed is dangerous for our current patients and our future patients. Our patients deserve for us to have a better education than you are proposing.

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Medical Resident

Submitter : **Dr. Orin Guidry** **Date: 06/12/2006**

Organization : **American Society of Anesthesiologists**

Category : **Health Care Professional or Association**

Issue Areas/Comments

FTE Resident Count and Documentation

FTE Resident Count and Documentation

See attachment

CMS-1488-P-1579-Attach-1.PDF

#1579

AMERICAN SOCIETY
OF ANESTHESIOLOGISTS

Office of Governmental Affairs
1101 Vermont Avenue, N.W.
Suite 606
Washington, DC 20005
(202) 289-2222
FAX (202) 371-0384
mkp@ASAwash.org

June 12, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Via Electronic Submission

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

Dear Administrator McClellan:

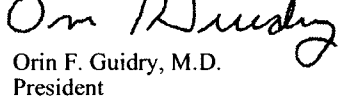
The American Society of Anesthesiologists welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rule entitled *"Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates."* 71 Fed. Reg. 23996 (April 25, 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 excluding 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,



Orin F. Guidry, M.D.
President

520 N. Northwest Highway. Park Ridge, IL 60068-2573
Telephone: (847) 825-5586. Fax: (847) 825-1692. E-mail: mail@ASAhq.org

Submitter : **Dr. Walid Saade** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

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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.

CMS-1488-P-1580-Attach-1.DOC

#1580

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

Submitter : **Ms. Nancy Galvagni** **Date: 06/12/2006**

Organization : **Kentucky Hospital Association**

Category : **Hospital**

Issue Areas/Comments

DRG Weights

DRG Weights

See Attachment. Disregard previously e-mail comments.

CMS-1488-P-1581-Attach-1.DOC

#1581

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 Kentucky Hospital Association's (KHA) 127 member hospitals, we 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).

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc). It also proposes refining the DRGs to better account for severity by implementing consolidated severity adjusted DRGs (CS-DRG), in FY 2008 or sooner. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education, among other policies.

While the KHA supports many of the proposed rule's provisions, we have serious concerns about the proposed changes to the DRG weights and classifications.

The hospital field supports meaningful improvements to Medicare's inpatient PPS. We support the goal of refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. 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 methodology 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.

The HRSVcc, which shifts payments to rural hospitals, increases Kentucky's $1.8 billion inpatient payments by $6.3 million in 2007 (0.35%). The implementation of CS-DRG methodology in 2008 has a significant negative impact on the rural hospitals in Kentucky. Even

though most of Kentucky's urban hospitals recoup in 2008 some of what they lost in 2007, they are still down for the two years and years going forward. The change in DRG in 2008 will reduce Kentucky inpatient payments by approximately $25 million compared to 2007. Moving forward requires thoughtful change.

Specifically, the KHA supports the following:

- **One-year Delay:** The KHA supports a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. Why change a methodology which has been in place since 1983 for one year to be replaced by a new system in 2008? CMS considers the 2007 change a first step in a major overhaul of the DRG system in 2008. How is 2007 a first step if it shifts dollars in the opposite direction of what is planned in 2008?

- **Valid Cost-based Weights:** We support moving to a DRG-weighting methodology based on hospital costs rather than charges if the calculations are correct.

- **A New Classification System Only if the Need Can Be Demonstrated:** The KHA does not support a new classification system at this time, 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:** Develop a methodology that would allow for a three-year phase-in which would allow the negatively impacted hospitals time to adjust their operations. CMS has a history of phasing in changes when hospitals are negatively impacted.

The KHA appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me at (502) 426-6220 or ngalvagni@kyha.com or Steve Miller at (502) 426-6220 or smiller@kyha.com.

Sincerely,

Nancy C. Galvagni
Senior Vice President

Submitter : **Mr. Paul Volek** **Date: 06/12/2006**

Organization : **University Hospital - Cincinnati**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See attached position on IME/DGME clarification.

CMS-1488-P-1582-Attach-1.PDF

#1582

The University Hospital
Health Alliance™

234 Goodman Street
Cincinnati, Ohio
45219-2316
513-584-1000

June 12, 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. This "clarification" is at odds with the historical CMS position that the activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. Furthermore, the location in which these activities are conducted is not relevant given that suitable lecture or meeting space is often not available or severely constrained by scheduling conflicts with in the hospital.

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,

Paul J. Volek
Administrative Director
Transplant Services

Submitter : **Dr. Karen Smith** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

CMS-1488-P-1583-Attach-1.DOC

#1553

Dear CMS policy maker

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being un related to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. That hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty . Rescind the interpretation of the IME and DME support rule

Sincerely,

Submitter : Dr. W.Ross Lawler **Date:** 06/12/2006

Organization : Dr. W.Ross Lawler

Category : Individual

Issue Areas/Comments

GME Payments

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.

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. Alan Guerci** **Date: 06/12/2006**

Organization : **St. Francis Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

St. Francis Hospital welcomes this opportunity to comment on the changes that the Centers for Medicare and Medicaid Services (CMS) have proposed to the hospital inpatient prospective payment system (IPPS) and fiscal year 2007 rates.

Please see attached comments.

CMS-1488-P-1585-Attach-1.RTF

#1585

CMS-1488-P
June 12, 2006

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

Comments on DRG Reclassifications, HSRV Weights, DRGs: Severity of Illness, Cost-Based Weights: Outlier Threshold

Dear Dr. McClellan:

St. Francis Hospital welcomes this opportunity to comment on the changes that the Centers for Medicare and Medicaid Services (CMS) have proposed to the hospital inpatient prospective payment system (IPPS) and fiscal year 2007 rates. After providing some basic information about our facility, St. Francis will provide comments addressing the following: (1) CMS's proposed changes disproportionately affect cardiac care centers; (2) CMS used a methodology designed to pay tertiary care hospitals less and other hospitals more, relied on inaccurate data, and failed to achieve its stated goal of increased payment accuracy; (3) CMS should utilize an open-source system to facilitate greater standardization; and (4) CMS should delay implementation of the proposed changes for at least one year.

St. Francis Hospital

St. Francis Hospital (provider number 330182) is New York's only designated hospital cardiac center. In 1979, the New York Department of Health gave the hospital

permission to close obstetrics, gynecology, neurosurgery and inpatient psychiatry in order to concentrate on cardiac care.

St. Francis performs more cardiac procedures than any other hospital in the Northeast. Currently, we perform about 10,000 cardiac catheterizations, 4,000 coronary angioplasties, and 1,700 open heart surgeries per year. Our doctors also implant about 1,000 automatic internal cardiac defibrillators (AICD or ICD) and 800 pacemakers each year. St. Francis is consistently ranked among one of the nation's best hospitals,[1] and has a 99% patient satisfaction rate.[2] The average daily occupancy rate of St. Francis Hospital, calculated at midnight, is around 110 percent. Patients choose St. Francis Hospital despite the over-crowding because of its reputation for quality care and experienced specialists.

Unlike a "specialty hospital,"[3] St Francis offers a wide range of hospital services from general and non-cardiac related specialized surgery programs (e.g., ENT related surgery), to emergency services, to general medicine. More than half of the total admissions to St. Francis Hospital result from Emergency Department visits, and the Emergency Department continues to provide the complete spectrum of adult medical and surgical emergency care to the community.

St. Francis Hospital also offers a variety of community services, including diabetes education, heart-healthy nutritional counseling, fitness programs, smoking cessation clinics, and stress workshops. The St. Francis Women's Center offers patients

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[1] Sample rankings include Money Magazine, Good Housekeeping, and America's Top Doctors.
[2] According to the Press Ganey Survey of patient satisfaction.
[3] Under Section 507 of the Medicare Modernization Act of 2003 (codified at 42 U.S.C. 1395nn(h)), a specialty hospital is defined as a hospital "primarily or exclusively engaged in the care and treatment" of one of the following categories: (1) patients with a cardiac condition; (2) patients with an orthopedic condition; or (3) patients receiving a surgical procedure.

advanced diagnostic and treatment options, including digital mammography with computer-aided detection (CAD); breast MRI and MRI-guided breast biopsy; stereotactic biopsy; ultrasound biopsy, and other ultrasound: breast, pelvic, abdominal, thyroid, renal and sonohysterograph; and bone densitometry.

St. Francis Hospital is a member of Catholic Health Services of Long Island (CHS), a five hospital, three nursing home, one inpatient rehab center network that also offers home nursing and hospice services. Last year, CHS lost $3.7 million on operations. The other CHS hospitals are St. Charles (Port Jefferson), St. Catherine of Siena (Smithtown), and Good Samaritan (West Islip), all in Suffolk County; and Mercy Medical Center (Rockville Centre) in Nassau County. Good Samaritan and Mercy have large charity care and bad debt loads. In 2004, the most recent year for which network-wide figures are available, CHS provided $11.3 million in charity care, wrote off $42 million in uncompensated care (bad debt), and subsidized $25 million in community services (clinics, health and education programs, etc), while losing $12.6 million on operations and joint ventures.

1. CMS's Proposed Rule Would Reduce the Quality of Care and Increase Mortality Rates.

Critics of the current payment methodology argue that the current DRG weighting system may result in higher-than-average profitability for surgical DRGs, and lower-than-average profitability for medical DRGs. Researchers modeling CMS's proposed rule and the current system confirmed the observation that virtually all of the cardiac surgery DRGs are profitable under the current system. *However*, these studies also found

that it would no longer be financially "feasible" for many hospitals to provide cardiac services if CMS implemented the proposed rule as is.[4]

The proposed rule would reduce the quality of care and increase mortality rates, particularly for cardiac care. Numerous studies have found an inverse relationship between a hospital's volume of surgical procedures and its surgical mortality rates.[5] With respect to cardiac care, hospitals performing large numbers of cardiac procedures have significantly lower mortality rates than hospitals performing fewer cardiac procedures, because experience improves cardiac care outcomes. St. Francis Hospital is a perfect example. St. Francis Hospital performs more cardiac procedures than any other hospital in the Northeast. Based on studies undertaken by both government entities and private researchers, St. Francis's risk-adjusted mortality rates have been significantly below both the New York State and national averages. CMS's proposed rule would significantly reduce payments for cardiac care and, consequently, will force many hospitals – including St. Francis – to reduce the number of cardiac procedures they perform. Patients requiring cardiac care will be forced to utilize hospitals with higher mortality rates and lower patient satisfaction.

Our preliminary analysis of the impact of CMS's proposed rule confirms this. We found that the proposed DRG weighting changes would reduce payments to St. Francis Hospital by over $20.8 million annually, an 11.9% loss. In order to remain financially viable in the face of these significant losses, St. Francis will be forced to reduce the

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[4] *See* Karen Heller, et al., Analysis of the Centers for Medicare & Medicaid Services' Proposals for Changing the Diagnosis-Related Group Weighting Methodology and Patient Classification System, The Health Economics and Outcome Research Institute (June 12, 2006).

[5] See, e.g., John Birkmeyer, et al., "Hospital Volume and Surgical Mortality in the United States," The New England Journal of Medicine Volume 346:1128-1137 (April 11, 2002) (Concluding that "In the absence of other information about the quality of surgery at the hospitals near them, Medicare patients undergoing selected cardiovascular or cancer procedures can significantly reduce their risk of operative death by selecting a high-volume hospital.").

number of cardiac cases it treats, and patients will be forced to turn to hospitals with less experience and higher mortality rates for treatment. Thus, CMS's proposed new payment methodology is at odds with improved cardiac care outcomes and reduced mortality rates.

Moreover, although St. Francis specializes in cardiac care, St. Francis is a member of the CHS network, which offers the full range of medical services to all patients, including large charity care and bad debt loads. In recent years, St. Francis has been the backbone of financial support for these services. Thus, St. Francis's projected $20.8 million loss would truly be a loss for the entire Long Island community.

Although CMS can and should improve the current DRG weighting system, numerous studies show that the proposed weighting system is, at best, no more accurate and, in many instances, less accurate than the current system. It is important for patient care and provider stability that CMS not implement a new methodology for the mere sake of change alone or to penalize or benefit certain classes of providers; the goal, instead, should be to properly align payments with cost.

2. CMS Used a Methodology Designed to Pay Tertiary Care Hospitals Less and Other Hospitals More, Relied on Inaccurate Data, and Failed to Achieve its Stated Goal of Increased Payment Accuracy.

Increased payment accuracy in the Medicare system has long been a priority of Congress, CMS, and the Medicare Payment Advisory Commission (MedPAC). In its most recent Report to Congress, MedPAC "focuses on improving Medicare payment accuracy and calibrating payment adequacy to the efficient provider."[6] To achieve a higher degree of payment accuracy in the IPPS, MedPAC recommended four specific

[6] *See* Testimony of Glenn Hackbarth, Chairman, MedPAC before the Subcommittee on Health, House Ways and Means Committee (March 1, 2006).

changes in March 2005: cost-based weights, hospital specific relative values, improved severity adjustment, and DRG specific outlier financing.[7] These recommendations are not new. MedPAC and its predecessor, ProPAC, have long recommended both the refinement of DRGs and the revision of the methodology for calculating the relative weights. In fact, the recommendations MedPAC made in March 2005 are essentially identical to the recommendations ProPAC made in 1995.

CMS's proposed rule is largely a response to the concerns about payment accuracy raised by MedPAC and echoed in Congress. CMS states that, in developing the proposed rule, it relied heavily upon MedPAC's recommendations, including the proposal to move towards cost-based weights.[8] However, in the proposed rule, CMS did not implement MedPAC's recommendations.

A. CMS Employed Statistical and Economic Techniques Designed to Pay Tertiary Care Hospitals Less and Other Hospitals More.

Statisticians, economists and other researchers have a variety of analytical tools at their disposal. Each of these tools has different purposes and produces different types of results. However, researchers must be careful not to choose a particular analytical tool simply because it will prove their preconceived notions or produce the desired outcomes.

In crafting the proposed IPPS rule, it appears CMS began with the premise that Medicare should pay less for some "high weight" DRGs, such as cardiac care, and more for some "low weight" DRGs such as eye disorders. Then, CMS constructed an analytical model that allowed them to prove their initial premise.

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[7] *See* Report to the Congress: Physician Owned Specialty Hospitals, MedPAC (March 2005).
[8] *See Proposed Rule* at 54-58

First, CMS selected an approach to calculating hospital specific cost-based weights which compresses the proposed DRG weights. While CMS adopted MedPAC's suggestion to move towards cost-based weights, CMS rejected MedPAC's proposed methodology. St. Francis Hospital agrees that CMS should move towards using cost-based weights. When calculated accurately, cost-based weights can greatly help improve the payment accuracy of the IPPS.

MedPAC recommended that CMS replace its charge-based relative weight methodology with a cost-based hospital specific relative weight (HSRV) methodology, by developing cost-to-charge ratios (CCRs) for individual hospitals at the most detailed department level. In the proposed rule, CMS rejected MedPAC's recommended methodology as too "administratively burdensome."[9] CMS proposed, instead, an entirely new, untestested methodology called the hospital-specific relative value cost center (HSRVcc) methodology.

While it may be appropriate to derive the DRG weights from an estimate of cost per case using the standard or HSRV methodology, there is no logical basis for the HSRVcc approach. It is merely an arbitrary computational formula. Mathematicians often note that simply resolving complex equations does not prove a hypothesis or prove that the numerical answer is correct. CMS's proposed approach to calculating weights suffers from the same fundamental shortcoming: there is an absence of underlying empirical justification for the approach.

Second, CMS used a geometric mean to calculate the cost-to-charge ratio for each cost center.[10] Statisticians use numerous types of "means," from simple arithmetic means

[9] *Id* at 59.
[10] *Id* at 68.

to harmonic means to logarithmic means. Each type has limitations and distortions. For example, a geometric mean, unlike an arithmetic mean, tends to dampen the effect of very high or low values. Thus, a geometric mean is always less than the arithmetic mean. A geometric mean is a useful tool to measure sparse or diverse data; used properly, it has the virtue of being able to smooth and compress the results. To use an example from another field, meteorologists often rely on geometric means to make weather forecasts. This analytical tool allows them to discount or undervalue very hot days and very cold days.

Similarly, CMS explicitly chose to use a geometric mean because it allowed the agency to develop a DRG weighting scheme that undervalued or discounted very high cost cases. The use of a geometric mean has the direct effect of decreasing the index value of high weight DRGs and increasing the index value of low weight DRGs.

Economists, statisticians and other researchers understand that probability and validity have different purposes. That is, for purposes of computing appropriate and fair payments, the most probable result is not always the most accurate result. While the use of a geometric mean may be appropriate for weather forecasts where probability is the goal, it is not appropriate for computing payments to hospitals where accuracy should be the primary goal. Some analysts argue that CMS may have chosen this statistical tool to validate a preconceived policy belief that hospitals treating the sickest patients should be paid less and other hospitals paid more.

Third, CMS excluded relevant data in a way that distorts the results. CMS says it excluded "aberrant" data. However, under CMS's approach, the vast majority of the

excluded data came from high weight DRGs.[11] Removing this data has the direct effect of "smoothing" the results -- reducing the index value of high weight DRGs and increasing the index value of low weight DRGs, thus causing distortions in the final set of CCRs.

St. Francis Hospital recommends that CMS use all data from hospitals that meet the following criteria: (1) in the FY 2004 MedPAR file, (2) with overlapping HCRIS data, *and,* (3) in the FY2007 proposed rule Impact File.

B. CMS relied on inconsistent and inaccurate data.

To achieve a more accurate payment structure, MedPAC recommended that CMS develop CCRs for hospitals at the most detailed department level by matching cost report and claims data from the same year. CMS's rejected this methodology as too "administratively burdensome." Instead, CMS used cost report data from FY2003 and claims data from the FY 2004 MedPAR file.[12] The cost report data from FY 2003 was used, CMS said, because it was "the most recent full set of data available."[13]

This approach elevates simplicity over accuracy. If medicine were a static field, in which cost report and claims data increased by a static percentage, using data sets from two different years would not be problematic. But medicine is a dynamic field, constantly evolving with the introduction of new technologies. Generally speaking, charges for medical services undergoing rapid technological advances increase at a much

[11] CMS modified the data by (1) removing statistical outliers that were beyond 3.0 standard deviation from the mean of the log distribution of both the charges per case and the charges per day for each DRG. *Proposed Rule* at 63. Then, after computing the HSRVs for each cost center for each DRG based on the "clean data," CMS removed any CCRs where the log of the cost center was greater or less than the mean log plus/minus 1.96 standard deviation. *Proposed rule* at 68.

[12] *Proposed Rule* at 61.
[13] *Id.*

more rapid rate than charges for care not experiencing similar changes; this is certainly the case with respect to cardiology. Consequently, CMS's reliance on cost report data and charge data from mismatched years is likely to lead to inaccurate and distorted results, particularly for high weight DRGs.

Moreover, CMS should not use 2003 cost report data because 2003 was the year in which drug-eluting stents were introduced. FDA approval for drug eluting stents was not granted until several months into the year, on April 24, 2003, and there was a shortage of drug eluting stents during the last months of 2003. Therefore, the costs of drug eluting stents were not adequately reflected in the 2003 cost reports.

In addition, and for a number of legitimate reasons, hospitals use a variety of approaches to recording costs. For example, in the reporting of costs of medical implants, some hospitals report the cost as "routine," other hospitals report the cost as "ancillary," and still other hospitals report the cost as "medical supplies sold." Such disparities in cost reporting resulted in inaccuracies in the proposed DRGs.

St. Francis Hospital notes that, when IPPS was first implemented, CMS required a base-year audit. The base year audit allowed CMS to craft a payment system grounded on a more level playing field. Requiring hospitals to standardize cost reports before major changes to the IPPS system are implemented would achieve similar benefits of consistency and accuracy.

St. Francis Hospital recommends that CMS require hospitals to standardize their cost reports before implementing a methodology that matches CCRs with MedPAR charges, and recommends that CMS further study potential distortions resulting from the use of cost report data and claims data from mismatched years.

D. CMS fails to achieve increased payment accuracy.

CMS claims that the proposed rule increases "payment accuracy. " Researchers and other analysts reviewing CMS proposed rule have found, in contrast, that the new CMS payment methodology is, at best, no more accurate and, in many instances, is less accurate than the current system. In addition, they have found that a number of other approaches to classifying DRGs and developing weights would be far more accurate.[14]

It appears that CMS defined "payment accuracy" as Medicare paying tertiary care hospitals less and other hospitals more. Under this definition, CMS's proposal achieves the stated goal. However, if one defines "payment accuracy" as Medicare reimbursing hospitals fairly, then CMS's approach falls far short.

3. CMS should consider developing a DRG system on an open-source basis.

CMS's proposed rule uses a grouping structure that is a proprietary product belonging to a single company. This decision has ramifications that extend far beyond the Medicare system because many private plans, including Medicare managed care plans and employer-sponsored plans, base their payments on the Medicare DRG system. Private payors and hospitals will have no choice but to purchase or license this proprietary software from the single company, thereby increasing the cost of health care.

[14] For example, New York State's methodology estimates cost per case in its patient-level database then derives DRG weights based on the standard methodology rather than the HSRV methodology. Analysts called this methodology "superior" to CMS's methodology because it recognizes and accommodates the substantial misalignment between charges reported in the cost reports and charges reported on the patient bills. *See* Karen Heller, et al., Analysis of the Centers for Medicare & Medicaid Services' Proposals for Changing the Diagnosis-Related Group Weighting Methodology and Patient Classification System, The Health Economics and Outcome Research Institute (June 12, 2006).

St. Francis Hospital recommends that CMS consider developing a DRG system based on an open-source system.

4. CMS has established an infeasible implementation date.

CMS proposes to adopt hospital specific cost-based weights in fiscal year 2007, and to implement severity adjustments in fiscal year 2008. CMS admits that these changes "would represent a major change to how hospitals are paid for Medicare inpatient services" and "believe[s] it may be appropriate to provide hospitals with additional time to plan for these changes."[15] St. Francis agrees that providing hospitals additional time to plan for such major changes is appropriate.

Moreover, DRGs are but one component of Medicare's highly interrelated payment methodology. While the proposed rule addresses DRG weights and severity adjustments, CMS admits that it is still in the process of determining whether and how to change the way that outliers are financed. In essence, CMS is asking hospitals and other parties who rely on Medicare to respond to an incomplete proposal. CMS should not implement HSRVs until it completes its evaluation of the MedPAC outlier proposal and ensures that any actions it takes with respect to outliers will not undermine the accuracy of the HSRV methodology.

St. Francis Hospital recommends that CMS delay implementation of the proposed HSRVcc and CS-DRG methodology for one year, and provide no less than a three-year

[15] *Proposed Rule* at 111.

transition to the new system from the effective date.[16] In addition, we recommend that severity adjustments be implemented concurrently with the change to cost-based weights.

[16] *Id.* at 114-115.

Submitter : **Mr. Stephen Brown** **Date: 06/12/2006**

Organization : **MediCorp Health System**

Category : **Hospital**

Issue Areas/Comments

Impact Analysis

Impact Analysis

See comments.

CMS-1488-P-1586-Attach-1.DOC

#1556

MediCorp Health System

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, D.C. 20201

Dear Dr. McClellan:

We appreciate the opportunity to submit comments on the fiscal year 2007 inpatient prospective payment system proposed rules. Mary Washington Hospital is a not-for-profit sole community hospital servicing Fredericksburg, Virginia and surrounding counties for over one hundred years. We recognize the importance of the proposed changes in the reimbursement system as reimbursement levels directly affect our ability to meet our community's health care needs.

While we support in concept most of the proposals as they are intended to provide a fairer way to compensate hospitals, we are concerned that the changes as currently proposed contain technical problems that, if enacted, will likely lead to other unfair payment practices. This is contrary to the intent of the new rules.

For example, while the development of DRG weights using costs instead of the current method of using charges might yield better results, a system that converts charges to costs, if not done correctly, may lead to unintended distortions. I believe that MedPac has recommended this change in their report last year. Their suggested methodology, however, was not followed, and instead a methodology was used by CMS that has several technical flaws.

The new proposals will make an already complex system to be even more complex. The hospital industry as represented by the AHA, the HFMA, and other organizations, has offered their support in developing a better system. We support the suggestion to delay the changes to the inpatient PPS DRG weights and reimbursement system for one year during which time a more thorough analysis and construction of a better system can be made.

In addition, while we support a system that is more equitable, we are sensitive to making abrupt changes in reimbursement. Lower reimbursements can cause a significant hardship on those affected hospitals. These hardships often result in consequences that have a negative affect on patient care. As such we endorse the concept of phasing the new system in over a three year period.

Again, we appreciate the opportunity to submit these comments. We look forward to participating with the other hospital providers and CMS in improving our current reimbursement system.

Sincerely,

Stephen F. Brown, Vice President, Financial Planning and Analysis
MediCorp Health System, 2300 Fall Hill Avenue, Suite 311, Fredericksburg, VA. 22401

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

Submitter : **Dr. Ricardo Vela** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

CMS-1488-P-1587-Attach-1.DOC

#1587

Dear CMS policy maker

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being un related to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

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Sincerely,

Submitter : **Mr. Kenneth Zieren** **Date: 06/12/2006**

Organization : **St. Luke's Episcopal Hospital**

Category : **Hospital**

Issue Areas/Comments

HSRV Weights

HSRV Weights

St. Luke's Episcopal Hospital, Home of the Texas Heart Institute, is a 915 bed, acute care teaching hospital located in the Texas Medical Center, Houston, Texas. It is a major cardiovascular health care provider, to both in and out of state residents. The Medicare program provides over 35% of total Revenue to the Hospital.

I am very concerned with the 2007 proposed inpatient reimbursement changes related to the DRG weighting and classification system. The proposed rules outline major shifts in DRG weights as a result of moving from a charge based to a cost based DRG weighting methodology. The resulting changes have a significant impact on Medicare payments to St. Luke's Episcopal Hospital. The reallocation of DRG weights would result in a payment decrease in excess of $3.0 million in 2007. The majority of the decrease is a result of the decline in the DRG weights for Cardiovascular related DRGs.

We do not oppose a move to a more accurate DRG allocation methodology; however believe that further refinements are needed. The determination of cost for specific DRGs for specific hospitals is a complicated process involving ratio of cost to charge calculations and estimating techniques that are quite complex. The process used by CMS uses 10 Cost Centers for each DRG to calculate individual costs for each Cost Center. These Cost Center totals are summed in order to compare to the estimated national costs by DRG. As a result of this process, several significant changes in DRG weights do not appear to be reasonable. For example, the proposed payment for drug eluting stent DRGs would be reduced by an average of 34 percent resulting in a reimbursement impact of $1.4 million for this single update.

For these reasons, I recommend a delay of one year in implementing these changes to provide time for more research. In addition, because of the massive reallocation of payment between hospitals, a transition period is strongly recommended.

Thank you for the opportunity to submit comments on the Inpatient Prospective Payment System and implications on St. Luke's Episcopal Hospital.

Sincerely,

Kenneth A. Zieren
Director - Compliance and Reimbursement
St. Luke's Episcopal Health System

Submitter : **Mr. Peter L. Gosline** **Date: 06/12/2006**

Organization : **Monadnock Community Hospital**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1488-P-1589-Attach-1.DOC

#1589

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 Monadnock Community Hospital (MCH), we 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. MCH is a Critical Access Hospital located in Peterborough, New Hampshire. As a hospital serving rural areas, we are especially interested in forums on areas impacting Critical Access Hospitals such as ours.

While meaningful improvements to Medicare's inpatient PPS are supportable, we think 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. Moving forward requires thoughtful change.

Specifically, we support the following:

- **One-year Delay:** We support a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. We are aware that the AHA and the hospital field are committed to working with CMS over the next year to address these concerns.

- **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:** We do not support a new classification system at this time, 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 are aware that the AHA commits to working with CMS to develop and evaluate alternatives for new weights and classifications.

In addition to the above points, we have the following comments regarding **Critical Access Hospitals:**

On November 14, 2005, CMS issued interpretive guidelines on the relocation of CAHs as a follow-up to the FY 2006 inpatient PPS final rule that established the "75% test" – serving 75 percent of the same population, providing 75 percent of the same services and employing 75 percent of the same staff – for necessary provider CAHs. The guidelines not only extended the 75% test to *all* CAHs, but it also altered the definitions of "mountainous terrain" and "secondary road."
We believe that these guidelines go well beyond the regulations included in the FY 2006 rule that provoked numerous critical responses from individual CAHs, associations and congressional representatives. The "mountainous terrain" and "secondary road" definitions are overly prescriptive and the 75% test does not provide reasonable flexibility based on natural variation in demographics, patient needs distribution patterns, normal employee and board attrition, and necessary changes in services to meet community needs. **Rural hospitals that move a few miles are clearly the same providers serving the same communities.**

Many CAHs are planning to rebuild in the near future to improve site safety and quality of care by adding fire and smoke barriers, upgrading infrastructure to support utilities and air handling, modernizing telecommunications to support health information technology, or making other essential upgrades. Facilities expect to relocate when they rebuild for a multitude of reasons: to be closer to a highway, to connect to municipal water and sewer, because of seismic safety concerns, or other similar concerns. **Such improvements will undoubtedly result in higher quality care, better patient outcomes and more efficient service, yet CMS' guidelines discourage these improvements.**

CMS' guidelines will not only impose an unnecessary burden on CAHs, but will preclude many of them from securing financing for needed capital improvements. The hospitals themselves, their hospital districts and their lenders cannot risk investing in a hospital that will be unsure of its status until a year after moving. **CMS should create a preliminary approval process to**

give assurances to those involved in the project that the CAH relocation will be approved if it meets the assertions made in the attestation submitted to CMS.

Again this year, almost 60 congressional representatives signed a letter to CMS showing their support for their CAHs and urging changes to these guidelines. We agree with their recommendations and reiterate our suggestion from last year that a safe harbor be established for hospitals relocating within five miles of their existing locations. These providers are not only clearly serving the same communities, but trying to improve the quality of and access to needed health care services. A safe harbor will reduce the administrative burden on not only the hospitals, but CMS and the state survey agencies as well. **We urge CMS to create a safe harbor for CAHs moving a short distance and to make significant changes to these guidelines based on the feedback from CAHs around the nation as detailed in our letter under separate cover to Thomas Hamilton, director of the survey and certification group.**

MCH appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me or Sharon E. Johnson at (603) 924-4699 x1112.

Sincerely,

Peter L. Gosline
President & CEO

CC: Deborah A. Shipman, CFO
Benjamin Wheeler, Chair, Board of Trustees

Bcc: Rick Pollack, EVP, AHA (Remove before sending)

Submitter : **Dr. Karen Walker** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

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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.

CMS-1488-P-1590-Attach-1.DOC

#1390

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

Submitter : **Dr. Alfred Wettermark** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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CMS-1488-P-1591-Attach-1.DOC

#1591

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I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

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Sincerely,

Submitter : **Mr. Stephen Harwell** **Date: 06/12/2006**

Organization : **Healthcare Association of New York State**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-1488-P-1592-Attach-1.DOC

#1592

June 12, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488 P and P2
7500 Security Boulevard
Baltimore, Maryland 21244-8012

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

Dear Dr. McClellan:

The Healthcare Association of New York State (HANYS), on behalf of our more than 550 hospitals, nursing homes, home health agencies, and other health care providers, welcomes the opportunity to comment on the proposed rule related to the Medicare Prospective Payment System (PPS) for inpatient admissions. Below are our comments, arranged by topic area.

DRG WEIGHTS

Summary and HANYS' Recommendations

The Centers for Medicare and Medicaid Services (CMS) has proposed substantial changes to the calculation of Diagnosis Related Groups (DRGs) and weights that will result in a significant redistribution of Medicare inpatient hospital payments in both federal fiscal year (FFY) 2007 and FFY 2008. HANYS' concerns with the CMS proposal are summarized below.

CMS proposes to revise the calculation of DRG weights in FFY 2007. The CMS proposal relies on the Hospital-Specific Relative Value (HSRV) methodology as the basis for determining the weights. Analysis has found that weights calculated using an HSRV methodology tend to be more compressed than weights calculated using other methodologies. To avoid systematic payment errors, this effect must be taken into account when applying the HSRV methodology. There is no evidence that CMS considered this issue or evaluated the proposed weights to ensure that they do not materially over-compress DRG payments.

In addition, CMS proposes a modified version of the HSRV weights characterized as the HSRV cost center (HSRVcc) methodology. The intent was to develop an alternative HSRV calculation that avoids the calculation of costs using hospital-specific cost-to-charge ratios (CCRs) by substituting national cost center charge ratios to "scale" the weights. The Medicare Payment Advisory Commission (MedPAC) recommended a hospital-specific cost-based HSRV methodology. According to CMS, the HSRVcc methodology achieves similar results in "a more administratively feasible manner." However, CMS did

not provide evidence to validate this statement. The HSRVcc methodology is substantially different from a cost-based HSRV methodology. It represents a distinct and untested method for calculating weights that should be fully analyzed to verify that it results in equitable DRG payments.

CMS should not select the HSRVcc methodology simply because it is administratively feasible, without considering the potential tradeoff between ease of calculation and accuracy of results. Cost-based weights may be more complex to calculate; however, other payment systems such as the Outpatient PPS and the Inpatient Rehabilitation Facility PPS calculate weights using costs determined at the hospital level. CMS did not indicate that it had explored such alternatives or compared the HSRVcc weights to weights calculated using other alternatives, to assess payment equity.

Finally, analysis by industry groups indicates that the CMS calculation of the proposed HSRVcc weights contains errors and technical problems. As a result, the tables and impact statements provided by CMS in the proposed rule are based on flawed calculations that result in an inaccurate representation of the effects that the revised weights would have on hospital payments. These problems must be addressed and the proposed weights recalculated and released for public evaluation before any decision can be made regarding the proposal.

CMS has proposed implementation of consolidated severity-adjusted (CS) DRGs in FFY 2008. CS DRGs are a modified version of the all-patient refined (APR) DRGs created by 3M Health Information Systems. While there is evidence that the current Medicare DRGs could benefit from refinement, the APR DRGs and CS DRGs represent a substantial restructuring of the patient classification system that goes beyond refinement of the current DRGs. Analysis has shown that the APR DRGs and CS DRGs, which are based on differences in patient severity, do not necessarily provide an accurate reflection of differences in complexity of treatment or relative resource use.

HANYS' Recommendations:

- **Implementation of revised weights should be postponed until FFY 2008. This would allow time for a thorough evaluation of the HSRVcc methodology and other alternative methodologies. H ANYS s upports a m ove t o t he c ost-based weights. However, weights calculated using the HSRVcc methodology, or alternative methods should be compared to weights based on costs determined using hospital-specific CCRs (such as the methodologies used for the Outpatient PPS or for the New York State Medicaid weights) to ensure the variance between profit margins by DRG is minimized.**

- **CMS should further evaluate the CS DRGs and consider alternative DRG refinements. CMS should first evaluate the current Medicare DRGs to determine the need for complete replacement of the system as opposed to focused improvement for specific problem areas. A patient classification system that is being used for reimbursement purposes should include resource use as a primary factor in determining the groups. A number of existing patient classification systems are based on refinements to the existing Medicare DRGs. These may provide a better reflection of resource use and complexity of treatment than the CS DRGs. In addition, systems that refine the existing DRGs would be less disruptive to existing systems and processes.**

- **The implementation of weight revisions and the implementation of new DRGs will both cause significant payment redistributions, often with offsetting results for individual hospitals. Therefore, simultaneous implementation -- assuming consensus on DRG refinements -- will be less disruptive and will avoid the payment swings that would result from separate changes.**

- **Any major changes to the DRG weights or patient classifications will result in significant payment redistribution between hospitals and DRGs. When weights or DRGs are implemented, a three-year transition period should be provided with a phase-in based on a blend of the revised and the current methodology. This would allow time for refinement of the new methodology and limit the degree of payment disruptions.**

  In addition, a "stop-loss" similar to the approach currently used under the Inpatient Psychiatric PPS should be instituted as part of this transition.

- **CMS should ensure that any alternative DRG system that is selected should be publicly available and that rules governing access to software and logic for the new DRGs is no more restrictive than rules regarding access to the current DRG system.**

Further details and support for HANYS' recommendations on DRG weights follow.

HSRV Methodology

The CMS proposal relies on the HSRV methodology as the basis for determining the weights. It is important to note that the CMS proposal is a modification of the standard HSRV and is not the same as the cost-based HSRV methodology that MedPAC analyzed. (The CMS modification is discussed in the following section). In theory, an HSRV calculation based on costs can provide an alternative to the current weight calculation. Another alternative is to calculate weights using the current methodology utilizing costs instead of charges. We believe that valid cost-based weights would provide more equitable payment than the current charge-based weights. However, CMS has not provided evidence to indicate that the HSRV approach, whether based on costs as MedPAC recommended or based on the CMS modification, is preferable to cost-based weight methodologies such as those used in the outpatient PPS and by some states. The HSRV approach must be validated for the inpatient PPS by comparing it to cost-based methodologies.

In addition, research has found that weights calculated using an HSRV methodology may be more compressed then weights calculated using other methodologies. An analysis by the RAND corporation found that:

> *". . . the weights will be a major determinant of hospital payment, so the finding of hospital level compression is important and the HSRV method results in more compression than either of the other methods."*

Source: *Interim Report on an Inpatient Rehabilitation Facility Prospective Payment System,* Grace M. Carter, Daniel A. Relles, and Barbara O. Wynn, with Jennifer H. Kawata, Susan M. Paddock, Neeraj Sood, and Mark E. Totten, July, 2000

In an analysis of DRG pricing policy, Carter and Rogowski report that:

"Rogowski and Byrne (1990) showed that in 1984 cost weights were even more compressed than charge weights. Cost-based weights calculated with the HSRV methodology were the most compressed among the tested methods used to calculate weights. Further, charge-based weights calculated w ith t he H SRV m ethodology w ere m ore compressed t han w ere c harge weights computed with the standard methodology."

"HSRV weights are more compressed than standard-method weights, a finding consistent with earlier research on FY 1984 data (Rogowski and Byrne, 1990). We believe that this compression arises primarily because of within-hospital cross-subsidies. Because the HSRV method standardizes on charges within individual hospitals, it is not affected by the distribution of adjusted charges across hospitals, which offsets compression in the standard method. Thus, the weights produce a measure of relative-resource consumption across DRGs that is more compressed than standard weights."

Source: "How recalibration method, pricing, and coding affect DRG weights," *Health Care Financing Review*, December 22,1992; Grace M. Carter, Jeannette A. Rogowski

While the HSRV methodology may provide an alternative to t he current charge-based weights, **any HSRV-derived weights must be evaluated and compared to weights that substitute costs for charges in the current methodology to determine which calculation provides the most equitable payments**.

HSRVcc Methodology

The CMS proposal was prompted by a MedPAC recommendation that the Medicare weights be calculated using an HSRV methodology. According to MedPAC, while a hospital relative-value method based on charges removes the effects of hospital-wide differences in charge markups or costs, it does not remove the effects of differences in markups across hospital service departments or among services within departments. To address this problem, MedPAC evaluated changing the basis of the weights from standardized charges to costs. According to MedPAC, *"[u]sing costs instead of charges removes the effects of differences in markups across hospital departments, which are often substantial. When combined with the hospital relative-value method, this approach has the potential to remove from the weights many—though not all—of the distortions that result from differences in hospitals' charging practices."* (Source: *MedPAC Report to the Congress: Physician-Owned Specialty Hospitals*, March 2005)

CMS agreed that it is appropriate to adjust the DRG relative weights to account for the differences in charge markups. However, CMS believes that MedPAC's methodology, which developed costs using hospital-specific departmental CCRs, would be administratively burdensome. Therefore, CMS proposed an alternative to MedPAC's approach that is intended to *"achieve similar results in a more administratively feasible manner."* This proposal, the HSRVcc methodology, *" . . . involves developing hospital-specific charge relative weights at the cost center level to remove the bias introduced by hospital*

characteristics (that is, teaching, Disproportionate Share Hospital, location, and size, among others) and then scaling the weights to costs using the national cost center charge ratios developed from the cost report data," according to CMS. The cost centers that CMS uses are comprised of eight ancillary cost groups, a routine cost category, and an intensive care cost category.

The HSRV methodology has a history of analyses and evaluations. As noted above, its problems and complications are known. However, the HSRVcc methodology proposed by CMS is untested. While CMS states that the results are similar to those obtained using a cost-based HSRV, little evidence is given to support this contention. Replacing hospital-specific CCRs with national average scaling factors clearly makes the calculation less complex. However, ease of calculation should not be the driving factor in selecting a means for determining weights. **A thorough analysis of the HSRVcc methodology must be conducted to determine whether the resulting weights provide equitable payment.**

Develop Weights Based on Actual Patient Costs

The goal in refining the DRG system should be to create an equal opportunity for return across DRGs that will provide an equal incentive to treat all types of patients and conditions. To evaluate methodologies against this standard, a means of calculating costs must be determined. There is general agreement that the best estimate of costs is obtained by applying hospital-specific department level CCRs based on each hospital's cost report to charges reported on patient claims.

There are many examples of weights that are calculated using hospital-specific CCRs including various Medicare PPS systems. For example, weights for the Medicare Outpatient PPS are calculated annually using hospital-specific CCRs and the Inpatient Rehabilitation Facility PPS uses hospital-specific CCRs to determine costs as part of an HSRV methodology.

New York State uses this basic method to calculate cost-based weights for Medicaid reimbursement. The New York weights are based on a detailed costing methodology that uses departmental CCRs. The calculation includes a process to review the match between cost report data and claims data and to correct for mismatches. In addition, the New York weights are adjusted to reflect differential nursing intensity within each DRG. The nursing intensity adjustment is based on input from clinical specialists and improves the accuracy of payment by refining the routine costs assigned to each DRG. A modified version of the New York methodology should be considered for the calculation of Medicare weights. At the least, CMS should calculate the weights using this methodology during its analysis for use as a standard to evaluate the equity of other weight calculations.

The increased complexity of cost-based weights is not an insurmountable problem. When MedPAC proposed a cost-based HSRV calculation, it acknowledged that it was difficult to replicate on an annual basis and suggested that means could be found to determine weights without performing the cost calculations every year. As an example, MedPAC suggested CMS could calculate the ratio of the cost weight to the charge weight for each DRG using data for a given year. Then the same ratio would be used to adjust the charge weights until the next major revision of the cost estimate. Other alternatives should be considered including periodic weight calculations based on costs with annual adjustments based on changes in charges or data from a sample of hospitals.

CMS should not select the HSRVcc methodology simply because it is administratively feasible without considering the potential tradeoff between ease of calculation and accuracy of results. Cost-based

weights may be more complex to calculate; however, other payment systems calculate weights using costs determined at the hospital level and there are alternatives to decrease the administrative burden. **Before selecting a weight calculation methodology, CMS should evaluate alternatives to determine which methodologies provide the best relationship between payments and costs.** CMS did not indicate it had undertaken such validation analyses.

Errors and Technical Problems

An analysis commissioned by the American Hospital Association (AHA), the Federation of American Hospitals, and the Association of Academic Medical Colleges identified several technical issues in the current CMS calculation of the weights. These included failure to exclude organ acquisition costs from the data, use of mean CCRs rather than charge-weighted CCRs in the calculation of the scaling factors, and use of overly stringent criteria to determine "outliers" for excluding data from the calculations. The AHA reports that this results in the exclusion of 198 hospitals' routine CCRs, accounting for over 26% of total routine charges. It also creates a mismatch between the CCRs used and the charges they are applied to, as the hospitals that are trimmed out of the CCRs are still included in the charges that are then reduced to costs and determine the cost shares.

CMS has not yet reacted to this analysis and it is unclear which, if any, of these problems will be addressed. Beyond these specific issues, the AHA analysis demonstrated that the impact of the proposed changes is highly unstable, with small changes in method leading to large changes in hospital payment. This makes it impossible to accurately assess the CMS proposal at this time.

In addition, a number of our members have noted that the CMS cost center methodology does not always accurately match costs and charges. **Any methodology that relies on data from both the cost reports and Medicare claims will encounter problems when matching departmental costs and charges from the cost reports to the charges reported on individual claims. It is important that the results of the match be evaluated for accuracy and then revised to correct material mismatches.** This is particularly important for expensive devices and implants where a mismatch can cause a substantial error in the weight for the associated DRGs. For example, while many hospitals report implant costs as medical supplies in the cost report, others report the cost of implants in the routine cost centers rather than the ancillary cost center for "Supplies Charged to Patients". There is no evidence that CMS assessed the accuracy of its match between cost reports and claims. Without such an assessment and implementation of a process to fix material mismatches, the weight calculations will not be accurate.

CMS should correct errors that have been identified in the calculation of the HSRVcc weights and evaluate recommendations for technical improvements to the calculation. CMS should make the revised HSRVcc and the impact statements available and allow additional time for public evaluation. No changes should be implemented without a thorough review of the revised outcome. A validation of payment equity should be conducted before the final decision is made.

DRGs: Severity of Illness

Consolidated Severity-Adjusted DRGs

CMS is proposing FFY 2008 implementation of consolidated severity-adjusted DRGs (CS DRGs). The CS DRGs are based on the APR DRGs developed by 3M Health Information Systems. Both systems

classify patients based on severity of illness. This represents a substantial change from the current Medicare DRGs, where resource use is a major determinant for patient classification. The 3M APR DRG system subdivides the DRGs by adding four severity of illness subclasses to each DRG. The underlying clinical principle of APR DRGs is that the severity of illness of a patient is highly dependent on the patient's underlying problem and that patients with high severity of illness are usually characterized by multiple serious diseases or illnesses. Therefore, patients with multiple comorbid conditions involving multiple organ systems are assigned to the higher severity of illness subclasses.

The basic structure and intent of the APR DRGs differ from the current Medicare DRGs. The 3M APR DRG Manual explains that:

> *"The original objective of the DRGs was to develop a patient classification system that related the types of patient treated to the resources they consumed. Thus, the DRGs focused exclusively on resource intensity. The CMS DRGs (formerly the HCFA DRGs) and the AP-DRGs have remained focused on this limited objective. As the health care industry has evolved there has been increased demand for a patient classification system that can be used for applications beyond resource use, cost, and payment."*

Before proposing replacement of the current Medicare DRGs, CMS should evaluate the need for complete replacement of the system as opposed to focused improvement for specific problem areas. In FFY 2005, CMS implemented a major restructuring of cardiac DRGs to improve payment equity. Similar targeted changes and refinements might be sufficient to correct Medicare DRG problems without the disruptions that would be caused by implementation of an entirely new system.

If a replacement DRG system is required, CMS should evaluate other alternative DRG systems. A patient classification system that is being used for reimbursement purposes should include resource use as a primary factor in determining the groups. A number of existing patient classification systems are based on refinements to the existing Medicare DRGs. All are based on the same basic structure as the current Medicare DRGs and should provide a better reflection of resource use and complexity of treatment than the CS DRGs. Alternatives that CMS should evaluate include:

- **Refined DRGs (RDRGs) that differentiate complications and comorbidities (CCs) into four levels based on resource intensity;**
- **All Patient DRGs (AP-DRGs) that are used in New York and include definition of more resource intensive complications as "major CCs"; and**
- **All Payer Severity-adjusted DRGs (APS DRGs) that define levels of severity within DRGs based on resource intensity.**

In addition to concerns about the suitability of the APR DRGs as a reimbursement tool, the APR DRGs would represent a substantial departure from the current DRGs that would require both significant system changes and additional training for medical records coders. The 3M APR DRG Manual describes numerous changes that were made when constructing the patient classification scheme. The Manual concludes that *"[a]ltogether these changes result in a set of base APR DRGs that are very different from those of other DRG classifications systems."* **Alternatives that refine the existing DRGs will be less**

disruptive to existing systems and processes.

Finally, the fact that the CS DRGs are constructed as a modification of the 3M APR DRGs leads to concerns about the proprietary nature of the 3M product. The current DRG GROUPER logic has been in the public domain since the inception of the PPS. The 3M APR DRGs require restrictive licensing agreements that strictly limit access to the system and its logic.

CMS should ensure that any alternative DRG system that is selected should be publicly available and that rules governing access to software and logic for the new DRGs are no more restrictive than rules regarding access to the current DRG system.

When considering adoption of any new DRG system that provides for more exact classification of patients, CMS should also consider system modifications that would allow for use of additional diagnosis and procedure codes. Current CMS DRG systems allow for the use of only nine diagnosis codes and six procedure codes. The claims data submitted by hospitals often contain codes beyond this limit. **The new DRG systems should provide for patient classification using additional codes above current system limits.**

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, an increase compared to the FFY 2006 payment threshold of $23,600. HANYS is concerned that the proposed threshold is too high. Based on CMS' current estimates, actual FFY 2005 outlier payments were 4.1% of total payments and FFY 2006 outlier payments are estimated to be 4.7% of total payments. **HANYS urges that the methodology recommended by AHA in its comment letter be used to calculate the threshold. The estimated fixed-loss amount that would result in 5.1% outlier payments under this methodology is $24,000.**

OCCUPATIONAL MIX ADJUSTMENT

Due to a recent U.S. Court of Appeals decision in *Bellevue Hospital Center v. Leavitt*, CMS was ordered to implement a full occupational mix adjustment to the FFY 2007 wage index, based on a new data collection. To comply with the court decision, CMS set forth a strict timeline for facilities to adhere to with minimal time to review and correct for errors.

Non-compliant Providers

HANYS joins AHA in recommending that no penalty be applied to providers that were unable to meet the June 1 deadline for their January through March occupational mix submission. Completion of the occupational mix survey by June 1 was a tremendous administrative burden for providers. For FFY 2007, we suggest that providers who did not submit in time continue to receive the national average, as do ne in the past survey. However, in subsequent years, if CMS implements a methodology intended to penalize those providers that did not fulfill their requirement, **HANYS joins AHA in recommending that CMS construct an application of the occupational mix adjustment that encourages hospitals to report but does not unfairly penalize neighboring hospitals.** CMS could

alternatively substitute the national average hourly wage for non-compliant 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 minimize the effects on other hospitals in the same labor market area.

Corrections for FFY 2008 and FFY 2009

Facilities were required to submit their January through March occupational mix data to their fiscal intermediary (FI) by June 1. Subsequently, facilities are given approximately two weeks to review the data published by CMS for errors due to CMS or FI mishandlings. In its response to MedPAC, CMS planned to provide an annual process and timetable for reviewing the occupational mix data, similar to the review process for wage index. However, for FFY 2007 providers received an abbreviated review process and were unable to correct for their own errors due to strict timeframes to implement by October 1.

HANYS strongly recommends that CMS in subsequent years provide a review process for the occupational mix data that allows sufficient time for providers to review and correct their own errors, in addition to any CMS or FI mishandlings of the data. This will ensure that providers have ample time to submit accurate and reliable data. In addition, **HANYS encourages CMS to consider allowing providers an opportunity to review their January through March occupational mix data for any errors or missing data and correct the data for use in the FFY 2008 and FFY 2009 wage index calculation.**

Comment Period

HANYS joins AHA in recommending that CMS publish the FFY 2007 occupational mix final rule as an interim final rule with a comment period. Individual providers are compared against national averages, based on total salaries and total hours submitted by all providers. Therefore, it is important that providers have an opportunity to review the results and comment on whether using data submitted by all hospitals is more beneficial than using the prior Bureau of Labor and Statistics data as a national benchmark. Without knowing the outcome of the occupational mix survey results, providers are unable to determine what the financial impact will be. While CMS might not have time to make changes for FFY 2007, it could entertain comments on the implementation for FFYs 2008 and 2009.

UPDATE FACTORS

The hospital update is based on a "marketbasket" factor that is intended to reflect the average change in the price of goods and services hospitals purchase to furnish inpatient care. CMS contracts with Global Insight, Inc. for marketbasket projections and its projection for FFY 2007 is 3.4%. We believe this projection significantly under-estimates the inflation pressure that hospitals face in serving Medicare beneficiaries.

The track record of Global Insight's projections has not proven to be satisfactory. After several years of consistent under-projections, HANYS and allied associations challenged the reliability of its projection methodology last year. In response, CMS worked with Global Insight and revised its projection methodology, increasing the 2006 projection from 3.2% in the proposed rule to 3.7% for the final rule. Even with this increase, it still is far short of Global Insight's latest 2006-forecasted marketbasket increase of 4.2%.

We believe that Global Insight's projection methodology has a built-in bias of under-projecting during the period when the overall economy is transitioning from a high growth and low inflation era to a low growth and high inflation period. During a transition period, the normal projection methodologies that use the extrapolation of historical data tend to have larger projection variances. Adjustments need to be made to correct for these systematic projection biases during the time of major business cycle reversals. Traditionally, CMS does not correct for marketbasket projection errors in subsequent years' payment rates. This policy may be warranted during stable economic conditions. This policy, however, can introduce significant overpayments or shortfalls during the period of major changes in economic trends.

General inflation indicators such as the Consumer Price Index (CPI) and the Gross Domestic Product (GDP) Implicit Price Deflator have both demonstrated that the inflation rate had bottomed out in 2002. Both series indicated that inflation rates moved higher in 2003, 2004, and 2005. This failure to capture the impact of this trend reversal may be the key factor of CMS' consistent under-projection of the marketbasket index during these years. The following table provides the CMS projection errors for these years.

	FFY 2003	FFY 2004	FFY 2005
Actual Cost Increase	4.0%	3.9%	4.2%
Projected Cost Increase	3.5%	3.4%	3.3%
Projection Shortfall	-0.5%	-0.5%	-0.9%

Worries about continued high inflation have recently been expressed by many Federal Reserve Board Governors. **HANYS is concerned about the major hospital payment shortfalls during 2003 to 2006 and the potential of continued loss in 2007 and beyond. We request that CMS either include an adjustment in its projection methodology to correct for this systematic bias, or adjust for projection errors in its subsequent years' payment rates.**

FTE RESIDENT COUNT AND DOCUMENTATION

By law, resident time spent in non-hospital settings in non-patient care activities cannot be included in a hospital's Direct Medical Education (DME) or Indirect Medical Education (IME) full-time equivalent (FTE) resident count. In contrast, in the hospital setting, resident time spent in non-patient care activities can be included in a hospital's DME resident count. However, only patient care activities may be counted for the purposes of IME.

CMS is making this clarification, in response to comments based on a 1999 letter from CMS "implying that didactic time spent in non-hospital settings could be counted for direct GME and IME." According to the proposed rule, CMS states that the "statement was inaccurate."

In the case of the hospital setting, CMS is not required by law to limit IME counts to time spent in patient care. In the proposed rule, CMS states, *"We understand that, as part of an approved medical residency*

program, residents are often required to participate in didactic and "scholarly" activities such as educational conferences, journal clubs, and seminars."

HANYS urges CMS to recognize that participation in such didactic activities is an integral part of residents' patient care experience. Specifically, we request that CMS align the IME and DME resident count philosophy as it relates to the hospital setting and allow the non-patient care activities to be counted for the purposes of IME. In addition, HANYS believes it will be difficult for hospitals to document time spent on these activities.

SCH/MDH CHANGES IN QUALIFICATION STATUS

Under current regulations, once a facility has been designated as a Sole Community Hospital (SCH) or a Medicare Dependant Hospital (MDH), the classification remains in effect without need for re-approval unless there is a change in the hospital's circumstances. Currently, regulations do not contain an explicit requirement that a SCH or MDH report to CMS a change in circumstances that would affect its status. In the case of MDHs, the FI is required to evaluate on an ongoing basis whether a hospital continues to qualify for MDH status. CMS is proposing to require a SCH or MDH to report to its appropriate CMS Regional Office when the circumstances under which the hospital was approved for SCH or MDH status have changed.

HANYS joins AHA in recommending that this function remain a responsibility of the FIs, who are in a better position to monitor these circumstances. If CMS requires hospitals to report changes in circumstances, then the specific types of situations should be noted and should only include aspects of their operation that are within their control (e.g., number of beds).

VALUE-BASED PURCHASING

Health Information Technology (IT)

HANYS, in collaboration with AHA, developed the following comments on health IT.

The proposed rule states that it "supports the adoption of health IT as a normal cost of doing business to ensure patients receive high quality care." It also notes that the quality and efficiency benefits of health IT may provide a policy rationale for promoting the use of health IT through the Medicare program. Consequently, CMS asks for comments on:

- its statutory authority to encourage adoption and use of IT;
- the appropriate role of IT in any value-based purchasing program; and
- the desirability of including use of certified health IT in hospital conditions of participation.

HANYS and AHA strongly believe that health IT is a very important tool for improving the safety and quality of health care, and our members are committed to adopting IT as part of their quality improvement

strategies. We also view IT as a public good that requires a shared investment between the providers and purchasers of care.

Health IT is a very costly tool, requiring both upfront and ongoing spending. A 2005 AHA survey of hospitals and health systems found that the median amount hospitals invested on health IT in one year was more than $700,000, which is 15% of total capital expenses. Survey respondents identified the upfront and ongoing costs of IT as the greatest barriers to further adoption. The survey also found that hospitals with negative margins and those with lower revenues use less IT. [1]

The proposed rule highlights the anticipated benefits of health IT as laid out by the RAND Corporation. However, it overlooks another of the study's major findings—that the financial benefits of IT investments accrue more to the payers and purchasers of care than the hospitals and health systems that pay for them.[2]

Simply put, providers have not seen financial returns greater than the costs of implementing clinical IT systems, particularly in the short term. They adopt clinical IT because it is the right thing to do for improving patient safety and quality of care, not because it saves them money. Thus, while IT may be a "normal cost of doing business," it systematically raises those costs. **Given that they reap many of the financial benefits of IT, HANYS and AHA believe that the payers and purchasers of care should share in the costs of IT.**

Finally, we learned through the Health Insurance Portability and Accountability Act (HIPAA) process that efficient health information exchange requires all parties to upgrade their systems and work from a common set of standards. As we move toward implementation of health IT in hospitals, payers—including the federal government—must modify their own systems to accept electronic data.

Statutory Authority. The broad question of whether CMS has statutory authority to encourage adoption and use of health IT will depend on the specific mechanisms it selects. However, more systematic approaches, such as value-based purchasing or payment adjustments, would require legislative action.

Value-based Purchasing. **With regard to IT, only programs that add funds to the Inpatient PPS should be pursued because IT is costly, requiring both upfront and ongoing expenditures.** Decreasing payments to those that have not been able to afford IT further limits their ability to invest. A budget-neutral approach also ignores the reality that health IT systematically increases hospitals' costs.

HANYS and AHA believe that value-based purchasing programs should build off the consensus measures endorsed by the broad spectrum of organizations—including CMS—that participate in the Hospital Quality Alliance (HQA). In general, HQA favors measures that address quality outcomes, rather than focusing on the tools used to obtain these outcomes.

Health IT can play a role in reducing the burden of quality reporting. Currently, electronic health records (EHRs) and other clinical IT systems do not automatically generate quality measures. Most hospitals still

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[1] "Forward Momentum: Hospital Use of Information Technology." Washington, DC: AHA (2005).
[2] R. Hillestad, J. Bigelow, A. Bower, F. Girosi, R. Meili, R. Scoville, and R. Taylor. "Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, and Costs," *Health Affairs*, September 1, 2005; 24(5): 1103 – 1117.

require special calculations—including expensive manual chart abstraction and use of third-party contractors—to submit quality data. CMS could advance the quality agenda by investing in the development of algorithms for the calculation of the quality measures it wants reported from EHRs and encouraging vendors to include them in their products.

Rather than including health IT in a value-based purchasing program, **CMS could support adoption of health IT through a payment adjustment funded with new money.** For example, it could increase payments by 1% to hospitals that use health IT that improves the safety and quality of care. This kind of payment adjustment represents Medicare's share of the necessary investment to achieve this goal and would recognize the greater costs of attaining a "wired" health care system. HANYS and AHA will pursue legislation authorizing such a payment adjustment. Other mechanisms, such as loan guarantees and grant funds, are needed to help hospitals finance the upfront costs of implementing health IT.

Conditions of Participation. HANYS and AHA firmly believe that **CMS should not include health IT in the Medicare conditions of participation (COP) for hospitals.** The COPs address the basic, essential infrastructure needed to ensure patient safety and must be clearly understood. Successful implementation of quality-enhancing IT requires careful planning and changes to work processes. The hospital field is still developing its understanding of how to implement these systems correctly. In addition, the commercial health IT applications available do not always meet hospitals' needs. The evidence on health IT does not yet support this level of requirement and would amount to an unfunded mandate. A recent report supported by the Agency for Healthcare Research and Quality found that the existing research on the quality benefits of health IT are limited to a handful of leadership institutions that generally developed their own systems. And, while promising, the results are not yet generalizable to the average community hospital using the vendor systems currently on the market.[3]

While HANYS and AHA appreciate the efforts of the Certification Commission on Health Information Technology (CCHIT) to provide the market with better confidence in vendor products, we do not believe those efforts are sufficiently advanced to warrant inclusion in any adoption incentives CMS might pursue. CCHIT is only at the beginning stages of looking into certification of hospital inpatient products. CCHIT's work on ambulatory products is more advanced but, while it shows promise, has not yet proven itself in the marketplace.

TRANSPARENCY OF HEALTH CARE INFORMATION

HANYS supports efforts to provide the public with meaningful information about the price of their hospital care. Hospitals are committed to sharing information that will help people make important decisions about their health care. Sharing pricing information, however, is more challenging because hospital care is unique. Hospital prices can vary based on patient needs and the services they use; prices reflect the added costs of serving the essential health care needs of a community 24 hours a day, seven days a week; and most hospitals cannot yet provide prices that reflect important information from other key players like the price of physician care while in the hospital or how much of the bill a patient's insurance company may cover. But more can, and should, be done to share hospital pricing information

[3] "Costs and Benefits of Health Information Technology." Agency for Healthcare Research and Quality Publication, No. 06-E006 (April 2006).

with consumers. HANYS would like to express support for the AHA recommendations on transparency of health care information.

HOSPITAL QUALITY DATA

HANYS will be providing a separate letter with additional comments on:

- quality reporting requirements necessary to receive the full marketbasket update;
- hospital-acquired infections; and
- hospital value-based purchasing.

HANYS appreciates having the opportunity to comment on the proposed rule. If you have any questions regarding our comments, please contact me at (518) 431-7777 or sharwell@hanys.org.

Sincerely,

Stephen Harwell
Director, Economic Analyses
Economics, Finance, and Information

SH:lw

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

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

CMS-1488-P-1593-Attach-1.DOC

#1593

Dear CMS policy maker

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being un related to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. That hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty . Rescind the interpretation of the IME and DME support rule

Sincerely,

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

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#1594

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. Gail Colby** **Date: 06/12/2006**

Organization : **MidMichigan Medical Center, Midland, MI**

Category : **Physician**

Issue Areas/Comments

GME Payments

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.

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,

Gail Colby, MD

Michigan Academy of Family Physicians
2164 Commons Parkway, Okemos, MI. 48864
Ph: 517-347-0098 or 1-800-833-5151
Fax: 517-347-1289
General Email: info@mafp.com

Submitter : **Mr. Eugene Colucci** **Date: 06/12/2006**

Organization : **Greenwich Hospital**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1596-Attach-1.PDF

#1596

June 12, 2006

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

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

Dear Dr. McClellan:

Greenwich Hospital appreciates the opportunity to provide these comments regarding the Centers for Medicare and Medicaid Services (CMS) proposed rule: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates [CMS-1488-P]. The CMS proposed rule sets forth numerous and sweeping operational and policy changes to the hospital inpatient prospective payment system (IPPS). These comments outline strategies to more effectively meet the proposed rule's stated objective of creating incentives for hospitals to operate efficiently and minimize costs while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs.

Greenwich Hospital supports the following recommendations:

- **Wage Index Budget Neutrality**: CMS eliminated Critical Access Hospital (CAH) data from the wage index file it uses to compute the national average hourly wage (NAHW). Because CAHs have lower average hourly wages than the average PPS hospital, the elimination of this data results in an overstated NAHW, which consequently reduces payment because of the budget neutrality adjustment. CMS should apply a positive budget neutrality adjustment in FY 2007 to compensate for the prior underpayments and should remove CAH data from all parts of the calculation.

5 Perryridge Road
Greenwich, CT 06830-4697
(203) 863-3000

- **DRG Changes**: Greenwich Hospital supports moving to a DRG-weighting methodology based on hospital costs rather than charges. Greenwich Hospital opposes the introduction of a new classification system at this time, as the need for a new system is still unclear.

- **Quality**: When expanding quality data reporting requirements for hospitals to receive a full market basket update to include all 21 measures that are currently part of the Hospital Quality Alliance's (HQA's) public reporting, CMS should make the data collection prospective by requiring that hospitals pledge to submit data for patients discharged on or after July 1, 2006 rather than January 1, 2006. Greenwich Hospital also urges CMS to continue to use HQA as the principal source of measures for hospital performance reporting and continue to align its efforts with those of HQA. Finally, it is critically important that CMS enhance its data submission, validation, and error correction processes, in order to ensure that hospitals are not inappropriately penalized for technical data issues.

- **Cost Outlier Threshold**: Greenwich Hospital urges CMS to adopt the AHA-recommended outlier threshold methodology, lowering the outlier threshold.

- **Value-Based Purchasing:** The primary goal of value-based purchasing, also known as pay-for-performance systems, should be to facilitate the development of a healthcare system that is safe, effective, patient-centered, timely, efficient, and equitable, and the systems should be designed to support that goal. Pay-for-performance systems should: be practical for hospitals to implement; ameliorate, not exacerbate, the financial challenges already facing hospitals by providing and aligning physician and hospital incentives, not imposing penalties; be based on measures that accurately assess a hospital's performance in delivering quality care; and compensate a hospital based on its own performance, irrespective of the performance of other hospitals.

We appreciate your consideration of these comments.

Sincerely,

Eugene Colucci / KF

Eugene Colucci
Sr. Vice-President, Finance/CFO

By Mail & Email

Submitter : **Ms. Cheryl DeMars**

Date: 06/12/2006

Organization : **Employer Health Care Alliance Cooperative**

Category : **Other Association**

Issue Areas/Comments

Transparency of Health Care Information

Transparency of Health Care Information

Thank you for the opportunity to comment on the proposed changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 Rates. The Employer Health Care Alliance Cooperative (The Alliance) fully supports the comments and recommendations made by the Consumer Purchaser Disclosure Group that you received. We would like to provide several comments focused on the integrity of claims / administrative data for use in quality and cost measurement.

Transparency of Health Care Information Section (beginning page 447)

We are responding to the operative question at the end of the section, which states:

We are seeking comment on any ways in which the Department can encourage transparency in health care quality and pricing whether through its leadership on voluntary initiatives or through regulatory requirements. We also are seeking comment on the Department s statutory authority to impose such requirements. (p. 451)

The chief concern of the provider community is that administrative data is incomplete and inaccurate to a degree you can not use it for quality and cost measurement. This issue can be addressed by making claims data more robust and improving the quality of this data. The following are three specific ways in which this can be accomplished via CMS:

1. Data reliability. The data presently recorded on the claims could be more reliably coded, which would increase the accuracy of the price and severity adjustment. CMS could provide stronger guidance in the recording of data onto the claim. For example, some diagnosis codes could be much more clearly defined to ensure diagnosis codes are consistently applied on the claim form. This is a recommendation made by the GAO approximately five years ago in a report to CMS that looked at inpatient claims data.

2. Assurance of full coding. CMS currently funds several types of claims data audits that look at different aspects of the claim. We suggest that CMS revisits its current objectives of its auditing function and augments these audits to verify the complete and accurate coding from the medical record to the claim form. CMS could institute various penalties for incomplete or inaccurate coding as a mechanism to improve the quality of the data.

3. Identification of risk / severity of the person. Purchasing needs to become more sensitive to severity and risk of the patient. Furthermore, the public reporting of quality and cost would benefit from claims data which is richer in detail in regard to the severity of the patient so as to better measure and report the quality and cost of care respecting. Thus, CMS could require the reporting of key additional data elements on the inpatient claim form, such as:

a. Present on Admission for each diagnosis code to ascertain: a) severity and risk at admission, and b) identify hospital acquired complications, such as infection.

b. A unique physician identifier for each coded procedure.

c. Referring / ordering physician for each coded procedure.

d. Vital signs (heart rate, blood pressure, temperature, and respiratory rate) recorded at presentation.

e. Key lab values (BUN, hematocrit, platelets, WBC, sodium, potassium, and creatinine) if obtained at the time of admission, excluding hospitalizations for psychiatric, obstetrical and newborn services.

f. Do Not Resuscitate order present (including date and time), if recorded during first 24 hours of patient presenting.

g. Time of day of admission, discharge, and each procedure.

h. The adoption of ICD10 codes.

Respectfully,

Cheryl DeMars
Chief Executive Officer

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

Organization :

Category : **Hospital**

Issue Areas/Comments

HSRV Weights

HSRV Weights

June 12, 2006

Dr. Mark McClellan
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244 8018.

Re: Comments on CMS-1206-P (Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 rates. 71 Fed Reg 23996

Dear Administrator McClellan:

St. Luke's Episcopal Hospital, Home of the Texas Heart Institute, is a 915 bed, acute care teaching hospital located in the Texas Medical Center, Houston, Texas. It is a major cardiovascular health care provider, to both in and out of state residents. The Medicare program provides over 35% of total Revenue to the Hospital.

I am very concerned with the 2007 proposed inpatient reimbursement changes related to the DRG weighting and classification system. The proposed rules outline major shifts in DRG weights as a result of moving from a charge based to a cost based DRG weighting methodology. The resulting changes have a significant impact on Medicare payments to St. Luke's Episcopal Hospital. The reallocation of DRG weights would result in a payment decrease in excess of $3.0 million in 2007. The majority of the decrease is a result of the decline in the DRG weights for Cardiovascular related DRGs.

We do not oppose a move to a more accurate DRG allocation methodology; however believe that further refinements are needed. The determination of cost for specific DRGs for specific hospitals is a complicated process involving ratio of cost to charge calculations and estimating techniques that are quite complex. The process used by CMS uses 10 Cost Centers for each DRG to calculate individual costs for each Cost Center. These Cost Center totals are summed in order to compare to the estimated national costs by DRG. As a result of this process, several significant changes in DRG weights do not appear to be reasonable. For example, the proposed payment for drug eluting stent DRGs would be reduced by an average of 34 percent resulting in a reimbursement impact of $1.4 million for this single update.

For these reasons, I recommend a delay of one year in implementing these changes to provide time for more research. In addition, because of the massive reallocation of payment between hospitals, a transition period is strongly recommended.

Thank you for the opportunity to submit comments on the Inpatient Prospective Payment System and implications on St. Luke's Episcopal Hospital.

Sincerely,

David C. Pate, J.D., M.D.
Chief Executive Officer
St. Luke's Episcopal Hospital
Houston, Texas

Submitter : **Mrs. Mary Therriault** **Date: 06/12/2006**

Organization : **Healthcare Association of New York State**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-1488-P-1599-Attach-1.DOC

#1599

June 12, 2006

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

Dear Dr. McClellan:

This letter responds to the April 25, 2005 *Federal Register* call for comments regarding the Reporting of Hospital Quality Data for Annual Hospital Payment Update (§412.64(d)(2)). The Healthcare Association of New York State (HANYS) and the hospitals in New York State strongly support the Hospital Quality Alliance (HQA) and the Centers for Medicare and Medicaid Services (CMS) Hospital Quality Initiative. Section 5001(a) of Pub. L. 109-171 Deficient Reduction Act (DRA) of 2005 sets out new requirements for the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program.

The rule also proposes that the data collection for the expanded set of quality measures begin with discharges occurring in the first calendar quarter of 2006: January 1, 2006 discharges. These data must be submitted to the CMS data warehouse no later than August 15, 2006 for hospitals paid under the CMS Prospective Payment System (PPS) to receive their full marketbasket update. Failure to submit the data on these additional measures in the timeframe proposed will result in those hospitals receiving the marketbasket update minus 2.0 percentage points.

HANYS and our members concur that valid data are paramount in this initiative.
We strongly recommend that:

- All data collection requirements must be based on prospectively collected quality measures and drawn from those contained in the HQA data pool.
- Hospitals should not be required to re-open records from which data have been previously abstracted and reported to CMS. New data collection requirements should be based on cases discharged on, or after, July 2006.
- CMS should provide adequate information so that the details of the validation process are transparent and available to all hospitals.

- CMS should modify the validation process to enable hospitals to appeal any mismatches identified by the Clinical Data Abstraction Center (CDAC), even if the hospital achieves a score of 80% or higher. Hospitals can then use the appeal process as a learning experience to improve data abstraction.

Hospital Quality Data for Annual Hospital Payment Update (§412.64(d)(2))

HANYS, in conjunction with our hospital members, has identified several significant areas of concern related to the Hospital Quality Data requirements:

Data Collection and Reporting

To comply with the proposed timing, hospitals would be required to retrospectively collect the ten new measures. This requirement for new data collection from previously abstracted charts will impose significant resource and staffing burdens on hospitals, particularly since hospitals will have submitted their data to the measurement vendors prior to the proposed reporting period.

Currently only 28% of New York State hospitals have submitted Surgical Infection Prevention (SIP) measures to the CMS warehouse. Only 21 hospitals have submitted SIP to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Therefore, we must respectfully disagree with the statement in the Federal Register that these additional measures do not add a significant burden on hospitals.

New York State hospitals have estimated that for the SIP cases the abstraction time is 20 minutes to 60 minutes. Hospitals simply do no have the staffing to perform their duties without investing in significant overtime and use of temporary staffing personal. The added data abstraction would have to be completed during off shifts, weekends, and require overtime payments to be completed by the August 15 deadline. In addition, hospitals would have to provide education and training of staff before of the new data collection begins.

Hospitals rely on their performance vendors to conduct preliminary review of their data for data completion and accuracy prior to the submission to CMS. Hospitals will be unable to obtain and respond to information contained in a preliminary analysis and will be required to renegotiate contracts with performance vendors for submission of the additional measures. Hospital data reporting will be further compromised by the lack or feedback from the Quality Net exchange, regarding edits of critical and missing data elements from patient level data. This is also valuable as a tool for ongoing education to promote reliable and accurate data abstraction

Last, in regard to this section, the August 1, 2006 deadline for completing the "Reporting Hospital Quality Data for Annual Payment Update Notice of Participation" time frames may well precede release of the final rule by CMS. Hospitals cannot be expected to make decisions about participation in selected measure sets, prior to receiving adequate information about the requirements of those measure sets.

Chart Validation and Transparency

New York State hospitals continue to be frustrated by the lack of clarity surrounding the process. Despite our communication with the state's Quality Improvement Organization (QIO) and with CMS, we have been unable to obtain a document describing element-by-element calculations for the Annual Payment Update process that can be understood at the hospital level. Given the increased financial implications for hospitals, the inability to clearly explain this calculation is significant.

HANYS believes that the validation process should clearly validate only the required measures for the Deficit Reduction Act (DRA) of 2005 requirement. If CMS chooses to continue to validate additional patient level elements that are submitted by the Performance Measurement Vendors on behalf of the hospitals, then the CMS Validation Report should clearly identify the elements that make up the DRA required measures.

Currently, hospitals may only appeal decisions if the validation score is less than 80%. New York State hospitals believe that any mismatch between their organizations and the CDAC validation represents an important quality improvement learning opportunity for the organization. It also provides an opportunity to identify discrepancies with the CDAC re-abstraction process. It is important for hospitals to understand the logic behind each element, if hospitals are to use the information to improve and provide the best care possible. It is also valuable for CMS to understand where better guidance can be provided to CDAC.

The CMS validation process is based on a small sample size that may yield large swings in the data calculation. HANYS recommends that a full calendar year of data rather than three quarters be used.

Value-Based Purchasing in FY 2009

HANYS supports the AHA in its hospital based value purchasing, as many of HANYS' members are smaller hospitals and will face challenges, regardless of the measures chosen for use in a pay-for-performance system. The limited number of patients in small hospitals means that their performance rates can be volatile and may lead to inappropriate conclusions about the quality of care provided. The implications of this volatility must be carefully considered so that hospitals with small sample sizes can participate and receive appropriate recognition for the excellence they achieve.

Payment rewards should be based on evidence-based measures of adherence to quality improving "processes." By using evidence-based *process* measures (e.g., aspirin provided at arrival to patients with acute myocardial infarction; antibiotics provided one hour prior to surgery), *every* provider has the opportunity to succeed, thereby improving the overall quality of the system. Incentive approaches should incorporate rewards for both attainment of a certain threshold of performance and improvement in performance.

HANYS is concerned about premature efforts to tie payments to issues that could change incentives, such as efficiency. We believe that, for now, pay-for-performance initiatives should focus solely on quality improvement. There is no common definition of efficiency of care for hospitals.

In addition, measuring and rewarding performance based on a particular definition of efficiency may have considerable consequences for patients. For example, just a few years ago, health maintenance organizations (HMOs) developed criteria for efficient care that their physicians and other providers were told to follow. However, the resulting headlines referencing denials of tests and treatments, and the accompanying public outcry, led to a fall out in traditional, staff-model HMOs. More work needs to be done to define what should be encouraged in terms of efficient care before it is incorporated into payment policy.

Incentive approaches to payment should use a system of rewards to increase payments or reduce regulatory burden for successful providers. Because the Medicare inpatient PPS already pays less than the cost of care for more than one-third of hospitals, incentives involving penalties should not be used. Additionally, rewards should be sizeable enough to cover the costs of implementing process changes and allow for reinvestment in quality improvement efforts.

To be effective, incentive approaches must align hospital and physician incentives. Incentive approaches rewarding improvement can be successful only if physician and hospital performance can be successfully aligned, in terms of both performance and finances.

The DRA required CMS to develop a plan to implement hospital value-based purchasing (pay for performance) beginning in federal fiscal year 2009. The plan must consider the following issues:

- Measure development—the ongoing development, selection and modification process for measures of quality and efficiency in hospital inpatient settings;
- Data infrastructure and refinement— reporting, collecting, and validating of quality data;
- Public reporting—disclosure of information on hospital performance; and

- Incentives— the structure of payment adjustments, including the determination of thresholds for quality improvements that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the payments.

HANYS members remain committed to providing safe, effective, patient-centered, timely, efficient and equitable care to all patients. We support the work being done by HQA and are committed to working with the lead organizations as new measures are developed.

HQA is not only accomplishing its goal of making standardized, easy-to-understand information available to the public, but also is reducing the measurement inconsistencies that had been generated by a large variety of separate organizations asking hospitals to produce quality information. These disparate data requests impede rather than support quality improvement.

New York State hospitals have invested significant resources in the HQA measures and the *Hospital Compare* Web site. **This is a solid foundation on which we must continue to build, and it should be the foundation for any pay-for-performance program included in legislation. To base the pay-for-performance initiative on the work of a group other than the HQA would be duplicative, wasting significant knowledge and expertise.**

Infection Control

Health care providers know that patient care is complex and individual patient responses to treatment vary. Not all infections are preventable. Some patients will develop infections as a result of underlying conditions or characteristics even when hospitals follow the evidence-based practice. If CMS is considering a pay-for-performance initiative pertaining to prevention of infections, then we suggest that the process include a review of the care provided. Hospitals should not be penalized if the patient's care was in accordance with the evidence-based standards.

HANYS appreciates the opportunity to comment on the proposed rules regarding hospital quality data. Please contact me at (518) 431-7757 or at mtherria@hanys.org with any questions or comments.

Sincerely,

Mary Therriault, Director
Quality and Research Initiatives

MT:ays

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

Organization : **Deaconess Hospital**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1488-P-1600-Attach-1.PDF

#1600

Deaconess Hospital

June 12, 2006

[illegible] • Oklahoma City, Okla. • 73112-2000
405.[illegible] • deaconessokc.org

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 Deaconess Hospital, we 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.

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc). It also proposes refining the DRGs to account for patient severity, with implementation likely in FY 2008. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education, among other policies.

While Deaconess Hospital supports many of the proposed rule's provisions, we have serious concerns about the proposed changes to the DRG weights and classifications.

The hospital field supports meaningful improvements to Medicare's inpatient PPS. We believe the hospital industry and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. 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. Moving forward requires thoughtful change.

June 12, 2006

Specifically, Deaconess Hospital supports the following:

- **One-year Delay:** Our hospital supports a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. The American Hospital Association, the Oklahoma Hospital Association and the hospital field are committed to working with CMS over the next year to address these concerns.

- **Valid Cost-based Weights:** We support moving to a DRG-weighting methodology based on hospital costs rather than charges, but we believe CMS' proposed HSRVcc method is flawed. The method and source data requires further study in order to develop a rational and improved system.

- **A New Classification System Only if the Need Can Be Demonstrated:** We do not support a new classification system at this time, 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.

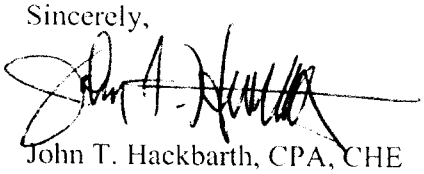
- **Three-year Transition:** Any changes should be implemented with a three-year transition, given the magnitude of payment redistribution across DRGs and hospitals. We believe that a transition period is necessary because of the significant redistributional effect of such changes.

- **Collaborative Approach to Moving Forward**: The American Hospital Association, the Oklahoma Hospital Associations, the hospital industry and Deaconess Hospital commits to working with CMS to develop and evaluate alternatives for new weights and classifications.

We would refer you to the detailed comments provided to you by the AHA that further explain our concerns and recommendations on the proposed DRG weight and classification system changes, as well as our position on many other issues in the proposed rule.

Deaconess Hospital appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me at (405) 604-4291.

Sincerely,



John T. Hackbarth, CPA, CHE
Vice President Finance/CFO

Submitter : **Dr. Jeremy Fish** **Date: 06/12/2006**

Organization : **Dr. Jeremy Fish**

Category : **Individual**

Issue Areas/Comments

GME Payments

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.

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,

Jeremy M. Fish, MD
Moraga, California

Submitter : Ms. Crystal Estabrook

Date: 06/12/2006

Organization : Iowa Health - Des Moines

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#1602

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 :

Date: 06/12/2006

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1603-Attach-1.DOC

#1603

801 Ostrum Street
Bethlehem, PA 18015

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 St. Luke's Hospital & Health Network we welcome this opportunity to comment on the proposed rule **"Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates,"** as published in the April 25, 2006, *Federal Register.*

The Centers for Medicare & Medicaid Services (CMS) has proposed the most significant changes to the Medicare inpatient prospective payment system since its inception in 1983. The proposed changes redistribute approximately $1.4 billion within the inpatient payment system.

While the proposed rule has many components, there are four key areas within the rule that will significantly impact Pennsylvania hospitals and health systems:

- ✔ Recalibration of Diagnosis Related Group (DRG) Weights
- ✔ Refinement of DRGs Based on Severity of Illness
- ✔ Wage Index and Occupation Mix Adjustment
- ✔ Hospital Quality of Care

To put our comments in context, more than 50% of Pennsylvania hospitals total reimbursement is derived from the Medicare and Medicaid programs. HAP informs us that this analysis shows that Pennsylvania hospitals are currently receiving approximately $0.96 in Medicare as compared to every dollar of cost to provide care. That coupled with Pennsylvania hospitals currently receiving $0.82 compared to every dollar of cost incurred for Medicaid patients poses significant challenges to providing quality care and services.

We join HAP in commending the Centers for Medicare & Medicaid Services for working toward the refinement of the inpatient prospective payment system to ensure equal opportunity for return across the DRGs, as well as to afford equal incentive to treat all types of patients and conditions.

However, we strongly urge CMS to consider a one-year delay in implementing refinements to the Medicare inpatient prospective system. **We support HAP's recommendation of a one-year delay in implementing proposed changes to the DRG weights.** While we agree with a move to cost-based weights, we believe there are flaws in the proposed methodology, modeling, and technical data used for refining the DRG payment system. A one-year delay would allow time to enable a more thorough analysis and to address flaws before implementation.

HAP also believes that more work must be done to assess the need and most appropriate approach for changing the patient classification system and we support this.

In addition to a one-year delay, we encourage CMS to consider a simultaneous implementation of the DRG weight changes and new classification system (after thoughtful consideration and determination that a new classification system is necessary) over a three-year transition period.

Finally, while we support the expansion of reporting of quality data **we recommend that CMS begin with third quarter 2006 discharges. We also suggest that CMS not include measures in the validation mix for annual payment until after one full year of reporting.** This delay will allow hospitals to learn from the review of records and feedback about data abstraction during the first year.

Finally, given the regulatory process, we do not believe that there has been adequate time for Pennsylvania hospitals to thoroughly analyze the proposed changes and assess impact to their individual facilities. Analysis that has been done has shown that even the slightest of changes in the proposed method results in potentially large changes to a hospital payment.

In essence—there is too much change, being proposed too fast. Such changes in the payment system deserve more thoughtful consideration and due diligence to ensure the end result will be the adoption of meaningful improvements to Medicare's inpatient prospective payment system.

Our hope is that given the significant impact these proposed changes will have on the hospital field as a whole, that CMS will impose a one-year delay to afford CMS and the hospital field time to work collaboratively to address concerns.

Again, we appreciate the opportunity to submit these comments and recommendations.

Sincerely,

Robert L. Wax, Esq.
Associate General Counsel

Submitter : **Mrs. Karen Heller** **Date: 06/12/2006**

Organization : **Greater New York Hospital Association**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See attachment for our comments on these topics:
DRG Reclassification
HSRV Weights
DRGs: Severity of Illness
Occupational Mix Adjustment
Hospital Quality Data
Value-Based Purchasing

CMS-1488-P-1604-Attach-1.PDF

#1604

Greater New York Hospital Association
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

June
Twelve
2006

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

Subject: Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule, *Federal Register* 71, no. 79 (April 25, 2006): 23996–24472. [CMS-1488-P]

Medicare Program; Hospital Inpatient Prospective Payment Systems; Implementation of the Fiscal Year 2007 Occupational Mix Adjustment to the Wage Index; Proposed Rule, *Federal Register* 71, no. 95 (May 17, 2006): 28644–28658. [CMS-1488-P2]

Dear Dr. McClellan:

On behalf of the more than 150 hospitals that make up the membership of the Greater New York Hospital Association (GNYHA), I appreciate this opportunity to comment upon the Centers for Medicare & Medicaid Services' (CMS's) proposed rule for the Federal fiscal year (FY) 2007 inpatient prospective payment system (PPS).

This year's proposed rule is the most significant in the history of the IPPS because it recommends a sweeping revision of the way in which CMS computes diagnosis related–group (DRG) weights and classifies cases into DRGs. The Health Economics and Outcomes Research Institute (THEORI) of GNYHA conducted an in-depth analysis of these proposals, which is presented in the attached paper. The following are our recommendations:

1. CMS should make no changes to the IPPS in FY 2007, as there is no longer sufficient time to implement a constructive policy.
2. CMS should withdraw the Hospital-Specific Relative Value Cost Center proposal because it would greatly decrease payment accuracy and it has no theoretical basis.

3. CMS should begin to phase in cost-based DRG weights in FY 2008.
4. In order to implement the optimal system of cost-based weights, during FY 2007, CMS should initiate a national project to correct misalignments between costs and charges in the cost reports and between charges in the cost reports and charges in the MedPAR file. Such a project would be administered by the fiscal intermediaries.
5. CMS should continue to derive the DRG weights based on the standard methodology; it should not change to the Hospital-Specific Relative Value methodology.
6. CMS should withdraw the Consolidated Severity-Adjusted DRG proposal, since it does not improve payment accuracy and it conflicts with many other health policy goals and activities.
7. CMS should continue to develop an improved patient classification system that would serve the needs of all potential users.

COMMENTS ON OTHER ISSUES

Below are our comments on the occupational mix adjustment and several quality issues. We are providing comments regarding graduate medical education (GME) payment policy in a separate letter.

Occupational Mix Adjustment

The occupational mix adjustment (OMA) to the area wage index is based upon data submitted by hospitals to CMS through a survey process. While the data submission is required, there are no penalties for failure to comply. Therefore, CMS must set a policy for adjusting the wage data of hospitals that do not respond to the survey. CMS proposed four options for consideration:

- Assign the hospital an OMA factor of 1.0, which is the policy CMS applied in fiscal years 2005 and 2006.
- Assign the hospital the average OMA factor for its labor market area.
- Assign the hospital the lowest OMA factor for its labor market area.
- Assign the hospital the average OMA factor for similar hospitals, based on factors such as geographic locale, bed size, teaching versus non-teaching status, and case mix.

We would like to recommend a different option, which is to assign the lower of (a) the hospital's OMA in FY 2006 or (b) the average OMA for the hospital's labor market area in FY 2007.

In general, the best proxy for a hospital's missing FY 2007 OMA is its FY 2006 OMA, even though the OMA formula changed from FY 2006 to FY 2007. The one exception to that rule would be if the hospital's labor market experienced an exogenous event that affected all hospitals, such as the implementation of mandatory registered nurse staffing ratios. In that event, the better proxy would be the average FY 2007 OMA of the entire labor market.

Hospital Quality Data

The Deficit Reduction Act of 2005 (DRA) required CMS to expand the measure set for which hospitals must submit valid quality data. It also increased the penalty for failing to do so from 0.4 percentage point to 2 percentage points.

Expanded Measure Set

CMS has proposed to expand the measure set to include all 21 process measures currently reported on the *Hospital Compare* Web site, and to make the expansion retroactive to January 1, 2006. We strongly urge CMS not do this, but rather to expand the measure set as of August 1, 2006. The January 1, 2006, implementation date would not be a hardship for hospitals that have been submitting data for the expanded measure set on a voluntary basis all along, but it would be a significant burden for those that have not. The hospitals simply do not have the resources to pay for the overtime that would be required to conduct retrospective chart abstractions, or to spend on vendors for this additional deliverable. An August 1, 2006, start date would permit hospitals to put structures and systems in place so they could meet the additional reporting obligation without having to redirect staff time from patient care activities.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

CMS is not proposing to include the HCAHPS survey in the expanded measure set for mandatory reporting; however, the Agency will begin to implement HCAHPS in October 2006. We are supportive of this initiative, but would like to request that CMS please make the survey available in languages other than English and Spanish. With such a diverse patient population as we have in New York City, we will not be able to conduct the survey adequately in only two languages.

Value-Based Purchasing

The DRA also requires CMS to implement a value-based purchasing program, beginning in FY 2009. To help it develop the program, the Agency posed six questions to commenters in the FY 2007 proposed rule:

1. How should incentives be structured?
2. What level of incentive is needed?
3. What should be the source of incentives (budget-neutral)?
4. What should be the form of incentives?
5. What should be the timing of incentives in relation to performance?
6. How should we develop composite scores?

To stimulate thinking, CMS described the Premier demonstration, during which 270 hospitals provided data voluntarily on 34 measures related to heart attack, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements. Each hospital's performance was evaluated separately for each condition, and hospitals performing in the top two deciles received bonuses. Hospitals whose performance did not improve from the base year were to receive a penalty, although such hospitals were permitted to withdraw from the program before the penalties were imposed. The bonuses were financed with $9 million in new money.

We believe that the Premier demonstration is not a viable model for the systemwide program that CMS must implement in FY 2009 because no new money is available for that program. Rather, incentives must be financed from existing funds that currently pay for program services.

1. How should incentives be structured?

As such, we would like to see the program modeled on the Reporting of Hospital Quality Data for the Annual Hospital Payment Update (RHQDAHPU). While not construed this way, the RHQDAHPU is a form of value-based purchasing. The value in this instance is the submission of valid quality data. We recommend that CMS make an additional portion of the annual update conditional upon achieving a certain performance goal or set of goals.

2. What level of incentive is needed?

The RHQDAHPU has been remarkably effective even though the penalty has been relatively small. CMS reports that in FY 2005, 98.3% of all hospitals submitted data, of which 96% met their validation test, for a net result of 94% of all hospitals submitting valid quality data. This is not surprising, since early experience with pay-for-performance programs has indicated that preventing the loss of funding is a very powerful incentive for changing behavior. Therefore, the additional portion of the update put at risk could be small.

3. What should be the source of incentives?
4. What should be the form of incentives?
5. What should be the timing of incentives in relation to performance?

As stated, the source should be the annual payment update and the form should be the avoidance of losing the portion at risk. The penalty for failing to achieve the performance goal would be prospective and it would probably pertain to performance from two years prior. We assume that CMS would need one year after the close of a "performance year" in order to complete its analysis.

6. How should we develop composite scores?

We believe that CMS should build up to multiple measures slowly. That is, the Agency should begin with a single project that all hospitals would undertake and should establish a national performance goal. Both the selection of the project and the performance goal should be determined through the rule-making process. In subsequent years, CMS should add new projects. Each year, hospitals would have to maintain or improve their performance levels on prior projects in addition to achieving new goals. The same amount of the update would be at risk every year; however, preserving it would require an expanding effort.

In the program we envision, the underlying ethos would be of a public health nature rather than a business nature. That is, the goal of the program would not be for hospitals to compete against each other, but for every hospital in the United States to systematically improve its performance every year. That is the only way to preserve resources in communities and ensure that all patients benefit.

Hospital-Acquired Infections

Finally, the DRA requires CMS to identify two hospital-acquired infections that would be appropriate to suppress in the DRG grouper so that they don't trigger an enhanced payment for patient illness severity. CMS must identify these conditions by October 1, 2007, and then implement the grouper change on October 1, 2008.

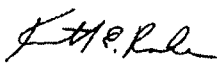
In collaboration with the GNYHA Outcomes Research Committee and Quality Steering Committee, we will conduct an empirical analysis that will identify infections as possible candidates. Unfortunately, because THEORI had to devote all of its resources to analyzing the DRG weighting and grouping proposals, we did not have an opportunity to begin this analysis during the comment period. We will complete our analysis within the next six months and provide our results to CMS during preparation of the FY 2008 proposed rule.

CONCLUSION

Again, we greatly appreciate the opportunity to provide these comments. If you or your staff have any questions or would like to discuss our comments further, please do not hesitate to contact Karen S. Heller, Senior Vice President and Executive Director, THEORI. She can be reached at (212) 506-5408 or at heller@gnyha.org.

My best.

Sincerely,



Kenneth E. Raske, President

Attachment

THEORI The Health Economics and Outcomes Research Institute
Karen S. Heller, Executive Director

The Health Economics and Outcomes Research Institute
of the Greater New York Hospital Association

Analysis of the Centers for Medicare & Medicaid Services' Proposals for Changing the Diagnosis Related-Group Weighting Methodology and Patient Classification System in the Inpatient Prospective Payment System

June 12, 2006

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CONTENTS

	Page
ACKNOWLEDGMENTS	3
EXECUTIVE SUMMARY	4
THEORI RECOMMENDATIONS	7
THEORI EMPIRICAL ANALYSIS—METHODS	7
Study Database	7
Estimating Cost per Case	8
Deriving Payments per Case	9
Deriving DRG Weights	10
THEORI EMPIRICAL ANALYSIS—RESULTS	11
Payment Accuracy	11
Destabilizing Effect of the HSRVcc Proposal	13
Hospital Fiscal Impact	14
DISCUSSION OUTLINE	16
MEDPAC'S RECOMMENDATIONS FOR IMPROVING PAYMENT ACCURACY	16
Basing the DRG Weights on Cost	17
Computing the Weights from the Hospitals' Relative Values In Each DRG	17
Refining the Current DRGs	18
Changing the Financing of Outlier Payments	18
CMS'S PROPOSALS FOR IMPROVING PAYMENT ACCURACY	18
The HSRVcc Methodology	18
Consolidated Severity-Adjusted DRGs	20
THE CHALLENGE OF CHANGING THE BASIS FOR THE DRG WEIGHTS FROM CHARGES TO COST	21
Significant Misalignments in the Cost and Charge Data	21
Why the Costs and Charges of High-Tech Devices Are Often Misaligned	22
The Optimal Approach to Estimating Case-Level Costs	22
IPPS PAYMENT IMBALANCES AND THE GROWTH OF SPECIALTY HOSPITALS	23
The Threat to General Hospitals	23

ACKNOWLEDGMENTS

At the Greater New York Hospital Association (GNYHA), The Health Economics and Outcomes Research Institute (THEORI) is responsible for analyzing issues and proposals with an econometric basis. As such, we took responsibility for analyzing the new proposals for diagnosis related-group (DRG) weighting and grouping that were put forth by the Centers for Medicare & Medicaid Services (CMS) in the Federal fiscal year (FY) 2007 proposed rule.

We began our analysis as an exercise in computing fiscal impact, which is always our starting point. We observed an extraordinary redistribution of funding from surgical to medical DRGs and, therefore, from tertiary and specialty hospitals to rural and community hospitals. We were concerned about the magnitude of the redistribution because, if warranted, it would mean that the current system is grossly inaccurate. To investigate this, we met regularly with finance executives at our member hospitals, who assured us that this was not the case. They said that there was a degree of imbalance between medical and surgical cases, but that it was not substantial.

More important, they told us that there was an exaggerated perception about the profitability of cardiac and orthopedic surgery cases because the cost of high-technology devices is greatly understated in the cost reports of many hospitals. They painstakingly educated us about the reasons for this, which have to do with the fact that the cost report instructions have not been updated to reflect developments in procurement practices for expensive items. This was nobody's fault, they said; it simply hadn't been made a priority. It should be one now, and one of our chief recommendations is that CMS undertake a project to reconcile conflicts in cost reporting so that the public data can be used reliably to develop payment policy.

We would like to thank our colleague, Patricia Wang, Senior Vice President of Health Finance, for convening our meetings with the GNYHA Committee on Finance and Reimbursement, and we would like to thank our members for the considerable time they spent teaching us about the complex and arcane aspects of the cost-reporting issues. In particular, we would like to acknowledge the contribution of John F. Collins, C.P.A., who is the Chief Financial Officer at Winthrop-University Hospital in Mineola, New York.

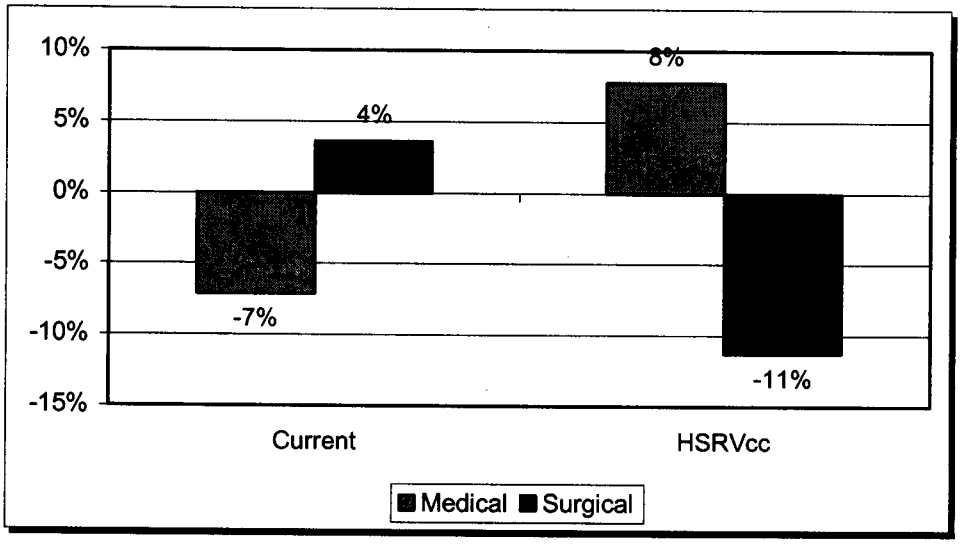
As a result of our education, we became very concerned that the redistribution caused by CMS's Hospital-Specific Relative Value Cost Center (HSRVcc) proposal was excessive, which would mean that there was a problem with the methodology. Therefore, although time was very short, we undertook a comprehensive empirical analysis, which demonstrated that the HSRVcc methodology worsens payment accuracy and is not a valid way to compute DRG weights. We also had tremendous difficulty understanding the theoretical rationale for the HSRVcc approach. We investigated this aspect of the proposal by consulting with Partha Deb, Ph.D., Associate Professor of Economics at Hunter College and the Graduate Center, City University of New York. We would also like to thank Dr. Deb for his time and insights.

EXECUTIVE SUMMARY

In the context of the proposed rule for the hospital inpatient prospective payment system (IPPS) and the FY 2007 rates, the Centers for Medicare & Medicaid Services (CMS) proposed to significantly change 1) the methodology it uses to calculate diagnosis related-group (DRG) weights, and 2) the classification system it uses to group patients into DRGs. The proposed methodology for computing DRG weights is called Hospital-Specific Relative Value Cost Centers (HSRVcc), and the proposed classification system is called Consolidated Severity-Adjusted DRGs (CS DRG).

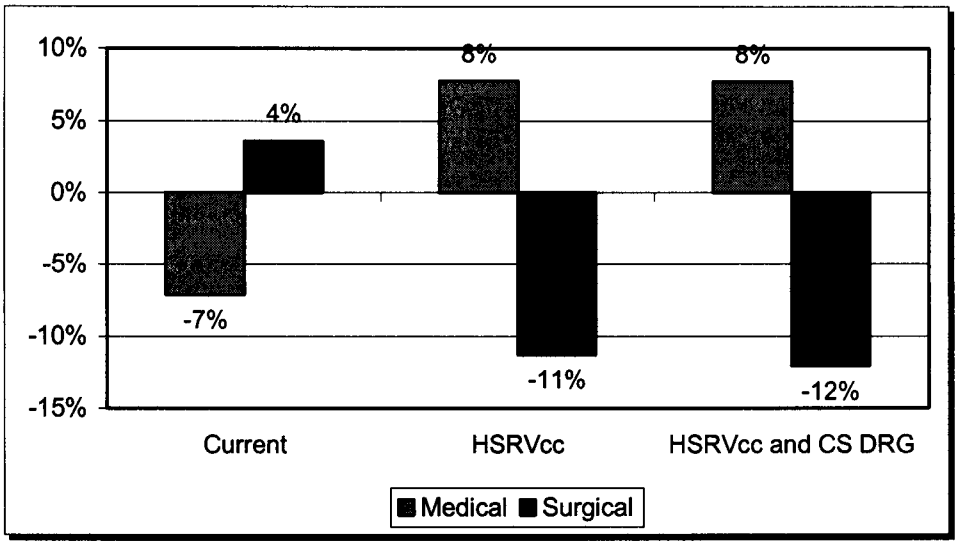
The HSRVcc methodology simply doesn't work and should be abandoned. Through a thorough empirical analysis, we have proven that the methodology significantly underpays for surgical cases and overpays for medical cases. It also greatly worsens the current inaccuracies in the IPPS, as shown in Figure 1. If implemented, the HSRVcc methodology would destabilize the hospital industry, cause negative ripple effects throughout the health care system and the general economy, and impair access to life-saving and enhancing services. It is unfortunate that CMS proposed the methodology without first determining whether it worked. And it was a mistake for the Medicare Payment Advisory Commission (MedPAC) and the Chairman of the House Ways & Means Committee to endorse the proposal without being assured of its efficacy.

Figure 1. Cost Margins of Medical and Surgical Cases
Under the Current and HSRVcc DRG Weighting Methodologies



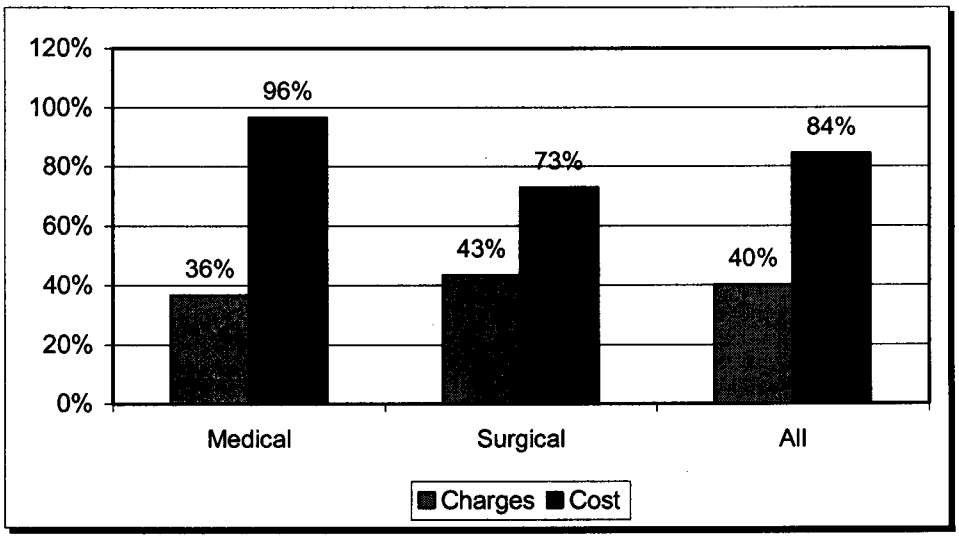
The CS DRG patient classification system should also be abandoned. It does not enhance IPPS payment accuracy, as shown in Figure 2, and it has many programmatic disadvantages.

Figure 2. Cost Margins of Medical and Surgical Cases
Under the Current, HSRVcc, and Combined HSRVcc and CS DRG Proposals



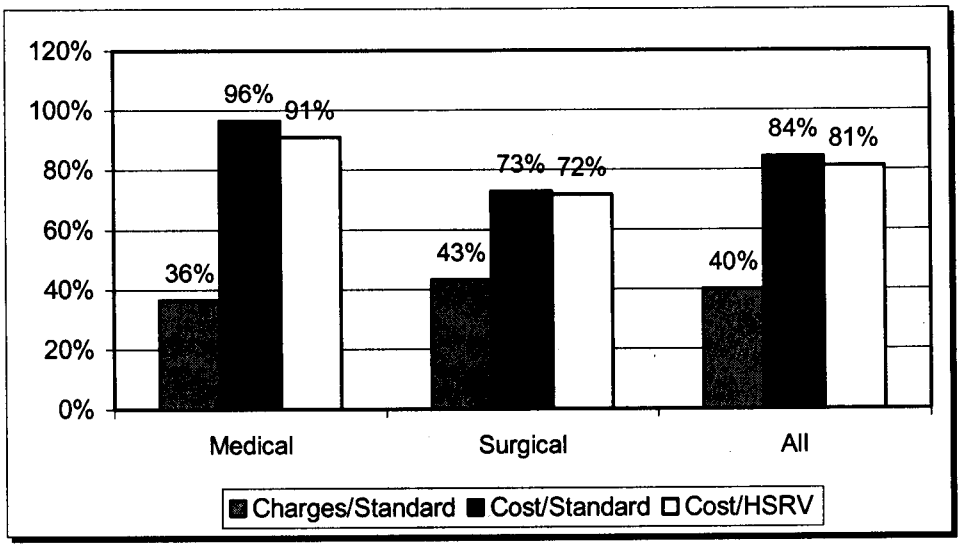
We believe that the best way to improve payment accuracy in the IPPS would be to change the basis for the DRG weights from charges to cost. Doing so would go a long way toward closing the current gap between the cost margins of medical and surgical cases, as shown in Figure 3.

Figure 3. Percentage of IPPS Payments Occurring in DRGs
With a Cost Margin Within the Mean Plus or Minus 5%,
Charges versus Cost



It is not necessary or desirable to change the methodology for computing the DRG weights from the standard approach to the Hospital-Specific Relative Value ("HSRV") methodology, as MedPAC recommends. The standard methodology performs slightly better than the HSRV methodology, as shown in Figure 4.

Figure 4. Percentage of IPPS Payments Occurring in DRGs
With a Cost Margin Within the Mean Plus or Minus 5%,
Charges versus Cost; Standard versus HSRV



Changing the basis for the DRG weights from charges to cost would be somewhat of a challenge at first because the requisite data are poor. Estimating case-level cost entails multiplying case-level charges in the Medicare Provider Analysis and Review (MedPAR) file by department-level cost-to-charge ratios (CCRs) developed from each hospital's Medicare cost report. This cannot be done with the raw data, however, because there are significant misalignments, both between costs and charges within the cost reports and between charges in the cost reports and charges in the MedPAR file. These misalignments must be corrected or they will produce inaccurate results.

The principal inaccuracy would be an underestimate of the cost of providing services that include high-technology devices. This would lead to underpayments for those services. The cost and charge misalignments associated with those devices are largely the result of a conflict between cost-report instructions that were written in the pre-IPPS era and current procurement practices. A focused initiative to resolve this conflict would correct the misalignments in a short period of time. Then CMS could proceed to use department-level CCRs to estimate case-level cost and derive DRG weights.

Switching the basis for the DRG weights from charges to cost would eliminate current Medicare overpayments for surgical cases. However, we do not believe that it would remove the incentive for physicians and others to open surgical specialty hospitals. That is because we don't believe that opportunities for financial gain derive nearly as much from IPPS payment imbalances as

from avoiding the need to cross-subsidize services for the poor and uninsured. To the extent that physician-owned specialty hospitals—and ambulatory surgery centers—destabilize the general hospitals in their community, the most effective response would be tighter regulation.

THEORI RECOMMENDATIONS

1. CMS should make no changes to the IPPS in FY 2007, as there is no longer sufficient time to implement a constructive policy.

2. CMS should withdraw the HSRVcc methodology, since it has no theoretical basis and would decrease payment accuracy.

3. CMS should begin to phase in cost-based weights in FY 2008.

4. In order to implement the optimal system of cost-based weights, during FY 2007, CMS should initiate a national project to correct misalignments between costs and charges in the cost reports and between charges in the cost reports and charges in the MedPAR file. Such a project would be administered by the fiscal intermediaries.

5. CMS should continue to derive the DRG weights based on the standard methodology; it should not change to the HSRV methodology.

6. CMS should withdraw the CS DRG proposal, since it does not improve payment accuracy and it conflicts with many other health policy goals and activities.

7. CMS should continue to develop an improved patient classification system that would serve the needs of all potential users.

THEORI EMPIRICAL ANALYSIS—METHODS

To analyze the efficacy of the HSRVcc and CS DRG proposals, we had to develop a patient-level database for which we would estimate cost per case and payments under a variety of scenarios.[1] That would allow us to customize clinical and hospital-level aggregations to compare cost margins. The aim of CMS's proposals was to improve payment accuracy, which would be measured by convergence in the cost margins among the DRGs.

Study Database

To develop our study database, we began with the FY 2004 MedPAR file and then excluded the following sets of hospitals: non-IPPS hospitals (including critical access hospitals), flat-rate hospitals, hospitals without a full year's worth of overlapping data in the Hospital Cost Reporting Information System (HCRIS) file, and hospitals that were not in the FY 2007 Impact File. Our final database included 3,164 hospitals, including Maryland hospitals, and 11 million discharges.

[1] Files for download are available at the THEORI Web site, www.theori.org.

Estimating Cost per Case

We estimated cost per case in the FY 2004 MedPAR file based upon a modified version of a process we undertake every year to estimate case-level cost in the New York Statewide Planning and Research Cooperative System (SPARCS) file. We go through this process to conduct comparative analyses of inpatient efficiency for our member hospitals and for research purposes.

Process to Estimate Case-Level Cost

The process we follow to estimate case-level cost is known as *charge mapping*. It was developed 20 years ago by Robert Knauf, Leo Lichtig, and their colleagues at Network, Inc., for New York State's Medicaid rate-setting system, which is based on cost instead of charges.[2] We conduct charge mapping annually for each hospital in the State using the following two-step process.

1. Within the cost report, we combine cost centers, as necessary, to align costs and charges.

    a. We compute a cost-to-charge ratio (CCR) for each cost center and determine whether each CCR is reasonable. This judgment is based on many years of experience with the data. Unreasonable CCRs indicate that costs and charges are probably misaligned.

    b. We combine clinically related cost centers, as necessary, to achieve reasonable CCRs. This results in a preliminary set of aggregated cost centers for each hospital.

2. We combine cost centers, as necessary, to align charges between the cost report and SPARCS.

    a. For each cost center in Worksheet C, we line up the inpatient charges with the aggregated charges reported in SPARCS.[3]

    b. We aggregate the charges in both data sets into the preliminary aggregated set we derived in step 1.

    c. We apply a single scalar to the SPARCS charges so that total charges match between the two databases.

    d. We combine clinically related cost centers, as necessary, until the charges are aligned between the two databases. This results in a final customized set of aggregated cost centers for each hospital. In rare situations, we end up with only one cost center for the entire hospital.

While the charge-mapping process may appear burdensome, it is actually quite efficient. Much of it has been automated because hospitals tend to be consistent in their reporting—for better or

[2] New York State derives its Medicaid DRG weights using the standard methodology.
[3] If CMS followed this approach, it would use Medicare program charges in Worksheet D-4, since they correspond with the Medicare fee-for-service charges in MedPAR.

worse. We also believe it is very worthwhile because it produces far more accurate estimates of cost at the case level than if we applied incorrect department-level CCRs or a single CCR.

Modified Charge Mapping for Proposed Rule Analysis

For our empirical analysis, we had to estimate case-level cost in MedPAR in a very compressed time frame. We began by aggregating the costs and charges in the cost reports and the charges in MedPAR into the 10 cost centers that CMS proposed. We then developed an algorithm to determine whether the data in the 10 cost centers were sufficiently aligned to use. **We were able to use 10 cost centers for 40% of the nation's hospitals**. For the remaining hospitals, we either aggregated the charges into two cost centers, one for routine and one for ancillary, or defaulted to a single cost center and a single CCR.[4]

Deriving Payments per Case

We estimated payment per case in the FY 2004 MedPAR file based on 10 different sets of DRG weights culled from more than 100 models. As shown in Table 1, we computed five sets of weights based on the current Medicare DRGs and five sets of weights based on the proposed CS DRGs. The models within each set are otherwise identical.

Table 1. THEORI Models

Grouping Methodology		Weighting Methodology		
Medicare	CS DRGs	Basis	Weighting Methodology	Cost-to-Charge Ratios (CCRs)
Model 1	Model 6	Charges	Standard	-
Model 2	Model 7	Cost	Standard	-
Model 3	Model 8	Cost	HSRV	-
Model 4	Model 9	Charges	HSRVcc	Unwtd. Geo Mean
Model 5	Model 10	Charges	HSRVcc	Aggregate

- Models 1 and 6 reflect the current methodology. Their weights were based on charges using the standard weighting methodology.
- Models 2 and 7 are the same as the first set, except that they are based on cost instead of charges.
- Models 3 and 8 are also based on cost, but their weights were derived using the HSRV methodology.
- Models 4 and 9 are based on the proposed HSRVcc methodology, which reflects unweighted geometric mean CCRs.
- Models 5 and 10 are also based on the HSRVcc methodology, but reflect aggregate mean CCRs (i.e., weighted arithmetic means).

[4] Our Web site, www.theori.org, provides a downloadable Excel file that contains the costs and charges for each cost center at each hospital in our database, and which includes a description of our charge-mapping algorithm.

Inlier Payments

Aside from the different DRG weights, the other payment variables that we used were the FY 2004 standardized amounts for operating and capital payments (which we took from the October 6, 2003, correction notice to the FY 2004 IPPS final rule) and the hospital-specific payment parameters from the FY 2007 Impact File. We assumed that all hospitals received their full update under the Reporting of Hospital Quality Data for Annual Hospital Payment Update (RHQDAHPU) program, and we included the complex payment formulas for hospitals located in Puerto Rico, as well as for Medicare-dependent and sole community hospitals. In order to estimate transfer payments in the CS DRG models, we followed CMS's criteria to identify which DRGs would be paid based upon the regular transfer-payment formula and which would be paid based upon the blended methodology.

Outlier Payments

We did not use our case-level cost estimates to compute outlier payments, but rather cost estimates derived by multiplying covered charges by the operating and capital CCRs in the FY 2007 Impact File. We derived an outlier threshold for each model so that total operating outlier payments equaled 5.1% of total operating IPPS payments. CMS allows capital outlier payments to float, so we did not force total IPPS payments to match across the 10 models.

Deriving DRG Weights

Standardization

When we used the standard weighting methodology, we standardized charges and cost. When we used the HSRV methodology, we did not. We do not standardize by CMS's formula because we believe that it is inaccurate. We developed our own formula under which we compute the basic payment that each hospital receives for all cases—i.e., the operating plus capital inlier payment *excluding the DRG adjustment*—and then divide that amount by the sum of the operating and capital standardized amounts (using the correct amounts for Puerto Rico hospitals). Then we divide total charges or total cost by the THEORI standardization factor.

Transfer Cases

DRG weights are derived from transfer-adjusted case counts. To derive the appropriate fraction for each case in the Medicare DRG models, we followed the existing rules and used the geometric mean lengths of stay from Version 23 of the Medicare DRG grouper, which were derived from the FY 2004 MedPAR file. Deriving the appropriate fraction for the CS DRG models was more difficult. CMS did not publish a list that identified which CS DRGs would be subject to the post-acute care transfer policy. Therefore, we used the criteria that were made available as part of the FY 2006 final rule to make this determination and then computed the transfer fractions accordingly.

HSRV Weights

HSRV weights are also derived from transfer-adjusted case counts. However, we used total cases for the iterative process of adjusting each hospital's DRG weights by its case-mix index.

HSRVcc Cost Shares

In Models 4 and 9, for the purpose of computing cost-center shares to derive a weighted average of the 10 HSRVcc weights in each DRG, we normalized the sum of the MedPAR charges in each cost center based on unweighted geometric mean CCRs, as CMS proposed. In deriving the unweighted geometric mean CCRs, we did not exclude hospitals based on the criteria that CMS used because the hospital exclusions we made when preparing our database eliminated facilities with aberrant data. In Models 5 and 10, we derived the cost shares based on aggregate (weighted arithmetic) mean CCRs. To compute each CCR, we summed the costs and charges in each of the 10 cost centers across all hospitals and then divided the sum of the costs by the sum of the charges.

Budget Neutrality

Each time we derived a set of weights, we applied a budget neutrality factor so that the sum of the DRG-weighted transfer-adjusted cases in that model matched the sum of the DRG-weighted transfer-adjusted cases based on the FY 2006 IPPS final rule weights.

THEORI EMPIRICAL ANALYSIS—RESULTS

As stated previously, we evaluated each model based upon its degree of cost-margin consistency.[5] We measured cost-margin consistency as the percentage of total IPPS payments related to DRGs with a cost margin within the national mean plus or minus 5%. Our study database of 11 million discharges in 3,164 IPPS hospitals represented operating and capital costs of $96 billion and total IPPS payments of $94 billion. Therefore, the national mean cost margin for the sample was negative 1.8%, and the target range was from negative 6.8% to positive 3.2%.

Payment Accuracy

As shown in Figure 5, under the current DRG weighting and grouping methodologies (Model 1), the percentage of IPPS payments related to DRGs with a cost margin within the target range was 40%. This is similar to the result of 35% that MedPAC obtained.[6] It confirms MedPAC's conclusion that there is insufficient consistency among the DRG cost margins and that changes are needed to improve payment accuracy. The question is: which changes?

As Figure 5 shows, the greatest improvement in cost-margin consistency resulted from switching the basis for the DRG weights from charges to cost (Model 2). This brought 84% of IPPS payments into DRGs with a target-range cost margin. Layering on the HSRV methodology (Model 3) did not improve payment accuracy; it even diminished it somewhat.

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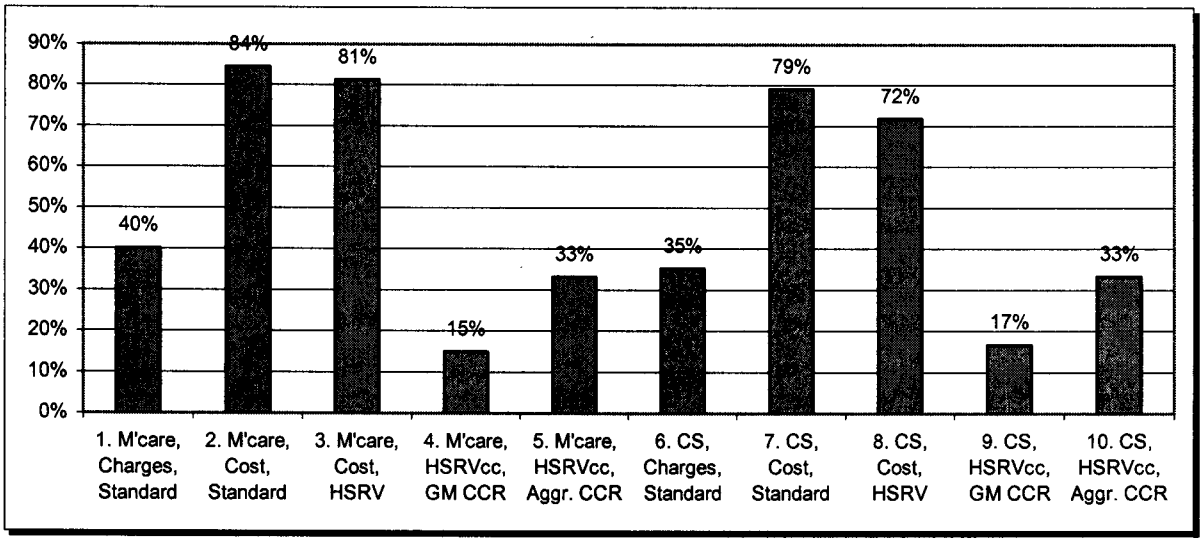
[5] Files for download are available at the THEORI Web site, www.theori.org.

[6] See MedPAC's 2005 *Report to Congress: Physician-Owned Specialty Hospitals*, Appendix D.

The most dramatic outcome was that the HSRVcc methodology (Model 4) drastically reduced payment accuracy. It lowered the share of IPPS payments related to DRGs with a target-range cost margin down to 15%. Changing the CCRs in the HSRVcc proposal (Model 5) improved the results; however, that outcome was still worse than what the current methodology achieved, 33% versus 40%, respectively.

Changing the patient classification system from the current Medicare DRGs to the CS DRGs (Models 6–10) moderately reduced payment accuracy, except in the HSRVcc model, where it had a negligible effect. Therefore, since the CS DRGs are problematic in many programmatic respects, which we discuss below, they should not be implemented.

Figure 5. % of Payments in All DRGs with a Cost Margin within the Target Range



In addition to looking at all DRGs combined, we reviewed the results based on three stratifications and observed the same pattern. Medicare DRGs based on cost and derived from the standard weighting methodology achieved the greatest cost margin consistency of all the models.

Table 2 shows the percentage of IPPS payments related to DRGs with a target-range cost margin for all DRGs, high-cost versus low-cost DRGs, and surgical versus medical DRGs. The models are paired by type and are shown in descending order of cost-margin consistency. In the Medicare DRG models (Models 1–5), high-cost DRGs were defined as having at least $110 million in costs. They represented 32% of all DRGs and 90% of total costs and IPPS payments. In the CS DRG models (Models 6–10), high-cost DRGs were defined as having at least $56.5 million in costs. They represented 39% of all DRGs and 90% of total costs and IPPS payments.

The results shown in Table 2 are also reported in Appendix A, along with the cost margins derived from each model and rankings based on cost-margin consistency. Appendix A also

provides the same information by Major Diagnostic Category (MDC). Appendix B lists all the Medicare DRGs, along with the cost margins derived from each model. Appendix C lists all the CS DRGs, along with the cost margins derived from each model.

Table 2. Percent of IPPS Payments in DRGs With a Target-Range Cost Margin, Medicare/CS DRG Pairs Sorted by Cost-Margin Consistency

Model and Methodology	All DRGs	By Cost Level		By Type	
		High	Low	Surgical	Medical
Standard weighting method applied to standardized cost/case:					
Model 2. Medicare DRGs	84%	85%	79%	73%	96%
Model 7. CS DRGs	79%	79%	83%	72%	86%
HSRV weighting methodology applied to non-stand. cost/case:					
Model 3. Medicare DRGs	81%	82%	79%	72%	91%
Model 8. CS DRGs	72%	71%	82%	61%	82%
Standard weighting method applied to stand. charges/case:					
Model 1. Medicare DRGs	40%	39%	51%	43%	36%
Model 6. CS DRGs	35%	34%	48%	43%	27%
HSRVcc method based on aggregate CCRs					
Model 5. Medicare DRGs	33%	33%	33%	39%	28%
Model 10. CS DRGs	33%	34%	28%	36%	31%
HSRVcc method based on unweighted geo. mean CCRs:					
Model 4. Medicare DRGs	15%	14%	24%	19%	11%
Model 9. CS DRGs	17%	16%	21%	15%	18%

Destabilizing Effect of the HSRVcc Proposal

The HSRVcc proposal causes excessive losses and gains among the DRGs. If it were implemented, it would destabilize the hospital system and the broader health care system as well because it would no longer be financially feasible to provide many surgical services. To illustrate this problem, Table 3 shows the effect of the HSRVcc and other DRG weighting options on the cost margins of the cardiac surgery DRGs in Major Diagnostic Category 5.

While our analysis confirms the observation that virtually all of the cardiac surgery DRGs are profitable under the current system, which derives weights from charges, it also shows that it would no longer be feasible to provide those services if the HSRVcc methodology were implemented. Even though the modified HSRVcc approach (Model 5) stemmed some of the losses generated by the proposed version (Model 4), the moderating effect was not nearly sufficient to render those services financially viable. Furthermore, as Table 3 shows, the best model in terms of payment accuracy, Model 2, which simply changes the basis for the DRG

weights from charges to cost, effectively eliminates opportunities for financial gain from specializing in these services.[7]

Table 3. Comparative Cost Margins in Cardiac Surgery DRGs

		Models				
		1	2	3	4	5
		Standard	Standard	HSRV	HSRVcc	HSRVcc
	Medicare Cardiac Procedure DRGs	Std. Charges	Std. Cost	Cost	GM CCR	Aggr. CCR
104	Cardiac Valve & Oth Major Cardiothoracic Proc w Card Cath	9%	3%	1%	-19%	-14%
105	Cardiac Valve & Oth Major Cardiothoracic Proc w/o Card Cath	6%	2%	0%	-20%	-15%
106	Coronary Bypass w PTCA	9%	2%	0%	-21%	-16%
108	Other Cardiothoracic Procedures	8%	3%	1%	-20%	-16%
110	Major Cardiovascular Procedures w CC	6%	3%	2%	-16%	-11%
111	Major Cardiovascular Procedures w/o CC	1%	-4%	-6%	-22%	-12%
117	Cardiac Pacemaker Revision Except Device Replacement	-1%	-2%	-3%	-6%	-4%
118	Cardiac Pacemaker Device Replacement	7%	-4%	-4%	-6%	5%
515	Cardiac Defibrillator Implant w/o Cardiac Cath	11%	0%	-1%	-11%	3%
518	Perc Cardio Proc w/o Coronary Artery Stent or AMI	8%	-5%	-6%	-20%	-8%
525	Other Heart Assist System Implant	17%	12%	10%	-5%	2%
535	Cardiac Defib Implant w Cardiac Cath w AMI/HF/Shock	11%	2%	0%	-13%	-3%
536	Cardiac Defib Implant w Cardiac Cath w/o AMI/HF/Shock	10%	1%	-1%	-14%	-2%
547	Coronary Bypass w Cardiac Cath w Major CV Dx	6%	0%	-1%	-24%	-20%
548	Coronary Bypass w Cardiac Cath w/o Major CV Dx	3%	-3%	-5%	-29%	-25%
549	Coronary Bypass w/o Cardiac Cath w Major CV Dx	5%	1%	0%	-23%	-20%
550	Coronary Bypass w/o Cardiac Cath w/o Major CV Dx	-1%	-4%	-6%	-30%	-26%
551	Permanent Cardiac Pacemaker Impl w Maj CV Dx or AICD Lead or Gnrtr	4%	-2%	-3%	-13%	-4%
552	Other Permanent Cardiac Pacemaker Implant w/o Major CV Dx	2%	-5%	-6%	-14%	-3%
555	Percutaneous Cardiovascular Proc w Major CV Dx	6%	-3%	-3%	-19%	-11%
556	Percutaneous Cardiovasc Proc w Non-Drug-Eluting Stent w/o Maj CV Dx	12%	-5%	-5%	-22%	-8%
557	Percutaneous Cardiovascular Proc w Drug-Eluting Stent w Major CV Dx	8%	-3%	-4%	-20%	-9%
558	Percutaneous Cardiovascular Proc w Drug-Eluting Stent w/o Maj CV Dx	12%	-5%	-6%	-22%	-7%

Hospital Fiscal Impact

Finally, we assessed the hospital-level fiscal impact of each model by comparing total IPPS payments under each model with IPPS payments under the current methodology, Model 1. These results are shown in Table 4. The best model in terms of payment accuracy, Model 2, which bases the DRG weights on cost instead of charges, also generated the smallest redistribution in IPPS payments, $700 million. This represents a swing of $1.4 billion, or 1% of total payments. The redistribution benefits rural, community, and high "disproportionate share" (DSH) hospitals, but it does not destabilize the rest of the industry. By contrast, the worst models in terms of payment accuracy, Models 4 and 9, which reflect the proposed HSRVcc methodology, would redistribute $2.6 billion and $2.4 billion, respectively, representing a swing of about $5 billion, or 5% of total IPPS payments. Clearly, this outcome is not warranted.

[7] In DRG 525, Other Heart Assist System Implant, the cost margin resulting from Model 2 of 12% is probably overstated because the cost of implants is understated.

Table 4. Dollar and Percentage Gain or Loss Associated with Each Model

		Model								
		2	3	4	5	6	7	8	9	10
DRG		Medicare	Medicare	Medicare	Medicare	CS	CS	CS	CS	CS
Weighting Method		Standard	HSRV	HSRVcc	HSRVcc	Standard	Standard	HSRV	HSRVcc	HSRVcc
Basis	N	Std. Cost	Cost	GM CCR	Aggr. CCR	Std. Charges	Std. Cost	Cost	GM CCR	Aggr. CCR
$ Change in Payments from the Current Methodology (Millions)										
All Hospitals	3,164	(0)	(0)	(1)	(1)	(0)	(0)	(0)	(2)	(2)
Losses		(703)	(871)	(2,573)	(1,904)	(1,124)	(1,227)	(1,283)	(2,420)	(1,815)
Gains		703	871	2,572	1,903	1,123	1,226	1,282	2,418	1,813
Total Swing		1,407	1,741	5,145	3,807	2,247	2,453	2,565	4,837	3,627
% of Total IPPS Pmts.		1%	2%	5%	4%	2%	3%	3%	5%	4%
Population Density										
Large Urban	1,245	(57)	(55)	(207)	(180)	327	258	273	77	97
Other Urban	995	(132)	(176)	(532)	(384)	(40)	(160)	(200)	(544)	(396)
Rural	924	189	231	737	563	(288)	(98)	(74)	465	297
Teaching Status										
Major Teaching	251	(176)	(212)	(755)	(615)	58	(116)	(129)	(653)	(523)
Other Teaching	730	(165)	(207)	(596)	(422)	179	20	(12)	(422)	(253)
Non-teaching	2,183	341	418	1,350	1,037	(237)	96	140	1,073	774
DSH Status										
High DSH	1,859	70	111	204	95	24	84	128	224	115
Low/No DSH	1,305	(70)	(111)	(205)	(96)	(24)	(85)	(129)	(226)	(117)
% Change in Payments from the Current Methodology										
All Hospitals	3,164	0%	0%	0%	0%	0%	0%	0%	0%	0%
Population Density										
Large Urban	1,245	0%	0%	0%	0%	1%	1%	1%	0%	0%
Other Urban	995	0%	0%	-2%	-1%	0%	0%	-1%	-2%	-1%
Rural	924	2%	2%	7%	6%	-3%	-1%	-1%	5%	3%
Teaching Status										
Major Teaching	251	-1%	-1%	-4%	-3%	0%	-1%	-1%	-3%	-3%
Other Teaching	730	0%	-1%	-2%	-1%	1%	0%	0%	-1%	-1%
Non-teaching	2,183	1%	1%	3%	3%	-1%	0%	0%	3%	2%
DSH Status										
High DSH	1,859	0%	0%	0%	0%	0%	0%	0%	0%	0%
Low/No DSH	1,305	0%	0%	-1%	0%	0%	0%	0%	-1%	0%

Our last set of results, shown in Table 5, features the percentage of hospitals in each category that lose or gain more than the value of the 3.4% market basket update in FY 2007. These results underscore the financial benefit to rural, community, and high-DSH hospitals of implementing Model 2, which bases the DRG weights on cost and derives them using the standard DRG weighting methodology.

Table 5. Percentage of Hospitals Losing or Gaining More than the Value of the 3.4% Market Basket Update										
		Model								
Model		2	3	4	5	6	7	8	9	10
DRG		Medicare	Medicare	Medicare	Medicare	CS	CS	CS	CS	CS
Weighting Method		Standard	HSRV	HSRVcc	HSRVcc	Standard	Standard	HSRV	HSRVcc	HSRVcc
Basis	N	Std. Cost	Cost	GM CCR	Aggr. CCR	Std. Charges	Std. Cost	Cost	GM CCR	Aggr. CCR
% of Hospitals Losing More than 3.4%										
All Hospitals	3,164	1%	2%	15%	10%	30%	20%	19%	16%	13%
Population Density										
Large Urban	1,245	2%	4%	17%	12%	15%	12%	12%	16%	13%
Other Urban	995	1%	3%	24%	15%	24%	19%	20%	27%	21%
Rural	924	0%	0%	2%	2%	56%	31%	27%	4%	4%
Teaching Status										
Major Teaching	251	0%	3%	45%	37%	10%	18%	18%	41%	37%
Other Teaching	730	1%	3%	26%	18%	13%	12%	12%	27%	20%
Non-teaching	2,183	1%	2%	7%	4%	38%	23%	21%	9%	8%
DSH Status										
High DSH	1,859	0%	1%	13%	9%	32%	20%	18%	13%	11%
Low/No DSH	1,305	2%	5%	18%	11%	27%	20%	20%	19%	16%
% of Hospitals Gaining More than 3.4%										
All Hospitals	3,164	16%	26%	63%	57%	10%	17%	19%	56%	46%
Population Density										
Large Urban	1,245	7%	15%	55%	47%	17%	26%	28%	54%	45%
Other Urban	995	9%	14%	46%	40%	8%	13%	13%	38%	30%
Rural	924	36%	54%	91%	89%	3%	10%	13%	77%	63%
Teaching Status										
Major Teaching	251	2%	5%	22%	14%	18%	16%	18%	24%	19%
Other Teaching	730	3%	6%	38%	31%	12%	18%	19%	35%	29%
Non-teaching	2,183	22%	35%	76%	70%	9%	17%	19%	66%	54%
DSH Status										
High DSH	1,859	20%	31%	65%	59%	10%	17%	20%	59%	48%
Low/No DSH	1,305	10%	18%	59%	54%	10%	16%	17%	51%	42%

DISCUSSION OUTLINE

In the following sections, we discuss theoretical and technical issues concerning:

- MedPAC's recommendations for improving payment accuracy;
- CMS's proposals for improving payment accuracy;
- The challenge of changing the basis for the DRG weights from charges to cost; and
- The relationship between IPPS payment imbalances and the growth of specialty hospitals.

MEDPAC'S RECOMMENDATIONS FOR IMPROVING PAYMENT ACCURACY

In its March 2005 report to Congress on specialty hospitals, MedPAC recommended that CMS implement four changes to the IPPS, as follows:

- Base the DRG weights on the estimated cost of providing care rather than on charges.
- Derive the weights from the national average of hospitals' relative values in each DRG.

- Refine the DRGs to more fully capture differences in severity of illness among patients.
- Adjust the DRG weights to account for differences in the prevalence of high-cost outliers.

Basing the DRG Weights on Cost

While MedPAC did not prescribe how CMS should base the DRG relative weights on the estimated cost of providing care, in conducting its own research, the Commission estimated cost per case in the MedPAR file by multiplying detailed department-level CCRs derived from the hospital cost reports by the corresponding detailed charges reported for each patient, and then summing the results.

This approach is computationally much more difficult than the one that CMS currently uses to estimate cost per case for the purpose of computing outlier payments. That approach is to multiply a single CCR by the total covered charges reported for each patient. As we discuss below, *we believe that CMS's approach is more accurate than MedPAC's, although both are very deficient.*

Computing the Weights from the Hospitals' Relative Values in Each DRG

The methodology that CMS currently employs to derive DRG weights—the standard approach—first derives the weighted average of all hospitals' average cost or charges per case in each DRG, and then computes the DRG weights by dividing each DRG's average by the overall average across all DRGs. By contrast, the HSRV methodology that MedPAC recommended derives DRG weights by first computing a set of weights for each hospital and then deriving a weighted average of all hospitals' weights in each DRG.

The HSRV methodology was developed by Julian Pettengill (of the Prospective Payment Assessment Commission, which is now MedPAC) and James Vertrees (of 3M Health Information Systems) and was described by Lave et al. in 1981.[8] The principal difference in outcome between the standard and HSRV methodologies is that the latter produces more compressed DRG weights. In 1992, Carter and Rogowski compared the DRG weights computed using the standard and HSRV methodologies and found that "both sets of weights produce equally good estimates of hospital-level costs *net of those expenses that are paid by outlier payments* [emphasis added]. The greater compression of the HSRV weights is counterbalanced by the fact that more high-weight cases qualify as outliers."[9]

Concerns have been raised about the HSRV methodology precisely because it depends more heavily on CMS's ability to reimburse outlier cases correctly. CMS has overestimated the outlier threshold for many years, thus under-reimbursing outlier cases.

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[8] J. Lave, J. Pettengill, L. Schmid, and J. Vertrees, "Measurement Issues in the Development of a Hospital Case Mix Index for Medicare," American Statistical Association Proceedings of the Social Statistics Section (1981), pp. 57–62.

[9] G. Carter, J. Rogowski, "How Recalibration Method, Pricing, and Coding Affect DRG Weights," Health Care Financing Review/14, no. 2 (Winter 1992): 83–96.

Refining the Current DRGs

Again, MedPAC did not prescribe the patient classification system that CMS should use to refine the DRGs; however, in conducting its own research, the Commission used 3M's APR-DRGs. APR-DRGs are based on a set of *basic* DRGs representing different principal diagnoses and procedures, which are then divided into four severity levels to account for differences in patient illness severity. The system represents the full patient population and is widely used for clinical research and sometimes for payment purposes.

Changing the Financing of Outlier Payments

Currently, *statistical outliers* are excluded from the computation of the DRG weights, but *high-cost outliers* are included. Therefore, the weights reflect the average cost of both inliers and high-cost outliers within each DRG. Outlier payments are financed through a 5.1% across-the-board reduction in all inlier payments. Thus, all cases contribute to the outlier pool. MedPAC's recommendation is to exclude both statistical and high-cost outliers from the computation of the DRG weights so that the weights will reflect the average cost of inlier cases only. Outlier payments would still be financed through a 5.1% across-the board reduction in all inlier payments, but the effect of the change would be to shift the financing of the outlier pool from all cases to cases in the DRGs with the highest prevalence of outlier cases.

Outlier cases occur most frequently in high-weight DRGs. Therefore, this change would compound the weight compression in those DRGs that would be caused by the HSRV methodology. We believe that each proposal alone would exacerbate payment inaccuracies and that the two combined would be quite deleterious. However, we intend to analyze the proposal to test our theory empirically.

CMS'S PROPOSALS FOR IMPROVING PAYMENT ACCURACY

CMS did not propose to implement the specific strategies that MedPAC recommended, either to derive the DRG weights or to refine the patient classification system. Nor did the Agency propose a change in outlier financing, as that would have required statutory authority. (CMS did say, though, that it would investigate MedPAC's outlier recommendation further.) Instead, with respect to the derivation of DRG weights, the Agency proposed the HSRVcc methodology, which substitutes for MedPAC's recommendations to change the basis for the weights from charges to cost and to change the derivation of the weights from the standard to the HSRV methodology.

The HSRVcc Methodology

Technical Description

The HSRVcc methodology would work as follows:

1. Group all charges in the cost reports and in MedPAR into the following 10 cost centers: routine days, intensive days, drugs, supplies and equipment, therapeutic services, operating

room, cardiology, laboratory, radiology, and other services and charges (excluding organ acquisition charges and charges billed to physicians).

2. Apply the HSRV methodology to the charges in each cost center to compute a national set of 10 cost-center weights per DRG. These are referred to as the "HSRVcc weights."

3. Compute a single set of weights for each DRG by taking a weighted average of the 10 cost-center weights in each DRG. A fixed set of cost-center shares would be used to derive the weighted average of the 10 HSRVcc weights in all DRGs.

4. To derive the fixed set of cost-center shares (CMS used the term "scalars"):

   a. Derive a national CCR for each cost center from the hospital cost reports.
   b. Sum the MedPAR charges in each cost center across all hospitals.
   c. Apply the CCRs to the sum of the MedPAR charges in each cost center.
   d. Divide each cost center's normalized charges by the sum of all normalized charges in all 10 cost centers.
   e. The result is each cost center's share.

5. To derive a national CCR for each cost center from the cost reports:

   a. Compute a CCR for each cost center for each hospital.
   b. Assess the array of CCRs in each cost center and exclude those that are too high or too low.
   c. Compute the unweighted geometric mean CCR from the remaining hospital-specific CCRs.
   d. The result is the national CCR for each cost center.

Interpretation of the HSRVcc Methodology

The HSRVcc methodology is a radical departure from all previous approaches to deriving DRG weights. It bears no relationship to the MedPAC proposals for which it would substitute. The easiest way to understand the methodology is to compare it with the IPPS adjustment for regional differences in input prices.

Although CMS does not describe it this way, there are two regional adjustments for input prices: one for labor inputs and another for non-labor inputs. The adjustment for labor inputs is the area wage index. The adjustment for non-labor inputs is the cost-of-living adjustment (COLA). The wage index that is applied to each hospital is higher or lower than 1.0; the COLA that is applied to each hospital is higher than 1.0 for hospitals located in Alaska and Hawaii and 1.0 for all other hospitals. The combined regional adjustment is a weighted average of these two adjustments. The labor and non-labor shares are fixed.

This analogy applies to the HSRVcc methodology in the following way:

- The wage indices and COLAs (two adjustments) are similar to the 10 HSRVcc weights in each DRG; and

- The labor and non-labor shares used to derive a combined regional adjustment are similar to the 10 fixed cost-center shares that would be used to derive a single DRG adjustment.

The way in which CMS actually describes the regional adjustment is to say that the standardized amount is divided into two parts representing the labor and non-labor shares. Each part is adjusted by the appropriate wage index or COLA, respectively, and then the adjusted parts are added together. To describe the HSRVcc methodology in this way, *what CMS is proposing to do is to divide the standardized amount into 10 parts representing each of the 10 cost centers. Each part would be adjusted by the appropriate HSRVcc weight, and then the adjusted parts would be added together.*

Critique of the HSRVcc Methodology

Several parties have noted flaws in the HSRVcc formula, such as deriving the CCRs from unweighted geometric means rather than weighted averages, and excluding hospitals with CCRs above or below an arbitrary threshold. We agree with those observations but believe there is a much more fundamental problem: *There is absolutely no logical basis or theoretical justification for the entire framework. It is merely a computational formula.* This concern is part of what prompted us to undertake our empirical analysis, which proved that the HSRVcc methodology does not work. It is unfortunate that CMS did not validate the HSRVcc concept before proposing its implementation.

Consolidated Severity-Adjusted DRGs

To refine the patient classification system, CMS contracted with 3M to customize its APR-DRG product for the mostly over-65 Medicare population. 3M did so primarily by combining severity levels 1 and 2 (the lowest-weight levels) *within* many basic DRGs, and by consolidating severity level 4 (the highest-weight level) *across* basic DRGs into two new DRGs within each MDC, one for medical and one for surgical.

Several concerns have been raised about the CS DRGs, including:

- The CS DRG severity levels are based largely on differences in patient demographic and clinical risk factors, which may not correlate well with differences in the resources needed to treat each patient.

- Many health services researchers, both public and private, use the current Medicare DRGs—which are in the public domain—for quality and other outcomes research.

  - The CS DRGs may not be clinically appropriate for these purposes.
  - The grouping logic is a proprietary product belonging to 3M.

- At a time when all parties are striving toward standardization—of HIPAA transaction sets, of payment practices, of quality measurement, of information systems for inter-operability—it would be preferable if CMS developed an open-source system that could accommodate all purposes.

Other concerns have been raised about the combination of the CS DRG and HSRVcc proposals:

- Many private plans—Medicare managed care and employer-sponsored—base their payments on the current Medicare DRGs and weights.
  - The HSRVcc weights cause huge swings in payment among the DRGs, which would ripple through the commercial sector.
  - The CS DRGs are problematic because they were not designed to accommodate non-Medicare populations.

THE CHALLENGE OF CHANGING THE BASIS FOR THE DRG WEIGHTS FROM CHARGES TO COST

In the proposed rule, CMS explained that the main reason for developing the HSRVcc methodology was that the Agency did not believe that it was administratively feasible to estimate the cost of each case in the MedPAR file annually. Based on our experience, we disagree, and would welcome the opportunity to work with CMS to develop its system. But while we don't perceive administrative barriers, we do know that there are significant problems with the cost-report data that would make it a challenge to start a new system.

Significant Misalignments in the Cost and Charge Data

As discussed previously, we agree with MedPAC's finding that there is a great deal of inconsistency among the DRG cost margins and that this is the result of using charges instead of cost to derive the DRG weights. However, we disagree with MedPAC's assumption that the above-average mark-ups are associated with the ancillary service cost centers. We believe, instead, that the above-average mark-ups are associated with routine cost centers in hospitals that happen to have a high volume of surgical cases. We know that such hospitals have higher-than-average overall mark-ups because there is an inverse correlation between the overall CCR and both volume and case mix. (Low CCRs are the inverse of high mark-ups.)

MedPAC indeed observed high mark-ups for ancillary services and lower mark-ups for routine services in the cost-report data, but those results were not real: they were a function of misalignments between costs and charges in the cost reports. For many tertiary hospitals, the costs of high-tech devices are reported incorrectly in the medical/surgical routine cost center, while their associated charges are reported correctly in several ancillary service cost centers, including Medical Supplies Charged to Patients, Operating Room, Cardiac Catheterization Laboratory, or Electrophysiology Laboratory. This severely understates their ancillary cost center CCRs and overstates their routine CCRs.

Because of this problem, applying detailed department-level CCRs to the associated charges in MedPAR understates the cost of related surgical cases and overstates the cost of medical cases. This problem must either be corrected or accommodated through charge mapping, but it cannot be ignored.

Why the Costs and Charges of High-Tech Devices Are Often Misaligned

The misalignment results from a conflict between the way in which the high-tech devices are purchased and the way in which the cost report instructs hospitals to assign supply costs. In the pre-IPPS era, when the cost-report instructions were largely written, virtually all supplies were purchased centrally. Therefore, the requirement to classify supply costs in the Central Services and Supplies cost center—a general service cost center—was reasonable. With the development of technological advances, such as stents, pacemakers, defibrillators, and orthopedic implants, the situation has changed. Those devices are so expensive that in order to control inventory costs, hospitals—advised by their supply chain consultants—have moved procurement responsibility for those items from the central supplies office to the ancillary departments in which they are used.

Because of the cost-report instructions, however, hospitals must reclassify the cost of these devices from their ancillary cost centers to Central Services and Supplies. *Then the allocation statistic for that cost center distributes most of those costs to the nursing floors—i.e., to the medical/surgical routine cost center*—because that is, indeed, where most centrally procured supplies are distributed. Therefore, the costs of cardiac and orthopedic devices are automatically stepped down to the routine cost center along with the rest of the supplies.

In order to ensure that the device costs end up in the appropriate ancillary cost centers rather than in the routine cost center, hospitals must obtain special permission from the fiscal intermediary to change the statistic for allocating the device costs correctly. Very sophisticated hospitals do this, but many—if not most—do not. Contrary to the cost-report instructions, some hospitals simply do not move the device costs up to the Central Services and Supplies cost center to begin with, which preserves the correct CCRs, but many have allowed the device costs to remain lodged in the routine cost center.

In order to correct this problem, CMS should initiate a national project to properly align costs and charges within the cost reports and to properly align charges in the cost reports with charges in the MedPAR file. The hospitals and fiscal intermediaries should also be directed to ensure a correct step-down of the device costs going forward. It is necessary to reclassify the device costs to the ancillary cost centers rather than the other way around because the MedPAR revenue codes for the devices recognize them as ancillary—not routine—charges. While the fiscal intermediaries have never addressed this problem, it would be relatively easy to correct with a focused effort.

The Optimal Approach to Estimating Case-Level Costs

The solution to the problem of misalignments in the cost reports is not to use a single CCR to estimate case-level costs because there are differences in mark-ups between routine and ancillary

cost centers, and among cost centers within each category. Contrary to what the cost-report data suggest, however, the routine cost-center mark-ups are generally higher than the ancillary ones. Regardless of the relative mark-ups, though, the fact that there are differences means that the most accurate cost estimates would derive from using correct department-level CCRs.

Therefore, in considering options for estimating case-level costs, the optimal course of action for CMS to take this year would be the following:

1. Undertake THEORI's recommended "alignment" project as soon as possible.
2. Develop a consensus on a set of aggregate cost centers for which CMS would derive CCRs on an annual basis.
3. Apply those CCRs annually to the matching MedPAR charges to derive case-level costs and DRG weights.

Each hospital's set of CCRs would serve a dual purpose. It would be applied to total charges to compute cost for the purpose of deriving DRG weights, and it would be applied to covered charges to compute cost for the purpose of deriving outlier payments.

IPPS Payment Imbalances and the Growth of Specialty Hospitals

The Congress and MedPAC must be commended for focusing on the issue of how charge-based DRG weights in the IPPS have created payment imbalances. They did so out of concern that these imbalances, which favor high-technology surgical services, could be spurring the growth of for-profit, physician-owned hospitals that specialize in such services. MedPAC's report on specialty hospitals expressed concern that, if this trend continued, it could destabilize general hospitals.

Our empirical analysis confirmed MedPAC's assessment of payment imbalances in the IPPS and we support the goal of correcting these problems. However, we doubt that this will have much impact on specialty hospital development because we do not believe that the Medicare IPPS has been the driving force behind this trend. Irrespective of Medicare payment policy, physicians and others will almost always be financially successful if they concentrate on a fully insured patient population. In other words, *we believe that a favorable payer mix is the more important variable.*

The Threat to General Hospitals

General hospitals with full-service emergency departments provide services to all members of their communities, regardless of their ability to pay. They derive their financing from Medicare, Medicaid, and private health plans, and they sometimes receive subsidies to help them provide charity care. The extent to which they are financially successful depends in large part upon their payer mix. Hospitals with a disproportionate share of poor and uninsured patients have far greater difficulty sustaining their operations than do other hospitals, although high-DSH tertiary hospitals often have a more favorable payer mix than their community hospital counterparts. That is because they can attract insured patients for high-technology surgical services that community hospitals do not provide.

Although the general hospital system contains inequities, most states try to minimize them by granting licenses only to hospitals that operate full-service emergency departments and/or obtain a certificate of need. Thus, for-profit hospitals that would aim to avoid poor and uninsured patients are not permitted to disrupt the equilibrium, such that it is. In states without such a regulatory structure, however, for-profit specialty hospitals have proliferated, as MedPAC observed. This has indeed led to great concerns about destabilization of the general hospital systems in those states.

The obvious solution to that problem is the development of a more appropriate regulatory structure. Furthermore, additional protections are needed where specialty hospitals are already controlled because free standing ambulatory surgery centers and other niche providers threaten general hospitals as well. We urge CMS, MedPAC, and the Congress to give further consideration to this issue.

Appendix A

Comparative Cost Margins in THEORI Models

MDC	Description	Cost Margins 1 M'care Standard Charges	2 M'care Standard Cost	3 M'care HSRV Cost	4 M'care HSRVcc GM CCR	5 M'care HSRVcc Agg. CCR	6 CS Standard Charges	7 CS Standard Cost	8 CS HSRV Cost	9 CS HSRVcc GM CCR	10 CS HSRVcc Agg. CCR
	All DRGs	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%
	High-Cost DRGs	-2%	-2%	-2%	-3%	-2%	-2%	-2%	-2%	-3%	-2%
	Low-Cost DRGs	-3%	-2%	-1%	7%	5%	-3%	-2%	-2%	6%	4%
	Surgical DRGs	4%	0%	-1%	-11%	-8%	3%	0%	-1%	-12%	-8%
	Medical DRGs	-7%	-4%	-3%	8%	4%	-6%	-3%	-2%	8%	4%
	All DRGs by Major Diagnostic Category:										
PRE	Transplants and Tracheostomies	8%	7%	7%	-12%	-12%	10%	8%	8%	-10%	-9%
1	Nervous System	-4%	-3%	-3%	-2%	-3%	-4%	-3%	-3%	-1%	-3%
2	Eye	-5%	-4%	1%	16%	13%	-5%	-4%	-1%	14%	11%
3	Ear, Nose, Mouth And Throat	-6%	-4%	-4%	10%	7%	-5%	-3%	-3%	6%	4%
4	Respiratory System	-7%	-3%	-2%	1%	-2%	-7%	-3%	-2%	2%	-2%
5	Circulatory System	1%	-2%	-3%	-10%	-6%	1%	-2%	-3%	-9%	-5%
6	Digestive System	-3%	-1%	-1%	2%	0%	-4%	-2%	-2%	1%	-1%
7	Hepatobiliary System And Pancreas	0%	-1%	0%	3%	1%	0%	-1%	-1%	1%	0%
8	Musculoskeletal System And Connective Tissue	-3%	-4%	-5%	-6%	-3%	-3%	-4%	-5%	-7%	-4%
9	Skin, Subcutaneous Tissue And Breast	-7%	-3%	-2%	19%	14%	-7%	-3%	-2%	18%	13%
10	Endocrine, Nutritional And Metabolic System	-7%	-3%	-2%	13%	8%	-7%	-4%	-3%	11%	7%
11	Kidney And Urinary Tract	-4%	-2%	-1%	9%	6%	-2%	-2%	-1%	8%	5%
12	Male Reproductive System	-3%	-5%	-5%	3%	1%	-3%	-5%	-5%	0%	-1%
13	Female Reproductive System	-2%	-3%	-4%	-1%	-2%	-3%	-4%	-4%	-4%	-5%
14	Pregnancy, Childbirth And Puerperium	-13%	-4%	0%	31%	24%	-14%	-4%	-1%	24%	17%
16	Blood and Blood Forming Organs and Immunological Disorders	-3%	-1%	0%	17%	14%	-3%	-1%	0%	16%	13%
17	Myeloproliferative DDs (Poorly Differentiated Neoplasms)	7%	5%	4%	14%	13%	6%	4%	3%	11%	10%
18	Infectious and Parasitic DDs	1%	2%	2%	5%	3%	1%	2%	3%	5%	3%
19	Mental Diseases and Disorders	-25%	-4%	2%	44%	30%	-25%	-4%	1%	44%	30%
20	Alcohol/Drug Use or Induced Mental Disorders	-20%	-4%	5%	40%	30%	-20%	-4%	3%	36%	27%
21	Injuries, Poison And Toxic Effect of Drugs	-1%	1%	1%	8%	6%	-4%	-1%	0%	5%	3%
22	Burns	4%	7%	11%	9%	6%	4%	8%	12%	9%	7%
23	Factors Influencing Health Status	-20%	-4%	-3%	16%	10%	-20%	-4%	-3%	17%	11%
24	Multiple Significant Trauma	3%	5%	6%	-8%	-7%	3%	5%	7%	-7%	-6%
25	Human Immunodeficiency Virus Infection	14%	5%	8%	18%	15%	13%	5%	8%	17%	14%
NA	O.R. Procedure Unrelated to Principal Diagnosis	6%	3%	2%	-5%	-4%	5%	3%	2%	-6%	-5%

Appendix A

Comparative Cost Margins in THEORI Models

MDC	Description	Cost Margins 1 M'care Standard Charges	2 M'care Standard Cost	3 M'care HSRV Cost	4 M'care HSRVcc GM CCR	5 M'care HSRVcc Agg. CCR	6 CS Standard Charges	7 CS Standard Cost	8 CS HSRV Cost	9 CS HSRVcc GM CCR	10 CS HSRVcc Agg. CCR
	Surgical DRGs by Major Diagnostic Category:										
PRE	Transplants and Tracheostomies	8%	7%	7%	-12%	-12%	10%	8%	8%	-10%	-9%
1	Nervous System	2%	-1%	-2%	-17%	-15%	2%	-1%	-2%	-17%	-15%
2	Eye	-4%	-2%	5%	11%	10%	-5%	-3%	1%	5%	5%
3	Ear, Nose, Mouth And Throat	0%	-2%	-2%	-5%	-5%	0%	-1%	-1%	-11%	-11%
4	Respiratory System	3%	3%	1%	-10%	-10%	-1%	0%	-2%	-17%	-17%
5	Circulatory System	7%	-1%	-2%	-17%	-10%	7%	-1%	-2%	-17%	-9%
6	Digestive System	1%	2%	2%	-7%	-7%	0%	1%	0%	-9%	-9%
7	Hepatobiliary System And Pancreas	3%	0%	0%	-6%	-6%	2%	-1%	-1%	-8%	-8%
8	Musculoskeletal System And Connective Tissue	-2%	-4%	-6%	-10%	-6%	-2%	-4%	-5%	-11%	-6%
9	Skin, Subcutaneous Tissue And Breast	0%	-1%	0%	8%	5%	1%	-1%	-1%	1%	-1%
10	Endocrine, Nutritional And Metabolic System	4%	0%	0%	-2%	-2%	6%	-1%	-1%	-11%	-9%
11	Kidney And Urinary Tract	4%	1%	0%	-2%	-2%	4%	0%	0%	-5%	-4%
12	Male Reproductive System	-3%	-5%	-5%	-1%	-2%	-3%	-5%	-5%	-4%	-5%
13	Female Reproductive System	-2%	-3%	-4%	-3%	-4%	-2%	-4%	-5%	-7%	-8%
14	Pregnancy, Childbirth And Puerperium	-11%	-3%	0%	21%	15%	-11%	-4%	0%	16%	10%
16	Blood and Blood Forming Organs and Immunological Disorders	7%	6%	6%	2%	2%	4%	4%	3%	-6%	-5%
17	Myeloproliferative DDs (Poorly Differentiated Neoplasms)	8%	6%	5%	1%	1%	6%	3%	2%	-4%	-4%
18	Infectious and Parasitic DDs	8%	7%	7%	1%	0%	7%	6%	6%	-2%	-3%
19	Mental Diseases and Disorders	-3%	4%	5%	7%	5%	-2%	6%	6%	6%	4%
20	Alcohol/Drug Use or Induced Mental Disorders	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
21	Injuries, Poison And Toxic Effect of Drugs	5%	6%	5%	4%	3%	2%	3%	3%	-2%	-2%
22	Burns	8%	9%	13%	1%	-1%	7%	9%	14%	1%	0%
23	Factors Influencing Health Status	0%	2%	2%	9%	10%	0%	0%	0%	-1%	2%
24	Multiple Significant Trauma	5%	5%	7%	-9%	-7%	5%	6%	8%	-8%	-6%
25	Human Immunodeficiency Virus Infection	19%	7%	9%	4%	4%	NA	NA	NA	NA	NA
NA	O.R. Procedure Unrelated to Principal Diagnosis	6%	3%	2%	-5%	-4%	5%	3%	2%	-6%	-5%

Appendix A

Comparative Cost Margins in THEORI Models

MDC	Description	Cost Margins 1 M'care Standard Charges	2 M'care Standard Cost	3 M'care HSRV Cost	4 M'care HSRVcc GM CCR	5 M'care HSRVcc Agg. CCR	6 CS Standard Charges	7 CS Standard Cost	8 CS HSRV Cost	9 CS HSRVcc GM CCR	10 CS HSRVcc Agg. CCR
	Medical DRGs by Major Diagnostic Category:										
PRE	Transplants and Tracheostomies	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
1	Nervous System	-6%	-4%	-4%	5%	1%	-6%	-4%	-4%	5%	2%
2	Eye	-5%	-5%	-4%	20%	16%	-6%	-5%	-4%	21%	17%
3	Ear, Nose, Mouth And Throat	-8%	-5%	-4%	15%	11%	-7%	-4%	-4%	15%	11%
4	Respiratory System	-8%	-3%	-2%	3%	-1%	-7%	-3%	-2%	3%	0%
5	Circulatory System	-7%	-5%	-4%	1%	-1%	-6%	-4%	-4%	2%	0%
6	Digestive System	-7%	-4%	-4%	11%	7%	-7%	-4%	-4%	11%	7%
7	Hepatobiliary System And Pancreas	-3%	-2%	-1%	13%	9%	-2%	-2%	-1%	11%	7%
8	Musculoskeletal System And Connective Tissue	-10%	-4%	-4%	19%	13%	-9%	-4%	-4%	16%	10%
9	Skin, Subcutaneous Tissue And Breast	-11%	-5%	-3%	26%	19%	-9%	-4%	-3%	24%	18%
10	Endocrine, Nutritional And Metabolic System	-10%	-4%	-3%	16%	11%	-9%	-4%	-3%	15%	10%
11	Kidney And Urinary Tract	-7%	-3%	-2%	14%	9%	-6%	-3%	-2%	14%	9%
12	Male Reproductive System	-8%	-5%	-4%	24%	19%	-7%	-4%	-3%	22%	17%
13	Female Reproductive System	-4%	-3%	-2%	21%	17%	-3%	-2%	-2%	18%	14%
14	Pregnancy, Childbirth And Puerperium	-14%	-4%	1%	40%	32%	-17%	-5%	-1%	30%	23%
16	Blood and Blood Forming Organs and Immunological Disorders	-4%	-2%	0%	19%	15%	-3%	-1%	0%	18%	15%
17	Myeloproliferative DDs (Poorly Differentiated Neoplasms)	6%	5%	4%	18%	16%	6%	5%	4%	16%	14%
18	Infectious and Parasitic DDs	-2%	0%	1%	7%	4%	0%	1%	2%	7%	4%
19	Mental Diseases and Disorders	-26%	-4%	2%	45%	31%	-25%	-4%	1%	45%	31%
20	Alcohol/Drug Use or Induced Mental Disorders	-20%	-4%	5%	40%	30%	-20%	-4%	3%	36%	27%
21	Injuries, Poison And Toxic Effect of Drugs	-6%	-2%	-2%	11%	8%	-7%	-3%	-2%	9%	6%
22	Burns	-3%	4%	8%	24%	20%	-2%	4%	8%	24%	19%
23	Factors Influencing Health Status	-22%	-5%	-3%	17%	10%	-22%	-4%	-3%	18%	12%
24	Multiple Significant Trauma	-2%	2%	3%	-5%	-6%	-1%	2%	4%	-4%	-5%
25	Human Immunodeficiency Virus Infection	13%	5%	8%	20%	17%	13%	5%	8%	17%	14%
NA	O.R. Procedure Unrelated to Principal Diagnosis	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Appendix A

Comparative Payment Accuracy in THEORI Models

MDC	Description	Percent of IPPS Payments in Cost Margin Target Range									
		1 M'care Standard Charges	2 M'care Standard Cost	3 M'care HSRV Cost	4 M'care HSRVcc GM CCR	5 M'care HSRVcc Agg. CCR	6 CS Standard Charges	7 CS Standard Cost	8 CS HSRV Cost	9 CS HSRVcc GM CCR	10 CS HSRVcc Agg. CCR
	All DRGs	40%	84%	81%	15%	33%	35%	79%	72%	17%	33%
	High-Cost DRGs	39%	85%	82%	14%	33%	34%	79%	71%	16%	34%
	Low-Cost DRGs	51%	79%	79%	24%	33%	48%	83%	82%	21%	28%
	Surgical DRGs	43%	73%	72%	19%	39%	43%	72%	61%	15%	36%
	Medical DRGs	36%	96%	91%	11%	28%	27%	86%	82%	18%	31%
	All DRGs by Major Diagnostic Category:										
PRE	Transplants and Tracheostomies	3%	2%	2%	3%	4%	1%	1%	1%	3%	4%
1	Nervous System	56%	94%	95%	36%	40%	46%	84%	81%	25%	36%
2	Eye	76%	100%	73%	0%	0%	70%	95%	82%	13%	14%
3	Ear, Nose, Mouth And Throat	63%	100%	100%	13%	14%	70%	89%	85%	15%	13%
4	Respiratory System	30%	100%	82%	12%	27%	35%	91%	90%	20%	33%
5	Circulatory System	23%	96%	97%	8%	34%	25%	87%	83%	9%	35%
6	Digestive System	53%	63%	92%	24%	24%	37%	74%	78%	17%	21%
7	Hepatobiliary System And Pancreas	83%	87%	88%	29%	34%	72%	74%	78%	19%	18%
8	Musculoskeletal System And Connective Tissue	74%	94%	53%	8%	52%	64%	89%	45%	12%	44%
9	Skin, Subcutaneous Tissue And Breast	35%	100%	100%	5%	8%	32%	90%	86%	9%	19%
10	Endocrine, Nutritional And Metabolic System	10%	99%	97%	4%	9%	8%	96%	85%	11%	21%
11	Kidney And Urinary Tract	55%	95%	100%	4%	6%	25%	80%	80%	29%	31%
12	Male Reproductive System	86%	100%	87%	18%	14%	81%	95%	79%	34%	52%
13	Female Reproductive System	89%	89%	94%	64%	64%	83%	75%	55%	22%	20%
14	Pregnancy, Childbirth And Puerperium	4%	95%	81%	0%	0%	7%	95%	81%	0%	1%
16	Blood and Blood Forming Organs and Immunological Disorders	73%	75%	75%	4%	4%	36%	81%	81%	5%	5%
17	Myeloproliferative DDs (Poorly Differentiated Neoplasms)	31%	51%	51%	10%	18%	36%	49%	57%	15%	17%
18	Infectious and Parasitic DDs	60%	67%	67%	28%	87%	30%	49%	49%	47%	75%
19	Mental Diseases and Disorders	3%	97%	32%	0%	0%	4%	99%	41%	1%	1%
20	Alcohol/Drug Use or Induced Mental Disorders	0%	90%	65%	0%	0%	7%	94%	36%	0%	0%
21	Injuries, Poison And Toxic Effect of Drugs	35%	55%	58%	31%	54%	37%	54%	73%	54%	57%
22	Burns	24%	31%	6%	59%	60%	29%	31%	7%	46%	60%
23	Factors Influencing Health Status	11%	96%	100%	0%	0%	12%	93%	82%	7%	2%
24	Multiple Significant Trauma	55%	25%	0%	26%	93%	43%	49%	26%	57%	57%
25	Human Immunodeficiency Virus Infection	0%	16%	16%	0%	0%	1%	31%	14%	0%	0%
NA	O.R. Procedure Unrelated to Principal Diagnosis	25%	25%	100%	100%	100%	29%	62%	62%	43%	78%

Appendix A		Comparative Payment Accuracy in THEORI Models									
		Percent of IPPS Payments in Cost Margin Target Range									
		1	2	3	4	5	6	7	8	9	10
MDC	Description	M'care Standard Charges	M'care Standard Cost	M'care HSRV Cost	M'care HSRVcc GM CCR	M'care HSRVcc Agg. CCR	CS Standard Charges	CS Standard Cost	CS HSRV Cost	CS HSRVcc GM CCR	CS HSRVcc Agg. CCR
	Surgical DRGs by Major Diagnostic Category:										
PRE	Transplants and Tracheostomies	3%	2%	2%	3%	4%	1%	1%	1%	3%	4%
1	Nervous System	79%	80%	87%	17%	25%	72%	71%	68%	5%	10%
2	Eye	75%	100%	45%	0%	0%	63%	95%	67%	32%	31%
3	Ear, Nose, Mouth And Throat	78%	100%	100%	63%	62%	86%	83%	72%	37%	29%
4	Respiratory System	51%	100%	100%	53%	52%	68%	74%	74%	0%	0%
5	Circulatory System	19%	97%	97%	5%	28%	27%	85%	84%	2%	31%
6	Digestive System	76%	26%	85%	18%	16%	45%	70%	68%	15%	15%
7	Hepatobiliary System And Pancreas	68%	75%	77%	62%	71%	74%	66%	76%	22%	20%
8	Musculoskeletal System And Connective Tissue	83%	95%	46%	10%	62%	72%	90%	42%	13%	51%
9	Skin, Subcutaneous Tissue And Breast	84%	100%	100%	16%	23%	81%	82%	66%	40%	62%
10	Endocrine, Nutritional And Metabolic System	41%	99%	86%	21%	48%	45%	71%	63%	31%	31%
11	Kidney And Urinary Tract	44%	87%	99%	15%	19%	40%	72%	71%	69%	75%
12	Male Reproductive System	90%	100%	85%	21%	17%	87%	95%	75%	42%	62%
13	Female Reproductive System	88%	88%	93%	73%	73%	85%	74%	51%	26%	23%
14	Pregnancy, Childbirth And Puerperium	4%	96%	96%	0%	0%	14%	91%	77%	0%	3%
16	Blood and Blood Forming Organs and Immunological Disorders	0%	0%	0%	54%	54%	42%	49%	49%	94%	92%
17	Myeloproliferative DDs (Poorly Differentiated Neoplasms)	8%	7%	7%	44%	81%	36%	37%	70%	61%	67%
18	Infectious and Parasitic DDs	0%	0%	0%	100%	100%	13%	16%	16%	88%	100%
19	Mental Diseases and Disorders	100%	0%	0%	0%	0%	90%	37%	37%	7%	8%
20	Alcohol/Drug Use or Induced Mental Disorders	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
21	Injuries, Poison And Toxic Effect of Drugs	22%	6%	6%	75%	76%	71%	40%	71%	100%	100%
22	Burns	0%	7%	7%	100%	100%	17%	20%	2%	78%	100%
23	Factors Influencing Health Status	100%	100%	100%	0%	0%	100%	94%	94%	100%	21%
24	Multiple Significant Trauma	41%	0%	0%	0%	91%	43%	43%	12%	54%	54%
25	Human Immunodeficiency Virus Infection	0%	0%	0%	0%	0%	NA	NA	NA	NA	NA
NA	O.R. Procedure Unrelated to Principal Diagnosis	25%	25%	100%	100%	100%	29%	62%	62%	43%	78%

Appendix A		Comparative Payment Accuracy in THEORI Models									
		Percent of IPPS Payments in Cost Margin Target Range									
		1	2	3	4	5	6	7	8	9	10
		M'care	M'care	M'care	M'care	M'care	CS	CS	CS	CS	CS
		Standard	Standard	HSRV	HSRVcc	HSRVcc	Standard	Standard	HSRV	HSRVcc	HSRVcc
MDC	Description	Charges	Cost	Cost	GM CCR	Agg. CCR	Charges	Cost	Cost	GM CCR	Agg. CCR
	Medical DRGs by Major Diagnostic Category:										
PRE	Transplants and Tracheostomies	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
1	Nervous System	46%	100%	99%	42%	46%	35%	89%	86%	31%	45%
2	Eye	77%	100%	100%	0%	0%	76%	95%	95%	0%	0%
3	Ear, Nose, Mouth And Throat	57%	100%	100%	0%	1%	61%	92%	92%	6%	7%
4	Respiratory System	27%	100%	79%	8%	24%	32%	92%	91%	21%	35%
5	Circulatory System	30%	94%	96%	11%	43%	22%	90%	81%	16%	41%
6	Digestive System	29%	100%	100%	29%	31%	28%	78%	88%	19%	25%
7	Hepatobiliary System And Pancreas	100%	100%	100%	0%	0%	69%	81%	81%	16%	16%
8	Musculoskeletal System And Connective Tissue	13%	91%	93%	0%	0%	16%	86%	60%	8%	8%
9	Skin, Subcutaneous Tissue And Breast	0%	100%	100%	0%	0%	13%	92%	93%	0%	6%
10	Endocrine, Nutritional And Metabolic System	0%	99%	100%	0%	0%	0%	100%	89%	9%	20%
11	Kidney And Urinary Tract	61%	99%	100%	0%	0%	17%	85%	85%	13%	13%
12	Male Reproductive System	62%	100%	100%	0%	0%	48%	99%	100%	0%	7%
13	Female Reproductive System	100%	100%	100%	0%	0%	62%	85%	85%	0%	0%
14	Pregnancy, Childbirth And Puerperium	4%	95%	69%	0%	0%	0%	97%	85%	0%	0%
16	Blood and Blood Forming Organs and Immunological Disorders	80%	82%	82%	0%	0%	36%	83%	83%	0%	0%
17	Myeloproliferative DDs (Poorly Differentiated Neoplasms)	40%	66%	66%	0%	0%	36%	52%	53%	4%	4%
18	Infectious and Parasitic DDs	87%	96%	96%	0%	83%	36%	60%	60%	35%	67%
19	Mental Diseases and Disorders	0%	100%	33%	0%	0%	1%	100%	41%	1%	1%
20	Alcohol/Drug Use or Induced Mental Disorders	0%	90%	65%	0%	0%	7%	94%	36%	0%	0%
21	Injuries, Poison And Toxic Effect of Drugs	47%	96%	100%	0%	38%	17%	62%	73%	32%	36%
22	Burns	72%	76%	3%	0%	0%	55%	53%	17%	0%	0%
23	Factors Influencing Health Status	0%	96%	100%	0%	0%	1%	93%	81%	0%	0%
24	Multiple Significant Trauma	100%	100%	0%	100%	100%	44%	64%	63%	67%	66%
25	Human Immunodeficiency Virus Infection	0%	17%	17%	0%	0%	1%	31%	14%	0%	0%
NA	O.R. Procedure Unrelated to Principal Diagnosis	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Appendix A		THEORI Models Ranked by Payment Accuracy									
		Model Rank Based on Percent of IPPS Payments in Cost Margin Target Range									
		1	2	3	4	5	6	7	8	9	10
		M'care	M'care	M'care	M'care	M'care	CS	CS	CS	CS	CS
		Standard	Standard	HSRV	HSRVcc	HSRVcc	Standard	Standard	HSRV	HSRVcc	HSRVcc
MDC	Description	Charges	Cost	Cost	GM CCR	Agg. CCR	Charges	Cost	Cost	GM CCR	Agg. CCR
	All DRGs	5	1	2	10	8	6	3	4	9	7
	High-Cost DRGs	5	1	2	10	8	7	3	4	9	6
	Low-Cost DRGs	5	3	4	9	7	6	1	2	10	8
	Surgical DRGs	5	1	3	9	7	6	2	4	10	8
	Medical DRGs	5	1	2	10	7	8	3	4	9	6
	All DRGs by Major Diagnostic Category:										
PRE	Transplants and Tracheostomies	4	7	6	3	2	8	9	10	5	1
1	Nervous System	5	2	1	9	7	6	3	4	10	8
2	Eye	4	1	5	9	9	6	2	3	8	7
3	Ear, Nose, Mouth And Throat	6	2	1	9	8	5	3	4	7	10
4	Respiratory System	7	1	4	10	8	5	2	3	9	6
5	Circulatory System	8	2	1	10	6	7	3	4	9	5
6	Digestive System	5	4	1	8	7	6	3	2	10	9
7	Hepatobiliary System And Pancreas	3	2	1	8	7	6	5	4	9	10
8	Musculoskeletal System And Connective Tissue	3	1	5	10	6	4	2	7	9	8
9	Skin, Subcutaneous Tissue And Breast	5	2	1	10	9	6	3	4	8	7
10	Endocrine, Nutritional And Metabolic System	7	1	2	10	8	9	3	4	6	5
11	Kidney And Urinary Tract	5	2	1	10	9	8	3	4	7	6
12	Male Reproductive System	4	1	3	9	10	5	2	6	8	7
13	Female Reproductive System	2	3	1	7	6	4	5	8	9	10
14	Pregnancy, Childbirth And Puerperium	6	1	4	8	8	5	2	3	8	7
16	Blood and Blood Forming Organs and Immunological Disorders	5	4	3	10	9	6	2	1	8	7
17	Myeloproliferative DDs (Poorly Differentiated Neoplasms)	6	2	3	10	7	5	4	1	9	8
18	Infectious and Parasitic DDs	5	4	3	10	1	9	7	6	8	2
19	Mental Diseases and Disorders	6	2	4	9	9	5	1	3	8	7
20	Alcohol/Drug Use or Induced Mental Disorders	6	2	3	6	6	5	1	4	6	6
21	Injuries, Poison And Toxic Effect of Drugs	9	4	2	10	6	8	7	1	5	3
22	Burns	8	6	10	3	2	7	5	9	4	1
23	Factors Influencing Health Status	6	2	1	9	9	5	3	4	7	8
24	Multiple Significant Trauma	4	9	10	7	1	6	5	8	2	3
25	Human Immunodeficiency Virus Infection	6	3	2	6	6	5	1	4	6	6
NA	O.R. Procedure Unrelated to Principal Diagnosis	10	9	1	1	1	8	5	6	7	4

Appendix A		THEORI Models Ranked by Payment Accuracy									
		Model Rank Based on Percent of IPPS Payments in Cost Margin Target Range									
		1	2	3	4	5	6	7	8	9	10
		M'care	M'care	M'care	M'care	M'care	CS	CS	CS	CS	CS
		Standard	Standard	HSRV	HSRVcc	HSRVcc	Standard	Standard	HSRV	HSRVcc	HSRVcc
MDC	Description	Charges	Cost	Cost	GM CCR	Agg. CCR	Charges	Cost	Cost	GM CCR	Agg. CCR
	Surgical DRGs by Major Diagnostic Category:										
PRE	Transplants and Tracheostomies	4	7	6	3	2	8	9	10	5	1
1	Nervous System	3	2	1	8	7	4	5	6	10	9
2	Eye	3	1	6	9	9	5	2	4	7	8
3	Ear, Nose, Mouth And Throat	5	1	1	7	8	3	4	6	9	10
4	Respiratory System	8	1	1	6	7	5	3	4	9	9
5	Circulatory System	8	1	2	9	6	7	3	4	10	5
6	Digestive System	2	6	1	7	8	5	3	4	9	10
7	Hepatobiliary System And Pancreas	6	3	1	8	5	4	7	2	9	10
8	Musculoskeletal System And Connective Tissue	3	1	7	10	5	4	2	8	9	6
9	Skin, Subcutaneous Tissue And Breast	3	1	1	10	9	5	4	6	8	7
10	Endocrine, Nutritional And Metabolic System	7	1	2	10	5	6	3	4	8	9
11	Kidney And Urinary Tract	7	2	1	10	9	8	4	5	6	3
12	Male Reproductive System	3	1	5	9	10	4	2	6	8	7
13	Female Reproductive System	2	3	1	7	6	4	5	8	9	10
14	Pregnancy, Childbirth And Puerperium	6	2	1	8	8	5	3	4	8	7
16	Blood and Blood Forming Organs and Immunological Disorders	8	8	8	4	3	7	6	5	1	2
17	Myeloproliferative DDs (Poorly Differentiated Neoplasms)	8	9	10	5	1	7	6	2	4	3
18	Infectious and Parasitic DDs	8	8	8	1	1	7	5	6	4	1
19	Mental Diseases and Disorders	1	7	7	7	7	2	4	3	6	5
20	Alcohol/Drug Use or Induced Mental Disorders	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
21	Injuries, Poison And Toxic Effect of Drugs	8	10	9	4	3	6	7	5	1	1
22	Burns	10	8	7	1	1	6	5	9	4	1
23	Factors Influencing Health Status	1	1	1	9	9	1	7	6	1	8
24	Multiple Significant Trauma	6	8	8	8	1	5	4	7	3	2
25	Human Immunodeficiency Virus Infection	1	1	1	1	1	NA	NA	NA	NA	NA
NA	O.R. Procedure Unrelated to Principal Diagnosis	10	9	1	1	1	8	5	6	7	4

Appendix A

THEORI Models Ranked by Payment Accuracy

MDC	Description	Model Rank Based on Percent of IPPS Payments in Cost Margin Target Range									
		1	2	3	4	5	6	7	8	9	10
		M'care Standard Charges	M'care Standard Cost	M'care HSRV Cost	M'care HSRVcc GM CCR	M'care HSRVcc Agg. CCR	CS Standard Charges	CS Standard Cost	CS HSRV Cost	CS HSRVcc GM CCR	CS HSRVcc Agg. CCR
	Medical DRGs by Major Diagnostic Category:										
PRE	Transplants and Tracheostomies	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
1	Nervous System	6	1	2	8	5	9	3	4	10	7
2	Eye	5	1	1	7	7	6	3	4	7	7
3	Ear, Nose, Mouth And Throat	6	2	1	10	9	5	4	3	8	7
4	Respiratory System	7	1	4	10	8	6	2	3	9	5
5	Circulatory System	7	2	1	10	5	8	3	4	9	6
6	Digestive System	7	2	1	6	5	8	4	3	10	9
7	Hepatobiliary System And Pancreas	1	1	1	9	9	6	5	4	8	7
8	Musculoskeletal System And Connective Tissue	6	2	1	9	9	5	3	4	8	7
9	Skin, Subcutaneous Tissue And Breast	7	2	1	7	7	5	4	3	7	6
10	Endocrine, Nutritional And Metabolic System	7	3	2	9	9	8	1	4	6	5
11	Kidney And Urinary Tract	5	2	1	9	9	6	4	3	8	7
12	Male Reproductive System	5	1	1	8	8	6	4	1	8	7
13	Female Reproductive System	1	1	1	7	7	6	5	4	7	7
14	Pregnancy, Childbirth And Puerperium	5	2	4	6	6	6	1	3	6	6
16	Blood and Blood Forming Organs and Immunological Disorders	5	4	3	7	7	6	2	1	7	7
17	Myeloproliferative DDs (Poorly Differentiated Neoplasms)	5	1	2	9	9	6	4	3	8	7
18	Infectious and Parasitic DDs	3	2	1	10	4	8	7	6	9	5
19	Mental Diseases and Disorders	8	1	4	8	8	5	1	3	7	6
20	Alcohol/Drug Use or Induced Mental Disorders	6	2	3	6	6	5	1	4	6	6
21	Injuries, Poison And Toxic Effect of Drugs	5	2	1	10	6	9	4	3	8	7
22	Burns	2	1	6	7	7	3	4	5	7	7
23	Factors Influencing Health Status	6	2	1	6	6	5	3	4	6	6
24	Multiple Significant Trauma	1	1	10	1	1	9	7	8	5	6
25	Human Immunodeficiency Virus Infection	6	3	2	6	6	5	1	4	6	6
NA	O.R. Procedure Unrelated to Principal Diagnosis	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Appendix B. Comparative Cost Margins in THEORI Models Based on Medicare DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 1 Standard Charges	2 Standard Cost	3 HSRV Cost	4 HSRVcc GM CCR	5 HSRVcc Agg. CCR
1	Craniotomy Age >17 w CC	21,549	456	1%	1%	0%	-22%	-20%
2	Craniotomy Age >17 w/o CC	9,400	120	-3%	-4%	-5%	-25%	-20%
6	Carpal Tunnel Release	371	2	-7%	-4%	-6%	6%	4%
7	Periph & Cranial Nerve & Other Nerv Syst Proc w CC	14,132	217	4%	1%	0%	-1%	-1%
8	Periph & Cranial Nerve & Other Nerv Syst Proc w/o CC	3,139	30	-1%	-5%	-5%	-7%	0%
9	Spinal Disorders & Injuries	1,725	15	-3%	-2%	-2%	4%	1%
10	Nervous System Neoplasms w CC	17,800	132	-6%	-4%	-6%	6%	3%
11	Nervous System Neoplasms w/o CC	2,948	15	-5%	-7%	-8%	11%	9%
12	Degenerative Nervous System Disorders	49,748	281	-10%	-3%	-4%	17%	11%
13	Multiple Sclerosis & Cerebellar Ataxia	6,332	35	-7%	-2%	-3%	27%	21%
14	Intracranial Hemorrhage or Cerebral Infarction	215,992	1,621	-8%	-4%	-4%	-1%	-4%
15	Nonspecific CVA & Precerebral Occlusion w/o Infarct	67,526	376	-9%	-6%	-4%	7%	4%
16	Nonspecific Cerebrovascular Disorders w CC	15,100	116	-4%	-3%	-3%	5%	1%
17	Nonspecific Cerebrovascular Disorders w/o CC	2,718	11	-3%	-6%	-7%	11%	8%
18	Cranial & Peripheral Nerve Disorders w CC	29,785	181	-6%	-3%	-3%	15%	11%
19	Cranial & Peripheral Nerve Disorders w/o CC	7,642	32	-4%	-5%	-4%	18%	15%
20	Nervous System Infection Except Viral Meningitis	5,906	95	2%	2%	2%	0%	-1%
21	Viral Meningitis	1,986	18	-3%	-1%	-1%	7%	4%
22	Hypertensive Encephalopathy	3,034	22	-10%	-5%	-3%	-4%	-6%
23	Nontraumatic Stupor & Coma	9,451	46	-8%	-5%	-4%	11%	7%
24	Seizure & Headache Age >17 w CC	57,731	353	-4%	-3%	-1%	8%	4%
25	Seizure & Headache Age >17 w/o CC	24,925	97	-7%	-6%	-4%	17%	13%
27	Traumatic Stupor & Coma, Coma >1 Hr	4,866	44	-1%	0%	2%	-3%	-4%
28	Traumatic Stupor & Coma, Coma <1 Hr Age >17 w CC	16,148	135	-5%	-3%	-3%	-7%	-9%
29	Traumatic Stupor & Coma, Coma <1 Hr Age >17 w/o CC	5,648	26	-9%	-7%	-7%	1%	-2%
31	Concussion Age >17 w CC	4,424	25	-1%	-4%	-2%	7%	5%
32	Concussion Age >17 w/o CC	1,642	6	0%	-6%	-4%	9%	7%
34	Other Disorders of Nervous System w CC	24,246	147	-4%	-3%	-3%	11%	7%
35	Other Disorders of Nervous System w/o CC	6,856	27	-7%	-6%	-6%	17%	14%
36	Retinal Procedures	1,368	6	-5%	-3%	12%	8%	10%
37	Orbital Procedures	1,138	9	1%	-1%	1%	6%	5%
38	Primary Iris Procedures	52	0	1%	-1%	2%	32%	28%
39	Lens Procedures with or without Vitrectomy	413	2	-1%	-2%	9%	17%	19%
40	Extraocular Procedures Except Orbit Age >17	1,256	9	-10%	-3%	5%	12%	11%
42	Intraocular Procedures Except Retina, Iris & Lens	1,071	6	-3%	-3%	3%	15%	15%
43	Hyphema	108	0	0%	-2%	1%	37%	33%
44	Acute Major Eye Infections	1,045	5	-11%	-5%	-1%	35%	28%
45	Neurological Eye Disorders	2,504	11	-1%	-5%	-6%	10%	8%
46	Other Disorders of the Eye Age >17 w CC	3,440	16	-6%	-4%	-3%	20%	15%
47	Other Disorders of the Eye Age >17 w/o CC	1,178	4	-8%	-6%	-4%	26%	23%

Appendix B. Comparative Cost Margins in THEORI Models Based on Medicare DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 1 Standard Charges	2 Standard Cost	3 HSRV Cost	4 HSRVcc GM CCR	5 HSRVcc Agg. CCR
49	Major Head & Neck Procedures	2,292	26	-3%	-2%	-3%	-16%	-14%
50	Sialoadenectomy	1,991	10	3%	-5%	-5%	-13%	-12%
51	Salivary Gland Procedures Except Sialoadenectomy	178	1	2%	-4%	-2%	-2%	-3%
52	Cleft Lip & Palate Repair	284	1	11%	-1%	-3%	-10%	-10%
53	Sinus & Mastoid Procedures Age >17	2,017	16	3%	-1%	-2%	-4%	-4%
55	Miscellaneous Ear, Nose, Mouth & Throat Procedures	1,244	8	-1%	-1%	-2%	-1%	-1%
56	Rhinoplasty	387	2	-6%	-6%	-5%	-6%	-6%
57	T&A Proc, Except Tonsillectomy &/or Adenoidectomy Only, Age >17	803	5	4%	2%	3%	6%	5%
59	Tonsillectomy &/or Adenoidectomy Only, Age >17	98	0	1%	-3%	-5%	1%	-1%
61	Myringotomy w Tube Insertion Age >17	206	2	-1%	0%	0%	7%	5%
63	Other Ear, Nose, Mouth & Throat O.R. Procedures	2,584	23	2%	0%	0%	1%	1%
64	Ear, Nose, Mouth & Throat Malignancy	2,975	23	-4%	-1%	0%	14%	11%
65	Dysequilibrium	37,229	131	-4%	-6%	-6%	11%	8%
66	Epistaxis	7,278	28	-11%	-5%	-5%	25%	21%
67	Epiglottitis	367	2	-17%	-4%	-4%	-3%	-5%
68	Otitis Media & URI Age >17 w CC	15,367	67	-15%	-4%	-4%	18%	12%
69	Otitis Media & URI Age >17 w/o CC	4,082	13	-16%	-6%	-3%	23%	18%
71	Laryngotracheitis	58	0	-14%	-7%	-10%	5%	1%
72	Nasal Trauma & Deformity	947	4	-3%	-4%	-4%	14%	11%
73	Other Ear, Nose, Mouth & Throat Diagnoses Age >17	8,597	45	-8%	-5%	-4%	15%	11%
75	Major Chest Procedures	41,539	769	2%	3%	1%	-17%	-16%
76	Other Resp System O.R. Procedures w CC	44,087	717	4%	3%	1%	-3%	-4%
77	Other Resp System O.R. Procedures w/o CC	1,932	14	-3%	-4%	-5%	-2%	-3%
78	Pulmonary Embolism	41,715	327	-14%	-5%	-7%	-1%	-5%
79	Respiratory Infections & Inflammations Age >17 w CC	155,805	1,495	-8%	-4%	-3%	4%	0%
80	Respiratory Infections & Inflammations Age >17 w/o CC	6,585	38	-15%	-6%	-5%	13%	7%
82	Respiratory Neoplasms	59,623	496	-5%	-3%	-4%	5%	2%
83	Major Chest Trauma w CC	6,047	37	-12%	-4%	-4%	6%	1%
84	Major Chest Trauma w/o CC	1,147	4	-8%	-4%	-4%	16%	11%
85	Pleural Effusion w CC	19,870	151	-9%	-4%	-4%	6%	2%
86	Pleural Effusion w/o CC	1,600	7	-9%	-6%	-5%	13%	9%
87	Pulmonary Edema & Respiratory Failure	75,901	640	-11%	-4%	-4%	-5%	-8%
88	Chronic Obstructive Pulmonary Disease	369,719	2,003	-12%	-6%	-4%	10%	5%
89	Simple Pneumonia & Pleurisy Age >17 w CC	493,648	3,145	-12%	-5%	-4%	9%	4%
90	Simple Pneumonia & Pleurisy Age >17 w/o CC	38,345	150	-15%	-6%	-5%	18%	12%
91	Simple Pneumonia & Pleurisy Age 0-17	39	0	-15%	-15%	-12%	4%	0%
92	Interstitial Lung Disease w CC	15,023	111	-10%	-4%	-4%	5%	0%
93	Interstitial Lung Disease w/o CC	1,323	6	-12%	-5%	-6%	14%	10%
94	Pneumothorax w CC	12,000	89	-14%	-4%	-4%	5%	1%
95	Pneumothorax w/o CC	1,427	6	-18%	-5%	-4%	18%	13%

Appendix B. Comparative Cost Margins in THEORI Models Based on Medicare DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 1 Standard Charges	2 Standard Cost	3 HSRV Cost	4 HSRVcc GM CCR	5 HSRVcc Agg. CCR
96	Bronchitis & Asthma Age >17 w CC	52,725	238	-12%	-6%	-3%	15%	10%
97	Bronchitis & Asthma Age >17 w/o CC	22,824	77	-12%	-6%	-1%	21%	15%
99	Respiratory Signs & Symptoms w CC	19,128	84	-8%	-5%	-5%	7%	5%
100	Respiratory Signs & Symptoms w/o CC	5,934	19	-5%	-6%	-6%	8%	8%
101	Other Respiratory System Diagnoses w CC	20,594	112	-9%	-5%	-4%	9%	5%
102	Other Respiratory System Diagnoses w/o CC	4,450	15	-6%	-5%	-2%	18%	16%
103	Heart Transplant or Implant of Heart Assist System	651	86	19%	18%	15%	0%	3%
104	Cardiac Valve & Oth Major Cardiothoracic Proc w Card Cath	19,555	866	9%	3%	1%	-19%	-14%
105	Cardiac Valve & Oth Major Cardiothoracic Proc w/o Card Cath	29,243	997	6%	2%	0%	-20%	-15%
106	Coronary Bypass w PTCA	3,236	123	9%	2%	0%	-21%	-16%
108	Other Cardiothoracic Procedures	7,682	254	8%	3%	1%	-20%	-16%
110	Major Cardiovascular Procedures w CC	52,822	1,207	6%	3%	2%	-16%	-11%
111	Major Cardiovascular Procedures w/o CC	9,132	130	1%	-4%	-6%	-22%	-12%
113	Amputation for Circ System Disorders Except Upper Limb & Toe	34,221	582	2%	2%	3%	-2%	-3%
114	Upper Limb & Toe Amputation for Circ System Disorders	7,732	77	-2%	-1%	0%	11%	6%
117	Cardiac Pacemaker Revision Except Device Replacement	4,855	38	-1%	-2%	-3%	-6%	-4%
118	Cardiac Pacemaker Device Replacement	7,119	63	7%	-4%	-4%	-6%	5%
119	Vein Ligation & Stripping	917	8	1%	2%	3%	8%	7%
120	Other Circulatory System O.R. Procedures	33,335	449	9%	4%	4%	5%	4%
121	Circulatory Disorders w AMI & Major Comp, Discharged Alive	143,188	1,365	-9%	-4%	-3%	-12%	-13%
122	Circulatory Disorders w AMI w/o Major Comp, Discharged Alive	52,278	306	-11%	-8%	-6%	-9%	-9%
123	Circulatory Disorders w AMI, Expired	30,820	282	1%	0%	1%	-7%	-7%
124	Circulatory Disorders Except AMI, w Card Cath & Complex Diag	119,063	955	1%	-5%	-5%	-11%	-8%
125	Circulatory Disorders Except AMI, w Card Cath w/o Complex Diag	86,579	499	5%	-6%	-7%	-14%	-9%
126	Acute & Subacute Endocarditis	5,302	84	0%	0%	-1%	-2%	-4%
127	Heart Failure & Shock	629,848	4,000	-9%	-4%	-3%	4%	0%
128	Deep Vein Thrombophlebitis	4,633	22	-19%	-7%	-4%	29%	22%
129	Cardiac Arrest, Unexplained	3,370	21	-2%	-1%	-1%	-6%	-6%
130	Peripheral Vascular Disorders w CC	80,889	473	-10%	-5%	-4%	19%	14%
131	Peripheral Vascular Disorders w/o CC	21,198	77	-17%	-6%	-5%	30%	24%
132	Atherosclerosis w CC	103,356	387	-10%	-7%	-3%	9%	6%
133	Atherosclerosis w/o CC	6,132	20	-5%	-6%	-4%	12%	12%
134	Hypertension	37,403	140	-8%	-6%	-3%	13%	9%
135	Cardiac Congenital & Valvular Disorders Age >17 w CC	6,760	38	-9%	-4%	-4%	6%	3%
136	Cardiac Congenital & Valvular Disorders Age >17 w/o CC	1,015	4	-2%	-6%	-6%	14%	12%
138	Cardiac Arrhythmia & Conduction Disorders w CC	187,300	971	-11%	-5%	-5%	3%	0%
139	Cardiac Arrhythmia & Conduction Disorders w/o CC	69,847	226	-11%	-7%	-6%	8%	6%
140	Angina Pectoris	31,908	102	-15%	-9%	-2%	12%	10%
141	Syncope & Collapse w CC	111,396	493	-4%	-6%	-6%	7%	4%
142	Syncope & Collapse w/o CC	46,900	159	-1%	-6%	-5%	10%	8%

Appendix B. Comparative Cost Margins in THEORI Models Based on Medicare DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 1 Standard Charges	2 Standard Cost	3 HSRV Cost	4 HSRVcc GM CCR	5 HSRVcc Agg. CCR
143	Chest Pain	219,967	718	-2%	-6%	-5%	6%	5%
144	Other Circulatory System Diagnoses w CC	89,572	700	-3%	-1%	-1%	9%	7%
145	Other Circulatory System Diagnoses w/o CC	5,286	20	-9%	-5%	-5%	14%	13%
146	Rectal Resection w CC	9,982	155	-2%	-1%	-2%	-12%	-12%
147	Rectal Resection w/o CC	2,403	21	-8%	-5%	-7%	-11%	-12%
148	Major Small & Large Bowel Procedures w CC	125,069	2,508	2%	4%	3%	-8%	-8%
149	Major Small & Large Bowel Procedures w/o CC	17,993	157	-10%	-6%	-7%	-8%	-9%
150	Peritoneal Adhesiolysis w CC	20,801	345	-1%	1%	0%	-8%	-9%
151	Peritoneal Adhesiolysis w/o CC	4,771	36	-9%	-6%	-6%	-5%	-6%
152	Minor Small & Large Bowel Procedures w CC	4,585	53	-4%	0%	-1%	-1%	-3%
153	Minor Small & Large Bowel Procedures w/o CC	1,880	13	-10%	-6%	-6%	-2%	-5%
154	Stomach, Esophageal & Duodenal Procedures Age >17 w CC	26,227	634	5%	6%	6%	-8%	-8%
155	Stomach, Esophageal & Duodenal Procedures Age >17 w/o CC	5,525	44	-6%	-5%	-5%	-10%	-9%
157	Anal & Stomal Procedures w CC	7,566	60	-3%	-2%	-1%	8%	5%
158	Anal & Stomal Procedures w/o CC	3,659	14	-5%	-7%	-5%	4%	2%
159	Hernia Procedures Except Inguinal & Femoral Age >17 w CC	17,404	146	-2%	-2%	-2%	1%	0%
160	Hernia Procedures Except Inguinal & Femoral Age >17 w/o CC	10,677	52	-5%	-6%	-7%	-5%	-4%
161	Inguinal & Femoral Hernia Procedures Age >17 w CC	9,561	66	0%	-3%	-3%	1%	-1%
162	Inguinal & Femoral Hernia Procedures Age >17 w/o CC	4,978	19	-2%	-7%	-5%	-5%	-4%
164	Appendectomy w Complicated Principal Diag w CC	5,410	71	0%	0%	-1%	-6%	-7%
165	Appendectomy w Complicated Principal Diag w/o CC	2,248	15	-5%	-6%	-6%	-4%	-5%
166	Appendectomy w/o Complicated Principal Diag w CC	4,454	36	1%	-2%	-3%	-4%	-4%
167	Appendectomy w/o Complicated Principal Diag w/o CC	4,127	20	0%	-6%	-6%	-10%	-8%
168	Mouth Procedures w CC	1,421	12	-2%	-1%	-1%	0%	-2%
169	Mouth Procedures w/o CC	700	3	-3%	-6%	-6%	-5%	-6%
170	Other Digestive System O.R. Procedures w CC	16,189	279	6%	4%	3%	-2%	-2%
171	Other Digestive System O.R. Procedures w/o CC	1,354	10	-6%	-6%	-6%	-6%	-6%
172	Digestive Malignancy w CC	30,097	256	-3%	-2%	-2%	10%	6%
173	Digestive Malignancy w/o CC	2,104	9	-5%	-7%	-6%	16%	13%
174	G.I. Hemorrhage w CC	244,076	1,536	-10%	-5%	-4%	3%	0%
175	G.I. Hemorrhage w/o CC	29,213	103	-11%	-7%	-6%	12%	8%
176	Complicated Peptic Ulcer	13,356	89	-5%	-3%	-3%	5%	2%
177	Uncomplicated Peptic Ulcer w CC	7,764	42	-6%	-6%	-4%	10%	6%
178	Uncomplicated Peptic Ulcer w/o CC	2,588	10	-4%	-6%	-4%	10%	7%
179	Inflammatory Bowel Disease	12,889	86	-6%	-3%	-3%	16%	11%
180	G.I. Obstruction w CC	83,133	491	-8%	-4%	-3%	18%	13%
181	G.I. Obstruction w/o CC	23,012	80	-12%	-7%	-7%	22%	15%
182	Esophagitis, Gastroent & Misc Digest Disorders Age >17 w CC	262,638	1,330	-7%	-5%	-4%	16%	11%
183	Esophagitis, Gastroent & Misc Digest Disorders Age >17 w/o CC	76,329	261	-6%	-6%	-5%	16%	13%
184	Esophagitis, Gastroent & Misc Digest Disorders Age 0-17	57	0	-16%	-11%	-9%	30%	24%

Appendix B. Comparative Cost Margins in THEORI Models Based on Medicare DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 1 Standard Charges	2 Standard Cost	3 HSRV Cost	4 HSRVcc GM CCR	5 HSRVcc Agg. CCR
185	Dental & Oral Dis Except Extractions & Restorations, Age >17	5,095	28	-5%	-2%	-2%	18%	15%
187	Dental Extractions & Restorations	548	3	-6%	-4%	-5%	14%	10%
188	Other Digestive System Diagnoses Age >17 w CC	83,127	566	-3%	-2%	-1%	14%	10%
189	Other Digestive System Diagnoses Age >17 w/o CC	11,725	42	-5%	-5%	-5%	20%	16%
190	Other Digestive System Diagnoses Age 0-17	57	0	-24%	-7%	-8%	29%	25%
191	Pancreas, Liver & Shunt Procedures w CC	9,595	242	10%	9%	8%	-6%	-5%
192	Pancreas, Liver & Shunt Procedures w/o CC	1,190	14	-4%	-5%	-6%	-18%	-17%
193	Biliary Tract Proc Except Only Cholecyst w or w/o C.D.E. w CC	4,151	83	3%	3%	2%	-9%	-9%
194	Biliary Tract Proc Except Only Cholecyst w or w/o C.D.E. w/o CC	476	5	-7%	-5%	-4%	-10%	-11%
195	Cholecystectomy w C.D.E. w CC	2,977	52	1%	0%	1%	-11%	-11%
196	Cholecystectomy w C.D.E. w/o CC	634	6	-4%	-6%	-4%	-11%	-11%
197	Cholecystectomy Except by Laparoscope w/o C.D.E. w CC	15,765	232	1%	0%	1%	-8%	-9%
198	Cholecystectomy Except by Laparoscope w/o C.D.E. w/o CC	4,087	28	-8%	-8%	-5%	-7%	-7%
199	Hepatobiliary Diagnostic Procedure for Malignancy	1,311	19	5%	2%	2%	-2%	-3%
200	Hepatobiliary Diagnostic Procedure for Non-Malignancy	855	15	12%	11%	13%	8%	8%
201	Other Hepatobiliary or Pancreas O.R. Procedures	2,455	55	11%	7%	6%	1%	1%
202	Cirrhosis & Alcoholic Hepatitis	24,750	204	-1%	-1%	0%	9%	5%
203	Malignancy of Hepatobiliary System or Pancreas	29,070	239	-2%	-3%	-4%	10%	7%
204	Disorders of Pancreas Except Malignancy	64,759	443	-3%	-1%	0%	18%	14%
205	Disorders of Liver Except Malig, Cirr, Alc Hepa w CC	28,211	213	-2%	-1%	1%	13%	9%
206	Disorders of Liver Except Malig, Cirr, Alc Hepa w/o CC	1,802	8	-7%	-5%	-4%	18%	13%
207	Disorders of the Biliary Tract w CC	32,050	226	-4%	-4%	-3%	11%	8%
208	Disorders of the Biliary Tract w/o CC	8,509	34	-4%	-7%	-5%	13%	11%
210	Hip & Femur Procedures Except Major Joint Age >17 w CC	119,753	1,267	-5%	-4%	-4%	-8%	-8%
211	Hip & Femur Procedures Except Major Joint Age >17 w/o CC	24,426	178	-7%	-7%	-7%	-9%	-9%
213	Amputation for Musculoskeletal System & Conn Tissue Disorders	9,347	110	-1%	0%	1%	7%	3%
216	Biopsies of Musculoskeletal System & Connective Tissue	16,362	168	3%	-3%	-5%	-1%	1%
217	Wnd Debrid & Skn Grft Except Hand, for Muscskelet & Conn Tiss Dis	16,096	281	5%	5%	5%	6%	4%
218	Lower Extrem & Humer Proc Except Hip, Foot, Femur Age >17 w CC	26,331	249	-2%	-3%	-4%	-5%	-5%
219	Lower Extrem & Humer Proc Except Hip, Foot, Femur Age >17 w/o CC	19,043	115	-5%	-6%	-7%	-10%	-8%
223	Major Shoulder/Elbow Proc, or Other Upper Extremity Proc w CC	12,213	77	-1%	-5%	-5%	-1%	0%
224	Shoulder, Elbow or Forearm Proc, Exc Major Joint Proc, w/o CC	9,809	43	0%	-6%	-8%	-9%	-6%
225	Foot Procedures	5,915	42	-3%	-4%	-4%	7%	4%
226	Soft Tissue Procedures w CC	6,124	57	0%	-1%	-2%	6%	3%
227	Soft Tissue Procedures w/o CC	4,596	23	-6%	-6%	-8%	-5%	-5%
228	Major Thumb or Joint Proc, or Oth Hand or Wrist Proc w CC	2,373	17	-2%	-3%	-4%	6%	4%
229	Hand or Wrist Proc, Except Major Joint Proc, w/o CC	1,044	4	-6%	-6%	-5%	2%	0%
230	Local Excision & Removal of Int Fix Devices of Hip & Femur	2,347	19	-4%	-3%	-3%	2%	0%
232	Arthroscopy	629	4	-5%	-5%	-7%	6%	7%
233	Other Musculoskelet Sys & Conn Tiss O.R. Proc w CC	14,156	157	-1%	-1%	-4%	0%	1%

Appendix B. Comparative Cost Margins in THEORI Models Based on Medicare DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 1 Standard Charges	2 Standard Cost	3 HSRV Cost	4 HSRVcc GM CCR	5 HSRVcc Agg. CCR
234	Other Musculoskelet Sys & Conn Tiss O.R. Proc w/o CC	6,985	48	0%	-6%	-8%	-7%	0%
235	Fractures of Femur	4,492	22	-13%	-5%	-4%	28%	21%
236	Fractures of Hip & Pelvis	38,207	177	-14%	-5%	-6%	23%	16%
237	Sprains, Strains & Dislocations of Hip, Pelvis & Thigh	1,822	7	-13%	-7%	-7%	24%	17%
238	Osteomyelitis	8,867	74	-3%	-2%	0%	19%	14%
239	Pathological Fractures & Musculoskeletal & Conn Tiss Malignancy	39,498	260	-10%	-4%	-5%	14%	9%
240	Connective Tissue Disorders w CC	11,395	101	2%	4%	3%	18%	15%
241	Connective Tissue Disorders w/o CC	2,376	10	-8%	-6%	-5%	24%	19%
242	Septic Arthritis	2,436	18	-7%	-1%	0%	22%	16%
243	Medical Back Problems	91,483	441	-11%	-5%	-6%	18%	12%
244	Bone Diseases & Specific Arthropathies w CC	14,281	67	-12%	-5%	-4%	22%	16%
245	Bone Diseases & Specific Arthropathies w/o CC	5,166	15	-14%	-6%	-5%	33%	27%
246	Non-Specific Arthropathies	1,266	5	-10%	-5%	-3%	20%	15%
247	Signs & Symptoms of Musculoskeletal System & Conn Tissue	19,268	72	-12%	-6%	-6%	18%	13%
248	Tendonitis, Myositis & Bursitis	13,660	74	-9%	-5%	-4%	14%	9%
249	Aftercare, Musculoskeletal System & Connective Tissue	12,636	55	-9%	-4%	-6%	23%	17%
250	Fx, Sprn, Strn & Disl of Forearm, Hand, Foot Age >17 w CC	3,767	16	-9%	-5%	-4%	19%	14%
251	Fx, Sprn, Strn & Disl of Forearm, Hand, Foot Age >17 w/o CC	1,860	6	-11%	-6%	-5%	25%	21%
253	Fx, Sprn, Strn & Disl of Uparm, Lowleg Ex Foot Age >17 w CC	22,557	109	-12%	-5%	-5%	20%	14%
254	Fx, Sprn, Strn & Disl of Uparm, Lowleg Ex Foot Age >17 w/o CC	9,222	27	-15%	-7%	-6%	29%	22%
256	Other Musculoskeletal System & Connective Tissue Diagnoses	6,385	34	-8%	-4%	-2%	25%	19%
257	Total Mastectomy for Malignancy w CC	12,452	63	-2%	-5%	-5%	-3%	-4%
258	Total Mastectomy for Malignancy w/o CC	10,937	44	-2%	-6%	-6%	-10%	-10%
259	Subtotal Mastectomy for Malignancy w CC	2,695	14	6%	-4%	-3%	2%	1%
260	Subtotal Mastectomy for Malignancy w/o CC	2,750	10	5%	-6%	-6%	-13%	-11%
261	Breast Proc for Non-Malignancy Except Biopsy & Local Excision	1,411	8	7%	-2%	-4%	2%	2%
262	Breast Biopsy & Local Excision for Non-Malignancy	567	3	-3%	-4%	-3%	10%	6%
263	Skin Graft &/or Debrid for Skn Ulcer or Cellulitis w CC	21,701	255	1%	2%	3%	15%	10%
264	Skin Graft &/or Debrid for Skn Ulcer or Cellulitis w/o CC	3,521	22	-11%	-6%	-2%	21%	14%
265	Skin Graft &/or Debrid Except for Skin Ulcer or Cellulitis w CC	3,983	40	4%	2%	1%	5%	3%
266	Skin Graft &/or Debrid Except for Skin Ulcer or Cellulitis w/o CC	2,104	12	-5%	-6%	-6%	-3%	-5%
267	Perianal & Pilonidal Procedures	245	1	-5%	-4%	0%	21%	16%
268	Skin, Subcutaneous Tissue & Breast Plastic Procedures	903	6	1%	0%	-1%	-1%	-2%
269	Other Skin, Subcut Tiss & Breast Proc w CC	9,704	103	0%	0%	0%	7%	4%
270	Other Skin, Subcut Tiss & Breast Proc w/o CC	2,364	12	-6%	-6%	-4%	6%	3%
271	Skin Ulcers	18,748	115	-11%	-4%	-1%	26%	19%
272	Major Skin Disorders w CC	5,375	34	-8%	-2%	-1%	25%	18%
273	Major Skin Disorders w/o CC	1,185	4	-11%	-5%	-3%	32%	27%
274	Malignant Breast Disorders w CC	2,073	15	-7%	-2%	-4%	14%	9%
275	Malignant Breast Disorders w/o CC	182	1	-12%	-7%	-3%	24%	21%

Appendix B. Comparative Cost Margins in THEORI Models Based on Medicare DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 1 Standard Charges	2 Standard Cost	3 HSRV Cost	4 HSRVcc GM CCR	5 HSRVcc Agg. CCR
276	Non-Malignant Breast Disorders	1,268	6	-8%	-5%	-2%	30%	24%
277	Cellulitis Age >17 w CC	101,491	547	-11%	-5%	-4%	25%	19%
278	Cellulitis Age >17 w/o CC	29,702	105	-16%	-6%	-4%	35%	27%
280	Trauma to the Skin, Subcut Tiss & Breast Age >17 w CC	16,999	77	-10%	-5%	-4%	18%	13%
281	Trauma to the Skin, Subcut Tiss & Breast Age >17 w/o CC	5,988	19	-10%	-5%	-4%	24%	20%
283	Minor Skin Disorders w CC	5,600	27	-9%	-5%	-3%	26%	20%
284	Minor Skin Disorders w/o CC	1,608	5	-12%	-7%	-4%	36%	30%
285	Amputat of Lower Limb for Endocrine, Nutrit & Metabol Disorders	6,858	86	-2%	-1%	0%	4%	1%
286	Adrenal & Pituitary Procedures	2,459	31	4%	2%	0%	-18%	-17%
287	Skin Grafts & Wound Debrid for Endoc, Nutrit & Metab Disorders	5,501	61	1%	2%	4%	14%	10%
288	O.R. Procedures for Obesity	9,051	103	11%	1%	0%	-12%	-7%
289	Parathyroid Procedures	6,473	35	3%	-3%	-4%	3%	2%
290	Thyroid Procedures	10,044	51	2%	-4%	-5%	-8%	-8%
291	Thyroglossal Procedures	59	0	27%	6%	5%	11%	10%
292	Other Endocrine, Nutrit & Metab O.R. Proc w CC	6,605	99	7%	2%	2%	-1%	-2%
293	Other Endocrine, Nutrit & Metab O.R. Proc w/o CC	328	3	-2%	-7%	-8%	-10%	-9%
294	Diabetes Age >35	87,220	419	-7%	-3%	-1%	16%	11%
295	Diabetes Age 0-35	3,598	17	-11%	-3%	1%	7%	4%
296	Nutritional & Misc Metabolic Disorders Age >17 w CC	228,843	1,175	-10%	-5%	-3%	16%	10%
297	Nutritional & Misc Metabolic Disorders Age >17 w/o CC	39,573	124	-13%	-6%	-5%	24%	18%
298	Nutritional & Misc Metabolic Disorders Age 0-17	62	0	-7%	7%	5%	47%	41%
299	Inborn Errors of Metabolism	1,233	9	-3%	3%	4%	21%	19%
300	Endocrine Disorders w CC	19,573	133	-9%	-4%	-4%	9%	4%
301	Endocrine Disorders w/o CC	3,502	14	-9%	-6%	-6%	23%	18%
302	Kidney Transplant	8,058	182	5%	2%	2%	-12%	-10%
303	Kidney, Ureter & Major Bladder Procedures for Neoplasm	22,056	306	-1%	1%	-1%	-12%	-11%
304	Kidney, Ureter & Major Bladder Proc for Non-Neopl w CC	12,721	182	6%	3%	3%	0%	-1%
305	Kidney, Ureter & Major Bladder Proc for Non-Neopl w/o CC	2,793	20	-3%	-6%	-7%	-12%	-10%
306	Prostatectomy w CC	5,927	43	-2%	-4%	-3%	6%	3%
307	Prostatectomy w/o CC	1,873	7	-4%	-6%	-6%	2%	1%
308	Minor Bladder Procedures w CC	6,587	63	2%	2%	2%	6%	5%
309	Minor Bladder Procedures w/o CC	3,271	17	-4%	-6%	-7%	-8%	-3%
310	Transurethral Procedures w CC	24,153	163	1%	-3%	-3%	7%	5%
311	Transurethral Procedures w/o CC	5,950	21	0%	-5%	-5%	0%	1%
312	Urethral Procedures, Age >17 w CC	1,354	9	-1%	-4%	-1%	10%	6%
313	Urethral Procedures, Age >17 w/o CC	476	2	-4%	-8%	-6%	-7%	-7%
315	Other Kidney & Urinary Tract O.R. Procedures	33,733	401	9%	2%	2%	3%	5%
316	Renal Failure	165,046	1,294	-6%	-2%	-1%	8%	4%
317	Admit for Renal Dialysis	2,449	12	-2%	-4%	-4%	22%	20%
318	Kidney & Urinary Tract Neoplasms w CC	5,430	38	-5%	-3%	-3%	16%	12%

Appendix B. Comparative Cost Margins in THEORI Models Based on Medicare DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 1 Standard Charges	2 Standard Cost	3 HSRV Cost	4 HSRVcc GM CCR	5 HSRVcc Agg. CCR
319	Kidney & Urinary Tract Neoplasms w/o CC	335	1	-8%	-5%	-7%	22%	21%
320	Kidney & Urinary Tract Infections Age >17 w CC	197,669	1,040	-9%	-5%	-4%	18%	12%
321	Kidney & Urinary Tract Infections Age >17 w/o CC	27,524	97	-12%	-6%	-4%	26%	19%
322	Kidney & Urinary Tract Infections Age 0-17	52	0	-11%	-10%	-9%	62%	51%
323	Urinary Stones w CC &/or ESW Lithotripsy	18,389	85	-1%	-6%	-5%	14%	11%
324	Urinary Stones w/o CC	4,623	13	-3%	-7%	-3%	21%	21%
325	Kidney & Urinary Tract Signs & Symptoms Age >17 w CC	8,675	35	-8%	-6%	-4%	30%	25%
326	Kidney & Urinary Tract Signs & Symptoms Age >17 w/o CC	2,328	6	-9%	-7%	-4%	43%	38%
328	Urethral Stricture Age >17 w CC	564	2	-4%	-5%	-4%	22%	18%
329	Urethral Stricture Age >17 w/o CC	65	0	1%	-5%	-6%	5%	5%
331	Other Kidney & Urinary Tract Diagnoses Age >17 w CC	49,526	329	-5%	-2%	-1%	18%	14%
332	Other Kidney & Urinary Tract Diagnoses Age >17 w/o CC	3,816	15	-7%	-5%	-3%	24%	21%
333	Other Kidney & Urinary Tract Diagnoses Age 0-17	226	2	2%	8%	9%	34%	31%
334	Major Male Pelvic Procedures w CC	8,856	74	-2%	-4%	-5%	-11%	-10%
335	Major Male Pelvic Procedures w/o CC	10,626	67	-2%	-6%	-8%	-18%	-16%
336	Transurethral Prostatectomy w CC	29,035	142	-5%	-5%	-5%	8%	6%
337	Transurethral Prostatectomy w/o CC	23,024	76	-5%	-6%	-6%	-6%	-7%
338	Testes Procedures, for Malignancy	595	5	-2%	-4%	-1%	7%	4%
339	Testes Procedures, Non-Malignancy Age >17	1,121	8	-1%	1%	2%	17%	13%
341	Penis Procedures	2,921	21	7%	-2%	-1%	15%	19%
342	Circumcision Age >17	519	2	-2%	-5%	-4%	11%	8%
344	Other Male Reproductive System O.R. Procedures for Malignancy	2,517	17	5%	-3%	-5%	0%	3%
345	Other Male Reproductive System O.R. Proc Except for Malignancy	1,333	9	1%	0%	2%	20%	16%
346	Malignancy, Male Reproductive System, w CC	3,539	23	-7%	-4%	-4%	17%	13%
347	Malignancy, Male Reproductive System, w/o CC	205	1	-1%	-6%	-7%	24%	22%
348	Benign Prostatic Hypertrophy w CC	3,763	16	-6%	-5%	-4%	24%	18%
349	Benign Prostatic Hypertrophy w/o CC	497	1	-6%	-6%	-4%	36%	32%
350	Inflammation of the Male Reproductive System	6,286	29	-10%	-5%	-4%	29%	23%
352	Other Male Reproductive System Diagnoses	853	4	-6%	-4%	-2%	30%	25%
353	Pelvic Evisceration, Radical Hysterectomy & Radical Vulvectomy	2,549	30	8%	4%	1%	-3%	-3%
354	Uterine, Adnexa Proc for Non-Ovarian/Adnexal Malig w CC	7,099	69	-2%	-2%	-2%	-4%	-5%
355	Uterine, Adnexa Proc for Non-Ovarian/Adnexal Malig w/o CC	4,550	25	-7%	-7%	-8%	-10%	-11%
356	Female Reproductive System Reconstructive Procedures	21,716	89	-2%	-6%	-6%	-3%	-3%
357	Uterine & Adnexa Proc for Ovarian or Adnexal Malignancy	5,199	72	2%	2%	1%	-6%	-6%
358	Uterine & Adnexa Proc for Non-Malignancy w CC	18,747	128	-3%	-4%	-4%	0%	-2%
359	Uterine & Adnexa Proc for Non-Malignancy w/o CC	25,441	116	-5%	-7%	-6%	-10%	-11%
360	Vagina, Cervix & Vulva Procedures	13,463	66	-2%	-5%	-6%	1%	1%
361	Laparoscopy & Incisional Tubal Interruption	237	2	-5%	-7%	-7%	-1%	0%
363	D&C, Conization & Radio-Implant, for Malignancy	1,974	12	-2%	-3%	-3%	13%	11%
364	D&C, Conization Except for Malignancy	1,326	7	-2%	-4%	0%	15%	11%

Appendix B. Comparative Cost Margins in THEORI Models Based on Medicare DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 1 Standard Charges	2 Standard Cost	3 HSRV Cost	4 HSRVcc GM CCR	5 HSRVcc Agg. CCR
365	Other Female Reproductive System O.R. Procedures	1,478	18	7%	6%	4%	6%	5%
366	Malignancy, Female Reproductive System w CC	4,355	34	-5%	-2%	-2%	15%	11%
367	Malignancy, Female Reproductive System w/o CC	383	1	-3%	-5%	-5%	31%	27%
368	Infections, Female Reproductive System	3,559	26	-5%	-4%	-3%	19%	13%
369	Menstrual & Other Female Reproductive System Disorders	3,194	12	-1%	-3%	0%	45%	40%
370	Cesarean Section w CC	1,646	11	-10%	-3%	1%	21%	15%
371	Cesarean Section w/o CC	2,004	8	-16%	-6%	-3%	20%	13%
372	Vaginal Delivery w Complicating Diagnoses	1,011	4	-13%	-2%	3%	34%	27%
373	Vaginal Delivery w/o Complicating Diagnoses	4,326	11	-18%	-6%	-2%	36%	27%
374	Vaginal Delivery w Sterilization &/or D&C	130	1	-13%	-4%	2%	36%	30%
376	Postpartum & Post Abortion Diagnoses w/o O.R. Procedure	353	1	-11%	-1%	3%	51%	45%
377	Postpartum & Post Abortion Diagnoses w O.R. Procedure	66	1	23%	19%	19%	22%	29%
378	Ectopic Pregnancy	174	1	3%	-3%	1%	15%	14%
379	Threatened Abortion	443	1	-26%	-9%	-5%	41%	32%
380	Abortion w/o D&C	69	0	2%	-1%	4%	35%	33%
381	Abortion w D&C, Aspiration Curettage or Hysterotomy	177	1	1%	-3%	2%	22%	19%
382	False Labor	39	0	-22%	-3%	-1%	21%	22%
383	Other Antepartum Diagnoses w Medical Complications	2,131	8	-10%	-1%	4%	48%	40%
384	Other Antepartum Diagnoses w/o Medical Complications	105	0	-20%	-7%	-1%	37%	30%
392	Splenectomy Age >17	2,012	37	5%	7%	6%	-4%	-2%
394	Other O.R. Procedures of the Blood & Blood Forming Organs	2,593	29	9%	6%	5%	8%	7%
395	Red Blood Cell Disorders Age >17	101,605	517	-6%	-3%	-1%	20%	16%
397	Coagulation Disorders	16,801	138	4%	3%	4%	17%	16%
398	Reticuloendothelial & Immunity Disorders w CC	16,491	127	-5%	-1%	-2%	16%	13%
399	Reticuloendothelial & Immunity Disorders w/o CC	1,436	6	-8%	-5%	-6%	21%	18%
401	Lymphoma & Non-Acute Leukemia w Other O.R. Proc w CC	5,921	101	8%	5%	3%	4%	3%
402	Lymphoma & Non-Acute Leukemia w Other O.R. Proc w/o CC	1,299	9	1%	-4%	-5%	6%	5%
403	Lymphoma & Non-Acute Leukemia w CC	29,336	326	1%	2%	1%	10%	8%
404	Lymphoma & Non-Acute Leukemia w/o CC	3,383	19	-3%	-4%	-5%	20%	17%
406	Myeloprolif Disord or Poorly Diff Neopl w Maj O.R.Proc w CC	2,081	36	4%	5%	4%	-7%	-7%
407	Myeloprolif Disord or Poorly Diff Neopl w Maj O.R.Proc w/o CC	533	4	-3%	-5%	-6%	-15%	-15%
408	Myeloprolif Disord or Poorly Diff Neopl w Other O.R.Proc	1,997	28	12%	9%	7%	12%	11%
409	Radiotherapy	1,650	13	5%	0%	0%	29%	24%
410	Chemotherapy w/o Acute Leukemia as Secondary Diagnosis	26,172	174	6%	1%	-1%	32%	32%
413	Other Myeloprolif Dis or Poorly Diff Neopl Diag w CC	4,708	38	-7%	-3%	-4%	11%	7%
414	Other Myeloprolif Dis or Poorly Diff Neopl Diag w/o CC	486	2	-7%	-6%	-8%	14%	11%
415	O.R. Procedure for Infectious & Parasitic Diseases	46,766	1,038	8%	7%	7%	1%	0%
416	Septicemia Age >17	218,145	2,154	-1%	0%	1%	5%	2%
418	Postoperative & Post-Traumatic Infections	25,730	177	-8%	-2%	-2%	23%	18%
419	Fever of Unknown Origin Age >17 w CC	14,504	77	-8%	-4%	-5%	16%	11%

Appendix B. Comparative Cost Margins in THEORI Models Based on Medicare DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 1 Standard Charges	2 Standard Cost	3 HSRV Cost	4 HSRVcc GM CCR	5 HSRVcc Agg. CCR
420	Fever of Unknown Origin Age >17 w/o CC	2,524	10	-9%	-6%	-6%	18%	13%
421	Viral Illness Age >17	10,582	51	-6%	-2%	-2%	21%	16%
422	Viral Illness & Fever of Unknown Origin Age 0-17	46	0	-3%	3%	5%	71%	62%
423	Other Infectious & Parasitic Diseases Diagnoses	7,793	90	4%	4%	4%	13%	11%
424	O.R. Procedure w Principal Diagnoses of Mental Illness	991	15	-3%	4%	5%	7%	5%
425	Acute Adjustment Reaction & Psychosocial Dysfunction	13,163	54	-16%	-6%	-5%	14%	9%
426	Depressive Neuroses	3,815	14	-27%	-5%	-3%	39%	29%
427	Neuroses Except Depressive	1,346	6	-30%	-3%	-4%	29%	20%
428	Disorders of Personality & Impulse Control	699	4	-25%	0%	1%	38%	26%
429	Organic Disturbances & Mental Retardation	22,899	119	-16%	-5%	-5%	17%	9%
430	Psychoses	63,666	370	-30%	-3%	5%	58%	42%
431	Childhood Mental Disorders	279	1	-33%	-6%	-2%	61%	44%
432	Other Mental Disorder Diagnoses	358	2	-18%	-4%	-6%	17%	11%
433	Alcohol/Drug Abuse or Dependence, Left AMA	4,361	10	-20%	-3%	7%	69%	58%
439	Skin Grafts for Injuries	1,579	20	7%	8%	8%	17%	13%
440	Wound Debridements for Injuries	5,067	59	3%	6%	5%	15%	11%
441	Hand Procedures for Injuries	689	4	-3%	-4%	-3%	-2%	-3%
442	Other O.R. Procedures for Injuries w CC	16,374	249	7%	6%	6%	1%	1%
443	Other O.R. Procedures for Injuries w/o CC	3,006	18	-6%	-5%	-5%	-3%	-2%
444	Traumatic Injury Age >17 w CC	5,201	24	-7%	-4%	-2%	20%	15%
445	Traumatic Injury Age >17 w/o CC	1,975	6	-8%	-6%	-3%	26%	21%
447	Allergic Reactions Age >17	5,568	20	-9%	-4%	-3%	11%	8%
449	Poisoning & Toxic Effects of Drugs Age >17 w CC	34,143	188	-7%	-3%	-1%	4%	1%
450	Poisoning & Toxic Effects of Drugs Age >17 w/o CC	6,518	18	-15%	-7%	-5%	14%	10%
452	Complications of Treatment w CC	25,100	166	-4%	0%	-1%	16%	13%
453	Complications of Treatment w/o CC	4,894	16	-11%	-6%	-7%	24%	21%
454	Other Injury, Poisoning & Toxic Effect Diag w CC	3,381	18	-7%	-3%	-1%	13%	9%
455	Other Injury, Poisoning & Toxic Effect Diag w/o CC	685	2	-2%	-7%	-3%	24%	21%
461	O.R. Proc w Diagnoses of Other Contact w Health Services	2,473	21	0%	2%	2%	9%	10%
462	Rehabilitation	7,268	67	-46%	-4%	0%	17%	7%
463	Signs & Symptoms w CC	27,773	121	-11%	-5%	-5%	15%	10%
464	Signs & Symptoms w/o CC	6,626	21	-11%	-6%	-5%	20%	15%
465	Aftercare w History of Malignancy as Secondary Diagnosis	181	1	-13%	-5%	-4%	37%	35%
466	Aftercare w/o History of Malignancy as Secondary Diagnosis	1,091	6	-11%	8%	2%	39%	35%
467	Other Factors Influencing Health Status	822	3	-13%	-7%	-5%	26%	23%
468	Extensive O.R. Procedure Unrelated to Principal Diagnosis	46,567	1,035	7%	4%	3%	-7%	-5%
471	Bilateral or Multiple Major Joint Procs of Lower Extremity	14,202	242	-1%	-4%	-7%	-16%	-7%
473	Acute Leukemia w/o Major O.R. Procedure Age >17	8,068	169	16%	15%	14%	17%	17%
475	Respiratory System Diagnosis with Ventilator Support	105,775	2,264	2%	3%	3%	-17%	-17%
476	Prostatic O.R. Procedure Unrelated to Principal Diagnosis	2,854	38	-2%	-3%	-2%	-2%	-5%

Appendix B. Comparative Cost Margins in THEORI Models Based on Medicare DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 1 Standard Charges	2 Standard Cost	3 HSRV Cost	4 HSRVcc GM CCR	5 HSRVcc Agg. CCR
477	Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis	26,247	316	3%	1%	1%	2%	0%
479	Other Vascular Procedures w/o CC	22,692	179	3%	-5%	-6%	-15%	-10%
480	Liver Transplant &/or Intestinal Transplant	714	46	16%	11%	12%	-6%	-4%
481	Bone Marrow Transplant	978	48	2%	6%	6%	11%	8%
482	Tracheostomy for Face, Mouth & Neck Diagnoses	4,752	102	-2%	2%	2%	-17%	-17%
484	Craniotomy for Multiple Significant Trauma	425	14	4%	4%	4%	-16%	-14%
485	Limb Reattachment, Hip & Femur Proc for Multiple Significant Trauma	3,194	62	3%	3%	4%	-8%	-7%
486	Other O.R. Procedures for Multiple Significant Trauma	2,293	73	7%	7%	10%	-8%	-6%
487	Other Multiple Significant Trauma	4,095	51	-2%	2%	3%	-5%	-6%
488	HIV w Extensive O.R. Procedure	721	20	19%	7%	9%	4%	4%
489	HIV w Major Related Condition	12,054	141	14%	6%	9%	19%	16%
490	HIV w or w/o Other Related Condition	4,604	31	8%	0%	3%	22%	18%
491	Major Joint & Limb Reattachment Procedures of Upper Extremity	18,312	174	-3%	-5%	-8%	-13%	-6%
492	Chemotherapy w Acute Leukemia or w Use of Hi Dose Chemoagent	3,685	88	11%	12%	11%	21%	20%
493	Laparoscopic Cholecystectomy w/o C.D.E. w CC	56,409	574	1%	-2%	-3%	-6%	-6%
494	Laparoscopic Cholecystectomy w/o C.D.E. w/o CC	22,916	126	1%	-6%	-6%	-8%	-6%
495	Lung Transplant	255	15	19%	9%	9%	-9%	-7%
496	Combined Anterior/Posterior Spinal Fusion	3,064	110	12%	5%	1%	-13%	-5%
497	Spinal Fusion Except Cervical w CC	25,099	494	6%	0%	-3%	-16%	-7%
498	Spinal Fusion Except Cervical w/o CC	16,662	253	3%	-3%	-6%	-20%	-9%
499	Back & Neck Procedures Except Spinal Fusion w CC	32,707	261	0%	-4%	-7%	-9%	-10%
500	Back & Neck Procedures Except Spinal Fusion w/o CC	43,579	219	-1%	-7%	-10%	-16%	-15%
501	Knee Procedures w PDX of Infection w CC	2,866	42	-1%	-1%	-3%	-3%	-4%
502	Knee Procedures w PDX of Infection w/o CC	646	5	-8%	-6%	-7%	-8%	-10%
503	Knee Procedures w/o PDX of Infection	5,312	37	-2%	-3%	-4%	0%	1%
504	Exten. Burns or Full Thickness Burn w/MV 96+Hrs w/Skin Gft	168	14	16%	13%	15%	-4%	-2%
505	Exten. Burns or Full Thickness Burn w/MV 96+Hrs w/o Skin Gft	147	2	32%	16%	20%	11%	12%
506	Full Thickness Burn w Skin Graft or Inhal Inj w CC or Sig Trauma	904	27	6%	9%	13%	3%	0%
507	Full Thickness Burn w Skin Grft or Inhal Inj w/o CC or Sig Trauma	269	4	-10%	-2%	3%	2%	-3%
508	Full Thickness Burn w/o Skin Grft or Inhal Inj w CC or Sig Trauma	563	5	-6%	2%	5%	26%	20%
509	Full Thickness Burn w/o Skin Grft or Inh Inj w/o CC or Sig Trauma	136	1	-10%	-4%	3%	29%	22%
510	Non-Extensive Burns w CC or Significant Trauma	1,518	13	-6%	2%	7%	25%	19%
511	Non-Extensive Burns w/o CC or Significant Trauma	554	3	-9%	4%	8%	29%	23%
512	Simultaneous Pancreas/Kidney Transplant	409	17	7%	6%	5%	-12%	-10%
513	Pancreas Transplant	184	6	-1%	1%	1%	-15%	-13%
515	Cardiac Defibrillator Implant w/o Cardiac Cath	41,010	1,220	11%	0%	-1%	-11%	3%
518	Perc Cardio Proc w/o Coronary Artery Stent or AMI	23,720	211	8%	-5%	-6%	-20%	-8%
519	Cervical Spinal Fusion w CC	10,307	147	4%	-2%	-3%	-14%	-8%
520	Cervical Spinal Fusion w/o CC	13,313	119	5%	-6%	-9%	-21%	-12%
521	Alcohol/Drug Abuse or Dependence w CC	28,640	139	-17%	-4%	3%	31%	23%

Appendix B. Comparative Cost Margins in THEORI Models Based on Medicare DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 1 Standard Charges	2 Standard Cost	3 HSRV Cost	4 HSRVcc GM CCR	5 HSRVcc Agg. CCR
522	Alc/Drug Abuse or Depend w Rehabilitation Therapy w/o CC	4,948	22	-42%	-7%	15%	58%	41%
523	Alc/Drug Abuse or Depend w/o Rehabilitation Therapy w/o CC	13,551	40	-19%	-3%	6%	54%	42%
524	Transient Ischemia	107,845	445	-3%	-7%	-5%	8%	5%
525	Other Heart Assist System Implant	286	19	17%	12%	10%	-5%	2%
528	Intracranial Vascular Proc w PDX Hemorrhage	1,622	80	3%	4%	3%	-19%	-17%
529	Ventricular Shunt Procedures w CC	3,683	53	3%	4%	1%	-6%	-5%
530	Ventricular Shunt Procedures w/o CC	2,198	16	-2%	-5%	-8%	-14%	-9%
531	Spinal Procedures w CC	4,359	84	6%	4%	3%	-7%	-5%
532	Spinal Procedures w/o CC	2,284	20	0%	-4%	-6%	-10%	-6%
533	Extracranial Procedures w CC	44,218	388	2%	-2%	-4%	-18%	-16%
534	Extracranial Procedures w/o CC	41,862	233	-1%	-6%	-8%	-24%	-21%
535	Cardiac Defib Implant w Cardiac Cath w AMI/HF/Shock	6,771	298	11%	2%	0%	-13%	-3%
536	Cardiac Defib Implant w Cardiac Cath w/o AMI/HF/Shock	7,363	279	10%	1%	-1%	-14%	-2%
537	Local Excis & Remov of Int Fix Dev Except Hip & Femur w CC	7,932	86	-1%	-1%	-2%	0%	-1%
538	Local Excis & Remov of Int Fix Dev Except Hip & Femur w/o CC	4,961	29	-5%	-7%	-8%	-12%	-11%
539	Lymphoma & Leukemia w Major or Procedure w CC	4,656	92	12%	10%	8%	0%	0%
540	Lymphoma & Leukemia w Major or Procedure w/o CC	1,391	10	-2%	-4%	-6%	-12%	-12%
541	ECMO or Trach w MV 96+Hrs or PDX Exc Face, Mouth & Neck w Maj O.R.	20,779	2,335	9%	7%	7%	-12%	-11%
542	Trach w MV 96+Hrs or PDX Exc Face, Mouth & Neck w/o Maj O.R.	22,243	1,570	8%	6%	7%	-15%	-14%
543	Craniotomy w/Implant of Chemo Agent or Acute Complx Cns PDX	4,982	139	3%	3%	2%	-18%	-17%
544	Major Joint Replacement or Reattachment of Lower Extremity	384,925	4,228	-5%	-5%	-7%	-11%	-5%
545	Revision of Hip or Knee Replacement	39,133	538	-1%	-3%	-6%	-13%	-6%
546	Spinal Fusion Exc Cerv with Curvature of the Spine or Malig	2,028	62	7%	3%	0%	-14%	-6%
547	Coronary Bypass w Cardiac Cath w Major CV Dx	32,661	1,074	6%	0%	-1%	-24%	-20%
548	Coronary Bypass w Cardiac Cath w/o Major CV Dx	31,834	792	3%	-3%	-5%	-29%	-25%
549	Coronary Bypass w/o Cardiac Cath w Major CV Dx	13,175	371	5%	1%	0%	-23%	-20%
550	Coronary Bypass w/o Cardiac Cath w/o Major CV Dx	32,781	667	-1%	-4%	-6%	-30%	-26%
551	Permanent Cardiac Pacemaker Impl w Maj CV Dx or AICD Lead or Gnrtr	53,038	915	4%	-2%	-3%	-13%	-4%
552	Other Permanent Cardiac Pacemaker Implant w/o Major CV Dx	79,002	896	2%	-5%	-6%	-14%	-3%
553	Other Vascular Procedures w CC w Major CV Dx	35,929	626	7%	2%	1%	-9%	-8%
554	Other Vascular Procedures w CC w/o Major CV Dx	69,692	819	3%	-2%	-2%	-12%	-9%
555	Percutaneous Cardiovascular Proc w Major CV Dx	65,614	870	6%	-3%	-3%	-19%	-11%
556	Percutaneous Cardiovasc Proc w Non-Drug-Eluting Stent w/o Maj CV Dx	45,245	422	12%	-5%	-5%	-22%	-8%
557	Percutaneous Cardiovascular Proc w Drug-Eluting Stent w Major CV Dx	86,938	1,348	8%	-3%	-4%	-20%	-9%
558	Percutaneous Cardiovascular Proc w Drug-Eluting Stent w/o Maj CV Dx	141,157	1,575	12%	-5%	-6%	-22%	-7%
559	Acute Ischemic Stroke with Use of Thrombolytic Agent	2,099	29	-2%	-3%	-3%	-20%	-19%

Appendix C. Comparative Cost Margins in THEORI Models Based on CS DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 6 Standard Charges	7 Standard Cost	8 HSRV Cost	9 HSRVcc GM CCR	10 HSRVcc Agg. CCR
1	Liver Transplant &/or Intestinal Transplant SOI 1 & 2	299	12	2%	0%	0%	-17%	-14%
2	Liver Transplant &/or Intestinal Transplant SOI 3	402	22	14%	9%	10%	-7%	-5%
3	Liver Transplant &/or Intestinal Transplant SOI 4	346	43	24%	17%	17%	0%	3%
4	Heart &/or Lung Transplant SOI 1 & 2	274	13	14%	9%	8%	-12%	-9%
5	Heart &/or Lung Transplant SOI 3	259	24	12%	11%	10%	-7%	-5%
6	Heart &/or Lung Transplant SOI 4	271	42	22%	19%	18%	1%	3%
7	Bone Marrow Transplant SOI 1	697	26	-2%	2%	0%	12%	8%
8	Bone Marrow Transplant SOI 2	210	12	-3%	5%	6%	10%	8%
9	Bone Marrow Transplant SOI 3	61	6	13%	14%	13%	9%	9%
10	Bone Marrow Transplant SOI 4	51	8	7%	12%	14%	10%	11%
11	Tracheostomy w Long Term Mechanical Ventilation w Extensive Procedure SOI 1 & 2	693	43	10%	12%	12%	-8%	-7%
12	Tracheostomy w Long Term Mechanical Ventilation w Extensive Procedure SOI 3	4,362	427	10%	9%	9%	-10%	-9%
13	Tracheostomy w Long Term Mechanical Ventilation w Extensive Procedure SOI 4	12,816	1,547	10%	8%	8%	-10%	-9%
14	Tracheostomy w Long Term Mechanical Ventilation w/o Extensive Procedure SOI 1 & 2	1,124	48	5%	8%	9%	-12%	-12%
15	Tracheostomy w Long Term Mechanical Ventilation w/o Extensive Procedure SOI 3	7,175	449	7%	6%	7%	-14%	-13%
16	Tracheostomy w Long Term Mechanical Ventilation w/o Extensive Procedure SOI 4	13,098	1,084	10%	7%	8%	-11%	-11%
17	Pancreas Transplant SOI 1 & 2	297	9	3%	2%	3%	-13%	-11%
18	Pancreas Transplant SOI 3	245	9	5%	4%	5%	-11%	-9%
19	Pancreas Transplant SOI 4	69	8	8%	11%	10%	-2%	-1%
20	Nervous System Procdures SOI 4	6,531	274	7%	5%	5%	-14%	-13%
21	Craniotomy for Trauma SOI 1	3,820	50	-5%	-3%	-4%	-25%	-24%
22	Craniotomy for Trauma SOI 2	527	10	-3%	-2%	-2%	-23%	-22%
23	Craniotomy for Trauma SOI 3	2,075	49	2%	2%	1%	-19%	-18%
24	Craniotomy Except for Trauma SOI 1	10,056	131	-2%	-3%	-4%	-23%	-20%
25	Craniotomy Except for Trauma SOI 2	9,904	185	0%	-1%	-2%	-22%	-20%
26	Craniotomy Except for Trauma SOI 3	4,760	141	2%	3%	3%	-17%	-15%
27	Ventricular Shunt Procedures SOI 1	1,589	11	0%	-4%	-6%	-10%	-6%
28	Ventricular Shunt Procedures SOI 2	3,281	32	-2%	-3%	-5%	-9%	-7%
29	Ventricular Shunt Procedures SOI 3	831	19	2%	4%	2%	-8%	-9%
30	Spinal Procedures SOI 1	2,588	22	3%	-3%	-4%	-4%	-1%
31	Spinal Procedures SOI 2	2,202	28	0%	-1%	-2%	-9%	-8%
32	Spinal Procedures SOI 3	1,455	39	5%	3%	3%	-10%	-8%
33	Extracranial Vascular Procedures SOI 1	47,448	268	0%	-6%	-7%	-22%	-19%
34	Extracranial Vascular Procedures SOI 2	33,012	251	0%	-4%	-5%	-19%	-16%
35	Extracranial Vascular Procedures SOI 3	6,694	108	3%	0%	-1%	-17%	-15%
36	Other Nervous System & Related Procedures SOI 1	2,249	18	3%	-3%	-3%	-4%	2%
37	Other Nervous System & Related Procedures SOI 2	3,368	41	2%	-3%	-4%	-5%	1%
38	Other Nervous System & Related Procedures SOI 3	2,756	52	4%	-1%	-2%	-8%	-5%
39	Nervous System Medical Diagnoses Except Infections SOI 4	28,488	523	3%	3%	4%	-7%	-8%
40	Infections of Nervous System SOI 4	1,285	39	5%	5%	6%	-7%	-7%
41	Spinal Disorders & Injuries SOI 1	283	1	-5%	-7%	-8%	15%	11%
42	Spinal Disorders & Injuries SOI 2	1,259	9	-3%	-4%	-4%	8%	4%
43	Spinal Disorders & Injuries SOI 3	770	9	-1%	-1%	0%	4%	1%

Appendix C. Comparative Cost Margins in THEORI Models Based on CS DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 6 Standard Charges	7 Standard Cost	8 HSRV Cost	9 HSRVcc GM CCR	10 HSRVcc Agg. CCR
44	Nervous System Malignancy SOI 1	1,419	7	-7%	-7%	-8%	9%	7%
45	Nervous System Malignancy SOI 2	7,995	47	-7%	-5%	-7%	12%	8%
46	Nervous System Malignancy SOI 3	7,186	64	-5%	-3%	-4%	6%	1%
47	Degenerative Nervous System Disorders Exc Mult Sclerosis SOI 1	5,861	24	-12%	-5%	-5%	26%	20%
48	Degenerative Nervous System Disorders Exc Mult Sclerosis SOI 2	25,893	126	-14%	-6%	-6%	20%	12%
49	Degenerative Nervous System Disorders Exc Mult Sclerosis SOI 3	9,672	71	-8%	-3%	-3%	13%	7%
50	Multiple Sclerosis & Other Demyelinating Diseases SOI 1	2,412	11	-5%	-4%	-4%	30%	26%
51	Multiple Sclerosis & Other Demyelinating Diseases SOI 2	3,602	22	-4%	-3%	-3%	21%	17%
52	Multiple Sclerosis & Other Demyelinating Diseases SOI 3	788	8	-3%	1%	0%	13%	10%
53	Intracranial Hemorrhage SOI 1	7,226	36	-13%	-7%	-7%	4%	0%
54	Intracranial Hemorrhage SOI 2	12,942	84	-12%	-6%	-6%	-4%	-8%
55	Intracranial Hemorrhage SOI 3	16,075	137	-7%	-3%	-3%	-3%	-6%
56	CVA & Precerebral Occlusion w Infarct SOI 1	17,297	82	-8%	-7%	-7%	5%	2%
57	CVA & Precerebral Occlusion w Infarct SOI 2	98,264	592	-10%	-6%	-6%	3%	0%
58	CVA & Precerebral Occlusion w Infarct SOI 3	52,439	476	-8%	-4%	-4%	-2%	-5%
59	Nonspecific Cva & Precerebral Occlusion w/o Infarct SOI 1	8,626	34	-8%	-7%	-6%	12%	10%
60	Nonspecific Cva & Precerebral Occlusion w/o Infarct SOI 2	40,445	200	-10%	-7%	-6%	9%	6%
61	Nonspecific Cva & Precerebral Occlusion w/o Infarct SOI 3	16,940	119	-9%	-5%	-4%	5%	1%
62	Transient Ischemia SOI 1	24,245	81	-2%	-7%	-6%	9%	7%
63	Transient Ischemia SOI 2	67,254	272	-4%	-7%	-5%	10%	7%
64	Transient Ischemia SOI 3	16,086	88	-4%	-6%	-5%	7%	3%
65	Peripheral, Cranial & Autonomic Nerve Disorders SOI 1	7,314	30	-4%	-5%	-4%	27%	25%
66	Peripheral, Cranial & Autonomic Nerve Disorders SOI 2	18,159	93	-8%	-5%	-4%	19%	14%
67	Peripheral, Cranial & Autonomic Nerve Disorders SOI 3	10,746	77	-5%	-2%	-2%	15%	11%
68	Bacterial & Tuberculous Infections of Nervous System SOI 1	80	1	-13%	-4%	-3%	5%	2%
69	Bacterial & Tuberculous Infections of Nervous System SOI 2	1,295	16	4%	1%	1%	5%	5%
70	Bacterial & Tuberculous Infections of Nervous System SOI 3	1,179	20	1%	1%	2%	1%	0%
71	Non-Bacterial Infections of Nervous System Exc Viral Meningitis SOI 1	1,552	7	-14%	-6%	-8%	18%	12%
72	Non-Bacterial Infections of Nervous System Exc Viral Meningitis SOI 2	1,747	15	-3%	-3%	-4%	9%	4%
73	Non-Bacterial Infections of Nervous System Exc Viral Meningitis SOI 3	1,433	20	0%	1%	0%	0%	-2%
74	Viral Meningitis SOI 1	351	2	-7%	-5%	-5%	18%	13%
75	Viral Meningitis SOI 2	923	6	-5%	-4%	-4%	10%	6%
76	Viral Meningitis SOI 3	475	5	-4%	-2%	-2%	3%	0%
77	Nontraumatic Stupor & Coma SOI 1	3,247	11	-5%	-6%	-6%	11%	8%
78	Nontraumatic Stupor & Coma SOI 2	8,566	39	-8%	-5%	-4%	12%	7%
79	Nontraumatic Stupor & Coma SOI 3	18,299	132	-4%	-4%	-4%	6%	1%
80	Seizure SOI 1	12,300	45	-5%	-5%	-3%	21%	16%
81	Seizure SOI 2	35,358	163	-7%	-5%	-3%	12%	8%
82	Seizure SOI 3	17,775	132	-5%	-3%	-1%	5%	1%
83	Migraine & Other Headaches SOI 1	4,341	15	-6%	-5%	-4%	24%	20%
84	Migraine & Other Headaches SOI 2	8,582	36	-7%	-6%	-5%	17%	13%
85	Migraine & Other Headaches SOI 3	1,717	10	-6%	-4%	-5%	10%	6%
86	Head Trauma w Coma >1 Hr or Hemorrhage SOI 1	2,977	13	-9%	-7%	-7%	3%	0%

Appendix C. Comparative Cost Margins in THEORI Models Based on CS DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 6 Standard Charges	7 Standard Cost	8 HSRV Cost	9 HSRVcc GM CCR	10 HSRVcc Agg. CCR
87	Head Trauma w Coma >1 Hr or Hemorrhage SOI 2	9,978	62	-8%	-6%	-6%	-3%	-6%
88	Head Trauma w Coma >1 Hr or Hemorrhage SOI 3	5,870	52	-5%	-2%	-2%	-3%	-6%
89	Brain Contusion/Laceration & Complicated Skull Fx, Coma <1 Hr or No Coma SOI 1	752	3	-10%	-6%	-5%	3%	0%
90	Brain Contusion/Laceration & Complicated Skull Fx, Coma <1 Hr or No Coma SOI 2	2,530	16	-8%	-6%	-6%	-3%	-7%
91	Brain Contusion/Laceration & Complicated Skull Fx, Coma <1 Hr or No Coma SOI 3	1,090	12	-7%	-2%	-2%	-8%	-10%
92	Concussion, Closed Skull Fx Nos, Uncomplicated Intracranial Injury, Coma <1 Hr or No Coma SOI 1	1,588	6	2%	-6%	-4%	12%	11%
93	Concussion, Closed Skull Fx Nos, Uncomplicated Intracranial Injury, Coma <1 Hr or No Coma SOI 2	4,653	21	-4%	-5%	-4%	11%	8%
94	Concussion, Closed Skull Fx Nos, Uncomplicated Intracranial Injury, Coma <1 Hr or No Coma SOI 3	1,545	12	-3%	-3%	-1%	4%	1%
95	Other Disorders of Nervous System SOI 1	19,298	78	-8%	-6%	-6%	18%	14%
96	Other Disorders of Nervous System SOI 2	16,494	86	-9%	-6%	-5%	13%	9%
97	Other Disorders of Nervous System SOI 3	5,770	45	-7%	-3%	-3%	7%	3%
98	Eye Procedures SOI 4	41	1	9%	8%	11%	1%	1%
99	Orbital Procedures SOI 1	329	2	-4%	-5%	0%	6%	5%
100	Orbital Procedures SOI 2	584	4	0%	-3%	-3%	2%	1%
101	Orbital Procedures SOI 3	193	2	-1%	1%	2%	-3%	-2%
102	Eye Procedures Except Orbit SOI 1	1,806	8	-6%	-4%	3%	7%	9%
103	Eye Procedures Except Orbit SOI 2	1,854	10	-9%	-4%	1%	7%	8%
104	Eye Procedures Except Orbit SOI 3	227	2	-3%	-2%	-3%	-1%	-1%
105	Eye Diagnoses SOI 4	71	1	11%	10%	13%	12%	10%
106	Acute Major Eye Infections SOI 1	303	1	-14%	-7%	-2%	52%	43%
107	Acute Major Eye Infections SOI 2	1,403	6	-11%	-6%	-4%	27%	20%
108	Acute Major Eye Infections SOI 3	384	3	-6%	-4%	-3%	21%	16%
109	Eye Disorders Except Major Infections SOI 1	1,310	4	-4%	-5%	-5%	23%	20%
110	Eye Disorders Except Major Infections SOI 2	3,469	14	-5%	-6%	-6%	18%	15%
111	Eye Disorders Except Major Infections SOI 3	880	5	-5%	-4%	-2%	16%	11%
112	Ear, Nose, Mouth & Throat Procedures SOI 4	559	20	6%	6%	7%	-10%	-10%
113	Major Cranial/Facial Bone Procedures SOI 1	244	2	-1%	-4%	-4%	-17%	-11%
114	Major Cranial/Facial Bone Procedures SOI 2	574	7	-2%	-1%	-1%	-16%	-13%
115	Major Cranial/Facial Bone Procedures SOI 3	734	18	2%	3%	4%	-16%	-15%
116	Major Larynx & Trachea Procedures SOI 1	44	0	-6%	-6%	-4%	-14%	-14%
117	Major Larynx & Trachea Procedures SOI 2	1,044	19	-4%	-1%	0%	-18%	-19%
118	Major Larynx & Trachea Procedures SOI 3	297	9	-1%	4%	4%	-15%	-16%
119	Other Major Head & Neck Procedures SOI 1	964	9	-4%	-4%	-5%	-20%	-20%
120	Other Major Head & Neck Procedures SOI 2	1,129	17	-2%	-1%	-2%	-15%	-12%
121	Other Major Head & Neck Procedures SOI 3	244	6	-1%	1%	2%	-19%	-18%
122	Facial Bone Procedures Except Major Cranial/Facial Bone Procedures SOI 1	532	3	1%	-5%	-3%	-9%	-7%
123	Facial Bone Procedures Except Major Cranial/Facial Bone Procedures SOI 2	763	6	-1%	-5%	-4%	-8%	-7%
124	Facial Bone Procedures Except Major Cranial/Facial Bone Procedures SOI 3	309	5	2%	1%	1%	-11%	-10%
125	Sinus & Mastoid Procedures SOI 1	851	4	1%	-5%	-6%	-11%	-9%
126	Sinus & Mastoid Procedures SOI 2	838	6	1%	-3%	-5%	-4%	-5%
127	Sinus & Mastoid Procedures SOI 3	199	3	7%	4%	1%	-3%	-4%
128	Cleft Lip & Palate Repair SOI 1	406	2	4%	-6%	-8%	-14%	-13%
129	Cleft Lip & Palate Repair SOI 2	183	1	-5%	-6%	-7%	-14%	-13%

Appendix C. Comparative Cost Margins in THEORI Models Based on CS DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 6 Standard Charges	7 Standard Cost	8 HSRV Cost	9 HSRVcc GM CCR	10 HSRVcc Agg. CCR
131	Tonsil & Adenoid Procedures SOI 1	203	1	-1%	-6%	-8%	3%	2%
132	Tonsil & Adenoid Procedures SOI 2	324	2	-3%	-3%	-3%	2%	0%
133	Tonsil & Adenoid Procedures SOI 3	102	2	4%	2%	4%	-2%	-3%
134	Other Ear, Nose, Mouth & Throat Procedures SOI 1	3,423	16	0%	-5%	-6%	-6%	-6%
135	Other Ear, Nose, Mouth & Throat Procedures SOI 2	3,379	22	-2%	-4%	-4%	-3%	-3%
136	Other Ear, Nose, Mouth & Throat Procedures SOI 3	922	13	0%	2%	2%	-6%	-7%
137	Ear, Nose, Mouth & Throat Diagnoses SOI 4	1,623	29	2%	5%	4%	-2%	-4%
138	Ear, Nose, Mouth, Throat, Cranial/Facial Malignancies SOI 1	315	1	-7%	-5%	-2%	18%	17%
139	Ear, Nose, Mouth, Throat, Cranial/Facial Malignancies SOI 2	1,321	7	-11%	-6%	-5%	14%	10%
140	Ear, Nose, Mouth, Throat, Cranial/Facial Malignancies SOI 3	1,711	17	-2%	0%	1%	7%	4%
141	Vertigo & Other Labyrinth Disorders SOI 1	12,910	39	-2%	-6%	-6%	15%	12%
142	Vertigo & Other Labyrinth Disorders SOI 2	21,007	76	-6%	-6%	-6%	12%	9%
143	Vertigo & Other Labyrinth Disorders SOI 3	3,304	15	-6%	-6%	-7%	9%	5%
144	Infections of Upper Respiratory Tract SOI 1	2,454	7	-16%	-6%	-4%	24%	19%
145	Infections of Upper Respiratory Tract SOI 2	13,023	48	-16%	-6%	-6%	21%	15%
146	Infections of Upper Respiratory Tract SOI 3	4,543	26	-13%	-3%	-4%	14%	9%
147	Dental & Oral Diseases & Injuries SOI 1	974	3	-8%	-7%	-6%	27%	24%
148	Dental & Oral Diseases & Injuries SOI 2	3,080	14	-7%	-5%	-5%	23%	19%
149	Dental & Oral Diseases & Injuries SOI 3	1,493	12	-5%	0%	-1%	15%	11%
150	Other Ear, Nose, Mouth, Throat & Cranial/Facial Diagnoses SOI 1	8,378	27	-11%	-6%	-5%	30%	26%
151	Other Ear, Nose, Mouth, Throat & Cranial/Facial Diagnoses SOI 2	8,512	39	-8%	-6%	-5%	18%	14%
152	Other Ear, Nose, Mouth, Throat & Cranial/Facial Diagnoses SOI 3	3,078	21	-6%	-4%	-4%	9%	5%
153	Respiratory & Chest Procedures SOI 4	5,004	218	6%	6%	5%	-13%	-12%
154	Major Respiratory & Chest Procedures SOI 1	4,436	54	-8%	-5%	-7%	-24%	-23%
155	Major Respiratory & Chest Procedures SOI 2	11,531	179	-6%	-4%	-6%	-24%	-23%
156	Major Respiratory & Chest Procedures SOI 3	5,486	132	-1%	0%	-2%	-19%	-19%
157	Other Respiratory & Chest Procedures SOI 1	5,093	42	-5%	-5%	-6%	-16%	-16%
158	Other Respiratory & Chest Procedures SOI 2	11,783	138	-4%	-3%	-4%	-14%	-14%
159	Other Respiratory & Chest Procedures SOI 3	6,427	132	-1%	1%	0%	-12%	-12%
160	Respiratory System Diagnoses Except w Ventilator Support 96+ Hours SOI 4	125,549	1,839	-1%	1%	2%	-7%	-8%
161	Respiratory System Diagnosis w Ventilator Support 96+ Hours SOI 1	521	11	-10%	0%	1%	-21%	-22%
162	Respiratory System Diagnosis w Ventilator Support 96+ Hours SOI 2	4,258	102	-3%	1%	2%	-20%	-20%
163	Respiratory System Diagnosis w Ventilator Support 96+ Hours SOI 3	15,862	471	2%	2%	3%	-18%	-18%
164	Respiratory System Diagnosis w Ventilator Support 96+ Hours SOI 4	23,721	842	6%	4%	5%	-15%	-15%
165	Cystic Fibrosis - Pulmonary Disease SOI 1	79	1	-2%	-1%	-3%	9%	4%
166	Cystic Fibrosis - Pulmonary Disease SOI 2	530	6	-4%	1%	-1%	13%	9%
167	Cystic Fibrosis - Pulmonary Disease SOI 3	747	11	-6%	1%	0%	13%	9%
168	Pulmonary Edema & Respiratory Failure SOI 1	1,131	5	-19%	-6%	-5%	5%	4%
169	Pulmonary Edema & Respiratory Failure SOI 2	20,383	127	-15%	-6%	-5%	0%	-4%
170	Pulmonary Edema & Respiratory Failure SOI 3	46,874	416	-11%	-4%	-4%	-6%	-9%
171	Pulmonary Embolism SOI 1	7,009	43	-16%	-6%	-8%	4%	0%
172	Pulmonary Embolism SOI 2	23,505	178	-13%	-6%	-7%	1%	-2%
173	Pulmonary Embolism SOI 3	16,884	176	-9%	-4%	-5%	-3%	-5%

Appendix C. Comparative Cost Margins in THEORI Models Based on CS DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 6 Standard Charges	7 Standard Cost	8 HSRV Cost	9 HSRVcc GM CCR	10 HSRVcc Agg. CCR
174	Major Chest & Respiratory Trauma SOI 1	3,852	16	-12%	-6%	-5%	13%	8%
175	Major Chest & Respiratory Trauma SOI 2	4,464	26	-12%	-4%	-4%	8%	4%
176	Major Chest & Respiratory Trauma SOI 3	3,339	31	-12%	-4%	-4%	-1%	-5%
177	Respiratory Malignancy SOI 1	2,854	14	-8%	-5%	-6%	14%	11%
178	Respiratory Malignancy SOI 2	26,140	168	-8%	-5%	-6%	10%	5%
179	Respiratory Malignancy SOI 3	34,252	349	-3%	-2%	-3%	4%	0%
180	Major Respiratory Infections & Inflammations SOI 1	5,713	31	-17%	-6%	-4%	13%	7%
181	Major Respiratory Infections & Inflammations SOI 2	58,777	413	-12%	-5%	-4%	10%	5%
182	Major Respiratory Infections & Inflammations SOI 3	83,811	848	-7%	-3%	-2%	5%	1%
183	Bronchiolitis & RSV Pneumonia SOI 1	46	0	-8%	-7%	-1%	27%	20%
184	Bronchiolitis & RSV Pneumonia SOI 2	222	1	-19%	-6%	-3%	18%	13%
185	Bronchiolitis & RSV Pneumonia SOI 3	137	1	-6%	-1%	-1%	8%	5%
186	Other Pneumonia SOI 1	28,552	107	-15%	-6%	-5%	20%	14%
187	Other Pneumonia SOI 2	272,801	1,390	-14%	-6%	-5%	14%	9%
188	Other Pneumonia SOI 3	212,317	1,603	-10%	-4%	-4%	7%	3%
189	Chronic Obstructive Pulmonary Disease SOI 1	88,784	354	-14%	-6%	-4%	16%	10%
190	Chronic Obstructive Pulmonary Disease SOI 2	183,036	918	-12%	-6%	-5%	12%	7%
191	Chronic Obstructive Pulmonary Disease SOI 3	91,602	649	-9%	-5%	-4%	6%	1%
192	Asthma SOI 1	9,247	30	-11%	-6%	-2%	23%	17%
193	Asthma SOI 2	19,293	81	-11%	-6%	-3%	17%	11%
194	Asthma SOI 3	5,039	31	-9%	-4%	-3%	11%	6%
195	Interstitial Lung Disease SOI 1	999	5	-8%	-5%	-5%	17%	13%
196	Interstitial Lung Disease SOI 2	7,933	47	-10%	-6%	-6%	9%	4%
197	Interstitial Lung Disease SOI 3	7,699	65	-10%	-4%	-4%	4%	-1%
198	Other Respiratory Diagnoses Except Signs, Symptoms & Minor Diagnoses SOI 1	3,942	16	-16%	-6%	-6%	18%	13%
199	Other Respiratory Diagnoses Except Signs, Symptoms & Minor Diagnoses SOI 2	20,995	114	-11%	-5%	-5%	11%	7%
200	Other Respiratory Diagnoses Except Signs, Symptoms & Minor Diagnoses SOI 3	12,851	108	-9%	-3%	-3%	7%	3%
201	Respiratory Signs, Symptoms & Minor Diagnoses SOI 1	20,879	68	-9%	-6%	-5%	16%	13%
202	Respiratory Signs, Symptoms & Minor Diagnoses SOI 2	40,863	164	-11%	-6%	-5%	16%	11%
203	Respiratory Signs, Symptoms & Minor Diagnoses SOI 3	15,442	88	-10%	-5%	-5%	11%	6%
204	Cardiothoracic Procedures SOI 4	21,817	1,253	12%	6%	5%	-12%	-9%
205	Vascular Procedures SOI 4	12,416	501	9%	7%	6%	-9%	-8%
206	Other Circulatory System Procedures SOI 4	19,764	596	9%	4%	4%	-13%	-8%
207	Cardiac Defibrillator & Heart Assist Implant SOI 1	5,485	138	13%	1%	0%	-10%	6%
208	Cardiac Defibrillator & Heart Assist Implant SOI 2	22,078	637	12%	2%	1%	-10%	5%
209	Cardiac Defibrillator & Heart Assist Implant SOI 3	25,509	907	12%	3%	2%	-8%	4%
210	Cardiac Valve Procedures w Cardiac Catheterization SOI 1	1,091	31	5%	-2%	-4%	-24%	-18%
211	Cardiac Valve Procedures w Cardiac Catheterization SOI 2	4,233	136	5%	-2%	-3%	-23%	-17%
212	Cardiac Valve Procedures w Cardiac Catheterization SOI 3	9,203	392	8%	2%	1%	-18%	-13%
213	Cardiac Valve Procedures w/o Cardiac Catheterization SOI 1	3,015	72	1%	-2%	-4%	-25%	-19%
214	Cardiac Valve Procedures w/o Cardiac Catheterization SOI 2	9,321	245	0%	-3%	-4%	-24%	-18%
215	Cardiac Valve Procedures w/o Cardiac Catheterization SOI 3	11,716	409	5%	1%	0%	-19%	-14%
216	Coronary Bypass w Cardiac Cath or Percutaneous Cardiac Procedure SOI 1	4,910	103	2%	-5%	-6%	-30%	-25%

Appendix C. Comparative Cost Margins in THEORI Models Based on CS DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 6 Standard Charges	7 Standard Cost	8 HSRV Cost	9 HSRVcc GM CCR	10 HSRVcc Agg. CCR
217	Coronary Bypass w Cardiac Cath or Percutaneous Cardiac Procedure SOI 2	34,554	850	2%	-4%	-5%	-27%	-23%
218	Coronary Bypass w Cardiac Cath or Percutaneous Cardiac Procedure SOI 3	24,474	796	5%	-1%	-1%	-22%	-19%
219	Coronary Bypass w/o Cardiac Cath or Percutaneous Cardiac Procedure SOI 1	5,226	90	-2%	-5%	-7%	-31%	-27%
220	Coronary Bypass w/o Cardiac Cath or Percutaneous Cardiac Procedure SOI 2	27,413	541	-2%	-5%	-6%	-29%	-25%
221	Coronary Bypass w/o Cardiac Cath or Percutaneous Cardiac Procedure SOI 3	13,681	369	3%	0%	-1%	-23%	-20%
222	Other Cardiothoracic Procedures SOI 1	493	9	3%	-1%	-2%	-20%	-15%
223	Other Cardiothoracic Procedures SOI 2	682	15	0%	-1%	-2%	-23%	-18%
224	Other Cardiothoracic Procedures SOI 3	1,581	53	5%	3%	2%	-18%	-15%
225	Major Thoracic & Abdominal Vascular Procedures SOI 1	3,133	37	-2%	-3%	-4%	-21%	-17%
226	Major Thoracic & Abdominal Vascular Procedures SOI 2	13,394	208	-4%	-3%	-5%	-25%	-23%
227	Major Thoracic & Abdominal Vascular Procedures SOI 3	10,521	238	3%	2%	1%	-17%	-15%
228	Permanent Cardiac Pacemaker Implant w AMI, Heart Failure or Shock SOI 1	1,342	19	6%	-3%	-3%	-11%	0%
229	Permanent Cardiac Pacemaker Implant w AMI, Heart Failure or Shock SOI 2	7,501	126	5%	-2%	-3%	-11%	-1%
230	Permanent Cardiac Pacemaker Implant w AMI, Heart Failure or Shock SOI 3	4,118	92	4%	0%	-1%	-11%	-6%
231	Perm Cardiac Pacemaker Implant w/o AMI, Heart Failure or Shock SOI 1	38,049	373	3%	-5%	-6%	-13%	0%
232	Perm Cardiac Pacemaker Implant w/o AMI, Heart Failure or Shock SOI 2	52,860	646	1%	-5%	-5%	-12%	-3%
233	Perm Cardiac Pacemaker Implant w/o AMI, Heart Failure or Shock SOI 3	13,440	236	1%	-2%	-2%	-12%	-6%
234	Other Vascular Procedures SOI 1	35,319	341	4%	-2%	-3%	-14%	-7%
235	Other Vascular Procedures SOI 2	49,294	597	3%	-2%	-2%	-13%	-8%
236	Other Vascular Procedures SOI 3	30,815	592	4%	1%	1%	-10%	-9%
237	Percutaneous Cardiovascular Procedures w AMI SOI 1	22,025	275	6%	-4%	-5%	-23%	-10%
238	Percutaneous Cardiovascular Procedures w AMI SOI 2	43,972	622	5%	-4%	-4%	-22%	-11%
239	Percutaneous Cardiovascular Procedures w AMI SOI 3	17,184	326	5%	-2%	-2%	-19%	-11%
240	Percutaneous Cardiovascular Procedures w/o AMI SOI 1	136,692	1,377	13%	-4%	-5%	-21%	-5%
241	Percutaneous Cardiovascular Procedures w/o AMI SOI 2	103,134	1,175	12%	-4%	-4%	-19%	-5%
242	Percutaneous Cardiovascular Procedures w/o AMI SOI 3	31,040	503	9%	-1%	-2%	-14%	-5%
243	Cardiac Pacemaker & Defibrillator Device Replacement SOI 1	6,076	48	8%	-4%	-4%	-5%	7%
244	Cardiac Pacemaker & Defibrillator Device Replacement SOI 2	1,181	19	9%	0%	-1%	-8%	6%
245	Cardiac Pacemaker & Defibrillator Device Replacement SOI 3	3,311	63	10%	-1%	-1%	-7%	8%
246	Cardiac Pacemaker & Defibrillator Revision Except Device Replacement SOI 1	3,267	18	-1%	-4%	-5%	-7%	-3%
247	Cardiac Pacemaker & Defibrillator Revision Except Device Replacement SOI 2	1,907	19	4%	0%	0%	-5%	1%
248	Cardiac Pacemaker & Defibrillator Revision Except Device Replacement SOI 3	1,168	19	6%	2%	2%	-6%	0%
249	Other Circulatory System Procedures SOI 1	1,517	11	-3%	-4%	-5%	0%	-3%
250	Other Circulatory System Procedures SOI 2	4,096	43	-2%	-3%	-3%	-3%	-5%
251	Other Circulatory System Procedures SOI 3	7,481	129	4%	1%	0%	-5%	-6%
252	Circulatory System Diagnoses SOI 4	95,936	1,561	4%	3%	4%	-7%	-7%
253	Acute Myocardial Infarction SOI 1	26,331	129	-13%	-9%	-8%	-7%	-6%
254	Acute Myocardial Infarction SOI 2	77,591	498	-12%	-7%	-6%	-8%	-9%
255	Acute Myocardial Infarction SOI 3	65,797	598	-10%	-5%	-4%	-10%	-11%
256	Cardiac Catheterization w Circ Disord Exc Ischemic Heart Disease SOI 1	10,515	63	5%	-6%	-7%	-12%	-7%
257	Cardiac Catheterization w Circ Disord Exc Ischemic Heart Disease SOI 2	18,221	136	1%	-6%	-6%	-11%	-7%
258	Cardiac Catheterization w Circ Disord Exc Ischemic Heart Disease SOI 3	40,044	419	0%	-3%	-4%	-9%	-8%
259	Cardiac Catheterization for Ischemic Heart Disease SOI 1	58,428	294	5%	-7%	-7%	-14%	-7%

Appendix C. Comparative Cost Margins in THEORI Models Based on CS DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 6 Standard Charges	7 Standard Cost	8 HSRV Cost	9 HSRVcc GM CCR	10 HSRVcc Agg. CCR
260	Cardiac Catheterization for Ischemic Heart Disease SOI 2	68,378	415	3%	-6%	-6%	-12%	-7%
261	Cardiac Catheterization for Ischemic Heart Disease SOI 3	17,133	144	1%	-5%	-5%	-10%	-7%
262	Acute & Subacute Endocarditis SOI 1	191	1	-8%	-6%	-8%	5%	1%
263	Acute & Subacute Endocarditis SOI 2	1,313	13	-7%	-3%	-4%	5%	1%
264	Acute & Subacute Endocarditis SOI 3	2,703	41	0%	-1%	-2%	0%	-3%
265	Heart Failure SOI 1	73,416	290	-12%	-6%	-5%	11%	6%
266	Heart Failure SOI 2	386,153	2,066	-12%	-6%	-5%	7%	3%
267	Heart Failure SOI 3	166,155	1,409	-9%	-4%	-4%	0%	-4%
268	Cardiac Arrest SOI 1	225	1	-10%	-6%	-5%	12%	11%
269	Cardiac Arrest SOI 2	1,033	4	-14%	-6%	-6%	6%	4%
270	Cardiac Arrest SOI 3	2,273	12	-9%	-4%	-3%	0%	-1%
271	Peripheral & Other Vascular Disorders SOI 1	26,400	101	-16%	-6%	-6%	31%	24%
272	Peripheral & Other Vascular Disorders SOI 2	58,083	295	-11%	-6%	-5%	23%	18%
273	Peripheral & Other Vascular Disorders SOI 3	32,329	248	-6%	-3%	-3%	13%	9%
274	Angina Pectoris & Coronary Atherosclerosis SOI 1	84,111	240	-8%	-7%	-5%	10%	9%
275	Angina Pectoris & Coronary Atherosclerosis SOI 2	121,748	427	-9%	-7%	-5%	9%	6%
276	Angina Pectoris & Coronary Atherosclerosis SOI 3	29,587	146	-9%	-6%	-4%	6%	3%
277	Hypertension SOI 1	13,061	37	-7%	-6%	-3%	20%	17%
278	Hypertension SOI 2	19,919	76	-9%	-6%	-3%	13%	9%
279	Hypertension SOI 3	4,415	25	-9%	-6%	-4%	4%	0%
280	Cardiac Structural & Valvular Disorders SOI 1	1,000	3	-1%	-6%	-7%	16%	15%
281	Cardiac Structural & Valvular Disorders SOI 2	3,843	17	-9%	-6%	-6%	9%	6%
282	Cardiac Structural & Valvular Disorders SOI 3	2,606	17	-9%	-3%	-3%	7%	3%
283	Cardiac Arrhythmia & Conduction Disorders SOI 1	64,296	202	-11%	-7%	-7%	9%	6%
284	Cardiac Arrhythmia & Conduction Disorders SOI 2	130,357	555	-12%	-7%	-6%	6%	3%
285	Cardiac Arrhythmia & Conduction Disorders SOI 3	55,376	356	-12%	-5%	-5%	1%	-3%
286	Chest Pain SOI 1	57,409	160	1%	-6%	-5%	8%	8%
287	Chest Pain SOI 2	62,675	214	-1%	-6%	-5%	7%	6%
288	Chest Pain SOI 3	11,607	56	-3%	-5%	-4%	6%	4%
289	Syncope & Collapse SOI 1	37,355	121	-1%	-6%	-5%	11%	9%
290	Syncope & Collapse SOI 2	91,483	372	-4%	-6%	-6%	9%	6%
291	Syncope & Collapse SOI 3	22,885	127	-4%	-6%	-5%	6%	2%
292	Cardiomyopathy SOI 1	425	2	-3%	-5%	-4%	11%	9%
293	Cardiomyopathy SOI 2	1,639	8	-13%	-5%	-5%	8%	5%
294	Cardiomyopathy SOI 3	1,406	10	-15%	-4%	-4%	1%	-3%
295	Malfunction, Reaction, Complication of Cardiac/Vasc Device or Procedure SOI 1	1,625	6	-5%	-5%	-6%	12%	11%
296	Malfunction, Reaction, Complication of Cardiac/Vasc Device or Procedure SOI 2	11,046	60	-8%	-4%	-4%	15%	12%
297	Malfunction, Reaction, Complication of Cardiac/Vasc Device or Procedure SOI 3	12,127	118	-2%	0%	0%	10%	7%
298	Other Circulatory System Diagnoses SOI 1	18,441	68	-10%	-6%	-5%	13%	9%
299	Other Circulatory System Diagnoses SOI 2	16,332	92	-11%	-5%	-5%	6%	3%
300	Other Circulatory System Diagnoses SOI 3	7,931	64	-10%	-3%	-4%	2%	-1%
301	Major Gastrointestinal Procedures SOI 4	27,537	1,107	8%	7%	7%	-10%	-9%
302	Other Gastrointestinal & Abdominal Procedures SOI 4	5,129	163	8%	7%	6%	-10%	-9%

Appendix C. Comparative Cost Margins in THEORI Models Based on CS DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 6 Standard Charges	7 Standard Cost	8 HSRV Cost	9 HSRVcc GM CCR	10 HSRVcc Agg. CCR
303	Major Stomach, Esophageal & Duodenal Procedures SOI 1	8,141	71	-6%	-5%	-6%	-11%	-10%
304	Major Stomach, Esophageal & Duodenal Procedures SOI 2	7,429	122	-3%	0%	0%	-11%	-11%
305	Major Stomach, Esophageal & Duodenal Procedures SOI 3	7,607	200	1%	3%	3%	-11%	-11%
306	Major Small & Large Bowel Procedures SOI 1	28,438	256	-10%	-5%	-7%	-7%	-8%
307	Major Small & Large Bowel Procedures SOI 2	60,978	802	-7%	-3%	-4%	-10%	-11%
308	Major Small & Large Bowel Procedures SOI 3	41,682	926	0%	1%	0%	-11%	-11%
309	Other Stomach, Esophageal & Duodenal Procedures SOI 1	652	4	-5%	-3%	-4%	-3%	-4%
310	Other Stomach, Esophageal & Duodenal Procedures SOI 2	1,131	11	-5%	-1%	-2%	-3%	-5%
311	Other Stomach, Esophageal & Duodenal Procedures SOI 3	582	11	-2%	2%	1%	-11%	-11%
312	Other Small & Large Bowel Procedures SOI 1	5,353	41	-8%	-4%	-5%	0%	-3%
313	Other Small & Large Bowel Procedures SOI 2	6,330	69	-6%	-2%	-3%	-3%	-5%
314	Other Small & Large Bowel Procedures SOI 3	3,745	69	-2%	2%	1%	-7%	-8%
315	Peritoneal Adhesiolysis SOI 1	2,716	24	-11%	-5%	-6%	-3%	-6%
316	Peritoneal Adhesiolysis SOI 2	5,500	72	-9%	-4%	-5%	-8%	-11%
317	Peritoneal Adhesiolysis SOI 3	3,625	70	-3%	0%	-1%	-11%	-12%
318	Appendectomy SOI 1	4,210	21	0%	-6%	-7%	-6%	-5%
319	Appendectomy SOI 2	9,627	76	-3%	-5%	-6%	-5%	-6%
320	Appendectomy SOI 3	2,510	37	-2%	0%	-1%	-11%	-11%
321	Anal Procedures SOI 1	4,958	20	-5%	-6%	-5%	13%	9%
322	Anal Procedures SOI 2	2,987	19	-1%	-3%	-2%	11%	7%
323	Anal Procedures SOI 3	789	9	-1%	0%	0%	5%	2%
324	Hernia Procedures Except Inguinal, Femoral & Umbilical SOI 1	13,002	69	-5%	-6%	-7%	-3%	-2%
325	Hernia Procedures Except Inguinal, Femoral & Umbilical SOI 2	14,578	113	-5%	-4%	-5%	-2%	-3%
326	Hernia Procedures Except Inguinal, Femoral & Umbilical SOI 3	3,487	51	0%	0%	0%	-8%	-9%
327	Inguinal, Femoral & Umbilical Hernia Procedures SOI 1	6,840	27	-2%	-7%	-6%	-3%	-3%
328	Inguinal, Femoral & Umbilical Hernia Procedures SOI 2	8,913	52	-3%	-5%	-5%	-1%	-2%
329	Inguinal, Femoral & Umbilical Hernia Procedures SOI 3	2,434	27	1%	0%	-1%	-6%	-8%
330	Other Digestive System & Abdominal Procedures SOI 1	1,474	11	-2%	-4%	-5%	-2%	-2%
331	Other Digestive System & Abdominal Procedures SOI 2	4,435	49	-1%	-2%	-3%	-4%	-5%
332	Other Digestive System & Abdominal Procedures SOI 3	3,716	74	5%	4%	3%	-3%	-3%
333	Digestive System Diagnoses SOI 4	29,695	506	5%	5%	5%	0%	-1%
334	Digestive Malignancy SOI 1	2,006	9	-6%	-6%	-6%	16%	13%
335	Digestive Malignancy SOI 2	12,717	75	-7%	-5%	-5%	13%	9%
336	Digestive Malignancy SOI 3	13,757	135	-2%	-1%	-1%	9%	6%
337	Peptic Ulcer & Gastritis SOI 1	20,810	76	-8%	-7%	-4%	16%	12%
338	Peptic Ulcer & Gastritis SOI 2	65,346	326	-9%	-6%	-5%	8%	4%
339	Peptic Ulcer & Gastritis SOI 3	40,347	317	-9%	-4%	-4%	-2%	-5%
340	Major Esophageal Disorders SOI 1	654	2	-4%	-3%	-2%	13%	10%
341	Major Esophageal Disorders SOI 2	4,540	23	-9%	-6%	-6%	4%	1%
342	Major Esophageal Disorders SOI 3	4,084	31	-8%	-4%	-4%	-2%	-4%
343	Other Esophageal Disorders SOI 1	12,690	42	-4%	-6%	-5%	8%	7%
344	Other Esophageal Disorders SOI 2	29,581	125	-7%	-6%	-5%	9%	6%
345	Other Esophageal Disorders SOI 3	10,895	75	-5%	-3%	-3%	7%	3%

Appendix C. Comparative Cost Margins in THEORI Models Based on CS DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 6 Standard Charges	7 Standard Cost	8 HSRV Cost	9 HSRVcc GM CCR	10 HSRVcc Agg. CCR
346	Diverticulitis & Diverticulosis SOI 1	26,426	97	-9%	-7%	-6%	19%	14%
347	Diverticulitis & Diverticulosis SOI 2	64,576	311	-10%	-7%	-6%	13%	9%
348	Diverticulitis & Diverticulosis SOI 3	21,014	160	-9%	-5%	-4%	5%	1%
349	Inflammatory Bowel Disease SOI 1	2,072	9	-9%	-6%	-5%	21%	16%
350	Inflammatory Bowel Disease SOI 2	7,005	39	-8%	-5%	-6%	15%	10%
351	Inflammatory Bowel Disease SOI 3	3,299	28	-5%	-3%	-3%	10%	6%
352	Gastrointestinal Vascular Insufficiency SOI 1	3,234	14	-6%	-6%	-8%	13%	8%
353	Gastrointestinal Vascular Insufficiency SOI 2	10,656	63	-7%	-6%	-6%	9%	4%
354	Gastrointestinal Vascular Insufficiency SOI 3	6,150	58	-5%	-2%	-2%	3%	0%
355	Intestinal Obstruction SOI 1	19,851	67	-12%	-7%	-7%	23%	16%
356	Intestinal Obstruction SOI 2	58,223	269	-11%	-6%	-6%	20%	13%
357	Intestinal Obstruction SOI 3	25,357	187	-7%	-3%	-3%	13%	8%
358	Major Gastrointestinal & Peritoneal Infections SOI 1	2,078	9	-12%	-6%	-8%	22%	15%
359	Major Gastrointestinal & Peritoneal Infections SOI 2	20,184	115	-10%	-5%	-6%	18%	12%
360	Major Gastrointestinal & Peritoneal Infections SOI 3	18,656	166	-4%	-2%	-2%	11%	6%
361	Non-Bacterial Gastroenteritis, Nausea & Vomiting SOI 1	13,288	37	-8%	-7%	-5%	25%	20%
362	Non-Bacterial Gastroenteritis, Nausea & Vomiting SOI 2	69,309	241	-11%	-6%	-5%	23%	17%
363	Non-Bacterial Gastroenteritis, Nausea & Vomiting SOI 3	25,274	134	-10%	-4%	-4%	17%	12%
364	Abdominal Pain SOI 1	11,808	37	-5%	-6%	-6%	18%	15%
365	Abdominal Pain SOI 2	28,683	117	-5%	-6%	-6%	15%	11%
366	Abdominal Pain SOI 3	8,742	51	-5%	-4%	-5%	12%	8%
367	Malfunction, Reaction & Complication of Gi Device or Procedure SOI 1	2,203	8	-12%	-5%	-4%	33%	26%
368	Malfunction, Reaction & Complication of Gi Device or Procedure SOI 2	10,361	52	-6%	-4%	-2%	24%	18%
369	Malfunction, Reaction & Complication of Gi Device or Procedure SOI 3	7,184	59	0%	0%	2%	18%	13%
370	Other & Unspecified Gastrointestinal Hemorrhage SOI 1	13,651	50	-14%	-7%	-5%	15%	11%
371	Other & Unspecified Gastrointestinal Hemorrhage SOI 2	51,411	249	-11%	-6%	-5%	11%	7%
372	Other & Unspecified Gastrointestinal Hemorrhage SOI 3	31,755	233	-9%	-4%	-4%	3%	0%
373	Other Digestive System Diagnoses SOI 1	35,799	118	-8%	-6%	-5%	22%	18%
374	Other Digestive System Diagnoses SOI 2	45,669	217	-9%	-5%	-5%	17%	12%
375	Other Digestive System Diagnoses SOI 3	26,792	197	-7%	-3%	-3%	10%	6%
376	Major Hepatobiliary, Pancreas & Liver Procedures SOI 4	2,260	108	15%	12%	12%	-4%	-2%
377	Cholecystectomy & Other Hepatobiliary, Pancreas & Abdominal Procedures SOI 4	5,760	175	9%	6%	6%	-9%	-9%
378	Major Pancreas, Liver & Shunt Procedures SOI 1	954	9	-1%	-4%	-5%	-12%	-11%
379	Major Pancreas, Liver & Shunt Procedures SOI 2	3,468	48	0%	-1%	-2%	-13%	-12%
380	Major Pancreas, Liver & Shunt Procedures SOI 3	4,120	105	2%	3%	3%	-11%	-11%
381	Major Biliary Tract Procedures SOI 1	301	3	-7%	-4%	-3%	-4%	-4%
382	Major Biliary Tract Procedures SOI 2	2,326	32	-4%	-3%	-2%	-10%	-11%
383	Major Biliary Tract Procedures SOI 3	1,660	34	0%	1%	0%	-10%	-11%
384	Cholecystectomy Except Laparoscopic SOI 1	4,425	31	-8%	-7%	-6%	-6%	-7%
385	Cholecystectomy Except Laparoscopic SOI 2	10,012	105	-5%	-5%	-4%	-9%	-10%
386	Cholecystectomy Except Laparoscopic SOI 3	6,091	102	-1%	-2%	-2%	-12%	-12%
387	Laparoscopic Cholecystectomy SOI 1	20,197	106	1%	-6%	-6%	-6%	-4%
388	Laparoscopic Cholecystectomy SOI 2	37,158	281	-1%	-6%	-6%	-7%	-7%

Appendix C. Comparative Cost Margins in THEORI Models Based on CS DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 6 Standard Charges	7 Standard Cost	8 HSRV Cost	9 HSRVcc GM CCR	10 HSRVcc Agg. CCR
389	Laparoscopic Cholecystectomy SOI 3	20,142	246	-1%	-3%	-4%	-9%	-9%
390	Other Hepatobiliary, Pancreas & Abdominal Procedures SOI 1	898	8	-3%	-4%	-2%	1%	0%
391	Other Hepatobiliary, Pancreas & Abdominal Procedures SOI 2	1,094	12	1%	-1%	-1%	0%	-1%
392	Other Hepatobiliary, Pancreas & Abdominal Procedures SOI 3	1,863	35	5%	3%	4%	-1%	-2%
393	Hepatobiliary, Pancreas & Abdominal Diagnoses SOI 4	13,054	242	8%	7%	8%	2%	1%
394	Hepatic Coma & Other Major Acute Liver Disorders SOI 1	1,249	4	-11%	-6%	-4%	26%	19%
395	Hepatic Coma & Other Major Acute Liver Disorders SOI 2	8,799	44	-7%	-5%	-3%	18%	12%
396	Hepatic Coma & Other Major Acute Liver Disorders SOI 3	8,629	75	-3%	0%	0%	10%	6%
397	Alcoholic Liver Disease SOI 1	276	1	-9%	-4%	-3%	32%	26%
398	Alcoholic Liver Disease SOI 2	3,538	17	-8%	-5%	-3%	19%	14%
399	Alcoholic Liver Disease SOI 3	7,003	56	-4%	-2%	-1%	7%	3%
400	Malignancy of Hepatobiliary System & Pancreas SOI 1	1,657	8	-4%	-5%	-7%	15%	12%
401	Malignancy of Hepatobiliary System & Pancreas SOI 2	11,881	74	-5%	-4%	-5%	15%	10%
402	Malignancy of Hepatobiliary System & Pancreas SOI 3	13,291	123	-2%	-2%	-3%	9%	6%
403	Disorders of Pancreas Except Malignancy SOI 1	13,793	59	-9%	-6%	-5%	19%	14%
404	Disorders of Pancreas Except Malignancy SOI 2	32,412	179	-6%	-4%	-3%	17%	12%
405	Disorders of Pancreas Except Malignancy SOI 3	15,719	144	-1%	1%	1%	12%	8%
406	Other Disorders of the Liver SOI 1	1,410	5	-6%	-5%	-2%	25%	20%
407	Other Disorders of the Liver SOI 2	8,707	43	-7%	-5%	-4%	18%	13%
408	Other Disorders of the Liver SOI 3	11,174	86	-4%	-4%	-2%	9%	5%
409	Disorders of Gallbladder & Biliary Tract SOI 1	6,721	26	-4%	-7%	-6%	15%	13%
410	Disorders of Gallbladder & Biliary Tract SOI 2	20,587	110	-6%	-6%	-5%	12%	9%
411	Disorders of Gallbladder & Biliary Tract SOI 3	11,538	94	-5%	-4%	-3%	8%	5%
412	Musculoskeletal System & Connective Tissue Procedures Except Spinal Fusion SOI 4	18,637	523	6%	4%	4%	-9%	-8%
413	Spinal Fusion Procedures SOI 4	1,337	65	10%	7%	5%	-11%	-7%
414	Hip Joint Replacement SOI 1	97,438	1,017	-5%	-6%	-8%	-12%	-6%
415	Hip Joint Replacement SOI 2	76,421	937	-4%	-5%	-7%	-11%	-5%
416	Hip Joint Replacement SOI 3	23,566	360	-1%	-2%	-4%	-12%	-7%
417	Knee Joint Replacement SOI 1	103,689	1,034	-5%	-6%	-9%	-16%	-8%
418	Knee Joint Replacement SOI 2	118,231	1,307	-4%	-5%	-8%	-14%	-7%
419	Knee Joint Replacement SOI 3	13,443	203	-1%	-2%	-4%	-12%	-6%
420	Dorsal & Lumbar Fusion Proc for Curvature of Back SOI 1	230	5	12%	5%	1%	-13%	-2%
421	Dorsal & Lumbar Fusion Proc for Curvature of Back SOI 2	515	16	9%	5%	2%	-12%	-3%
422	Dorsal & Lumbar Fusion Proc for Curvature of Back SOI 3	308	16	10%	5%	0%	-12%	-5%
423	Dorsal & Lumbar Fusion Proc Except for Curvature of Back SOI 1	15,868	243	5%	-1%	-4%	-16%	-6%
424	Dorsal & Lumbar Fusion Proc Except for Curvature of Back SOI 2	21,992	395	7%	1%	-2%	-15%	-6%
425	Dorsal & Lumbar Fusion Proc Except for Curvature of Back SOI 3	6,018	173	9%	4%	2%	-11%	-4%
426	Amputation of Lower Limb Except Toes SOI 1	2,145	15	-13%	-6%	-4%	4%	0%
427	Amputation of Lower Limb Except Toes SOI 2	14,709	140	-8%	-4%	-2%	3%	-1%
428	Amputation of Lower Limb Except Toes SOI 3	16,865	262	-1%	0%	1%	1%	-2%
429	Hip & Femur Procedures for Trauma Except Joint Replacement SOI 1	21,178	151	-9%	-7%	-7%	-7%	-7%
430	Hip & Femur Procedures for Trauma Except Joint Replacement SOI 2	72,966	628	-7%	-6%	-7%	-8%	-8%
431	Hip & Femur Procedures for Trauma Except Joint Replacement SOI 3	36,345	444	-5%	-4%	-4%	-9%	-9%

Appendix C. Comparative Cost Margins in THEORI Models Based on CS DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 6 Standard Charges	7 Standard Cost	8 HSRV Cost	9 HSRVcc GM CCR	10 HSRVcc Agg. CCR
432	Hip & Femur Procedures for Non-Trauma Except Joint Replacement SOI 1	1,925	15	-5%	-6%	-7%	-12%	-9%
433	Hip & Femur Procedures for Non-Trauma Except Joint Replacement SOI 2	6,671	71	-5%	-4%	-5%	-8%	-7%
434	Hip & Femur Procedures for Non-Trauma Except Joint Replacement SOI 3	2,811	50	0%	0%	0%	-4%	-4%
435	Intervertebral Disc Excision & Decompression SOI 1	36,426	175	-1%	-7%	-10%	-15%	-15%
436	Intervertebral Disc Excision & Decompression SOI 2	36,594	237	0%	-6%	-9%	-12%	-10%
437	Intervertebral Disc Excision & Decompression SOI 3	18,104	182	0%	-3%	-6%	-4%	-2%
438	Skin Graft, Except Hand, for Musculoskeletal & Connective Tissue Diagnoses SOI 1	376	3	-4%	-3%	-3%	-3%	-5%
439	Skin Graft, Except Hand, for Musculoskeletal & Connective Tissue Diagnoses SOI 2	868	12	5%	3%	5%	6%	3%
440	Skin Graft, Except Hand, for Musculoskeletal & Connective Tissue Diagnoses SOI 3	527	16	9%	11%	11%	8%	6%
441	Skin Graft, Except Hand, for Musculoskeletal & Connective Tissue Diagnoses SOI 4	81	6	9%	9%	9%	-2%	-2%
442	Knee & Lower Leg Procedures Except Foot SOI 1	18,040	104	-6%	-6%	-7%	-6%	-6%
443	Knee & Lower Leg Procedures Except Foot SOI 2	22,336	191	-4%	-4%	-5%	-5%	-4%
444	Knee & Lower Leg Procedures Except Foot SOI 3	5,896	88	1%	0%	0%	-5%	-5%
445	Foot & Toe Procedures SOI 1	2,813	14	-6%	-6%	-9%	-8%	-8%
446	Foot & Toe Procedures SOI 2	10,676	78	-6%	-5%	-4%	7%	2%
447	Foot & Toe Procedures SOI 3	9,910	108	-2%	-2%	-1%	7%	3%
448	Shoulder, Upper Arm & Forearm Procedures SOI 1	18,835	88	-1%	-6%	-9%	-10%	-7%
449	Shoulder, Upper Arm & Forearm Procedures SOI 2	35,780	291	-2%	-6%	-8%	-11%	-6%
450	Shoulder, Upper Arm & Forearm Procedures SOI 3	4,312	58	-1%	-1%	-3%	-9%	-8%
451	Hand & Wrist Procedures SOI 1	1,845	8	-1%	-5%	-6%	-2%	-2%
452	Hand & Wrist Procedures SOI 2	2,291	15	-6%	-5%	-6%	-1%	-3%
453	Hand & Wrist Procedures SOI 3	540	7	2%	2%	3%	5%	3%
454	Tendon, Muscle & Other Soft Tissue Procedures SOI 1	4,560	24	-8%	-6%	-7%	0%	-2%
455	Tendon, Muscle & Other Soft Tissue Procedures SOI 2	5,569	45	-5%	-4%	-3%	5%	1%
456	Tendon, Muscle & Other Soft Tissue Procedures SOI 3	2,585	41	2%	2%	2%	3%	1%
457	Other Musculoskeletal System & Connective Tissue Procedures SOI 1	2,658	13	-3%	-6%	-7%	-4%	-3%
458	Other Musculoskeletal System & Connective Tissue Procedures SOI 2	7,024	67	-2%	-3%	-5%	-4%	-3%
459	Other Musculoskeletal System & Connective Tissue Procedures SOI 3	2,309	39	2%	1%	0%	-2%	-3%
460	Other Musculoskeletal System & Connective Tissue Procedures SOI 4	360	13	7%	7%	7%	-4%	-4%
461	Cervical Spinal Fusion & Other Back/Neck Proc Exc Disc Excis/Decomp SOI 1	17,957	153	7%	-4%	-7%	-17%	-9%
462	Cervical Spinal Fusion & Other Back/Neck Proc Exc Disc Excis/Decomp SOI 2	12,197	144	4%	-2%	-4%	-14%	-8%
463	Cervical Spinal Fusion & Other Back/Neck Proc Exc Disc Excis/Decomp SOI 3	2,461	54	4%	2%	1%	-11%	-8%
464	Musculoskeletal System & Connective Tissue Diagnoses SOI 4	7,884	152	5%	6%	6%	0%	-1%
465	Fracture of Femur SOI 1	2,870	8	-18%	-9%	-8%	33%	27%
466	Fracture of Femur SOI 2	8,864	35	-15%	-7%	-7%	25%	19%
467	Fracture of Femur SOI 3	4,637	29	-11%	-4%	-4%	14%	9%
468	Fracture of Pelvis or Dislocation of Hip SOI 1	5,191	16	-19%	-7%	-9%	28%	19%
469	Fracture of Pelvis or Dislocation of Hip SOI 2	13,747	55	-17%	-7%	-8%	22%	14%
470	Fracture of Pelvis or Dislocation of Hip SOI 3	7,219	42	-13%	-5%	-7%	15%	8%
471	Fractures & Dislocations Except Femur, Pelvis & Back SOI 1	8,161	24	-15%	-7%	-7%	30%	24%
472	Fractures & Dislocations Except Femur, Pelvis & Back SOI 2	21,624	86	-14%	-6%	-6%	23%	16%
473	Fractures & Dislocations Except Femur, Pelvis & Back SOI 3	7,205	45	-11%	-5%	-5%	14%	8%
474	Musculoskeletal Malignancy & Pathol Fracture D/T Muscskel Malig SOI 1	1,108	5	-9%	-6%	-8%	15%	11%

Appendix C. Comparative Cost Margins in THEORI Models Based on CS DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 6 Standard Charges	7 Standard Cost	8 HSRV Cost	9 HSRVcc GM CCR	10 HSRVcc Agg. CCR
475	Musculoskeletal Malignancy & Pathol Fracture D/T Muscskel Malig SOI 2	6,726	41	-8%	-5%	-5%	15%	10%
476	Musculoskeletal Malignancy & Pathol Fracture D/T Muscskel Malig SOI 3	8,144	83	-4%	-2%	-3%	9%	4%
477	Osteomyelitis, Septic Arthritis & Other Musculoskeletal Infections SOI 1	935	4	-11%	-5%	-4%	21%	15%
478	Osteomyelitis, Septic Arthritis & Other Musculoskeletal Infections SOI 2	8,315	56	-7%	-5%	-2%	20%	14%
479	Osteomyelitis, Septic Arthritis & Other Musculoskeletal Infections SOI 3	6,737	70	-1%	-1%	1%	15%	10%
480	Connective Tissue Disorders SOI 1	3,882	16	-9%	-6%	-5%	23%	17%
481	Connective Tissue Disorders SOI 2	6,275	37	-7%	-4%	-3%	18%	14%
482	Connective Tissue Disorders SOI 3	4,393	43	-1%	0%	-1%	10%	6%
483	Other Back & Neck Disorders, Fractures & Injuries SOI 1	40,803	151	-14%	-7%	-7%	20%	14%
484	Other Back & Neck Disorders, Fractures & Injuries SOI 2	53,260	260	-13%	-6%	-7%	16%	9%
485	Other Back & Neck Disorders, Fractures & Injuries SOI 3	18,600	140	-9%	-4%	-5%	10%	4%
486	Malfunction, Reaction, Complic of Orthopedic Device or Procedure SOI 1	4,290	12	-9%	-7%	-8%	13%	9%
487	Malfunction, Reaction, Complic of Orthopedic Device or Procedure SOI 2	8,103	38	-10%	-5%	-5%	20%	15%
488	Malfunction, Reaction, Complic of Orthopedic Device or Procedure SOI 3	3,315	28	-6%	-2%	-1%	16%	11%
489	Other Musculoskeletal System & Connective Tissue Diagnoses SOI 1	14,247	42	-12%	-6%	-5%	29%	24%
490	Other Musculoskeletal System & Connective Tissue Diagnoses SOI 2	37,090	151	-13%	-6%	-6%	21%	15%
491	Other Musculoskeletal System & Connective Tissue Diagnoses SOI 3	12,271	78	-8%	-3%	-3%	15%	9%
492	Skin, Subcutaneous Tissue, Breast & Related Procedures SOI 4	832	30	14%	11%	12%	3%	2%
493	Skin Graft for Skin & Subcutaneous Tissue Diagnoses SOI 1	4,556	32	0%	-3%	-3%	4%	0%
494	Skin Graft for Skin & Subcutaneous Tissue Diagnoses SOI 2	4,240	45	0%	-1%	-1%	11%	6%
495	Skin Graft for Skin & Subcutaneous Tissue Diagnoses SOI 3	1,982	38	7%	5%	5%	9%	5%
496	Mastectomy Procedures SOI 1	17,414	70	0%	-6%	-7%	-9%	-8%
497	Mastectomy Procedures SOI 2	8,170	42	-2%	-5%	-6%	-5%	-5%
498	Mastectomy Procedures SOI 3	558	6	1%	0%	0%	-4%	-5%
499	Breast Procedures Except Mastectomy SOI 1	4,167	19	3%	-5%	-5%	-4%	-3%
500	Breast Procedures Except Mastectomy SOI 2	325	2	3%	-5%	-6%	-13%	-11%
501	Breast Procedures Except Mastectomy SOI 3	310	3	3%	0%	1%	4%	2%
502	Other Skin, Subcutaneous Tissue & Related Procedures SOI 1	2,896	15	-4%	-5%	-4%	1%	-1%
503	Other Skin, Subcutaneous Tissue & Related Procedures SOI 2	6,140	52	-3%	-3%	-3%	4%	1%
504	Other Skin, Subcutaneous Tissue & Related Procedures SOI 3	3,324	53	2%	3%	2%	3%	1%
505	Skin, Subcutaneous Tissue & Breast Diagnoses SOI 4	4,615	82	7%	6%	6%	5%	2%
506	Skin Ulcers SOI 1	3,190	13	-16%	-6%	-1%	34%	26%
507	Skin Ulcers SOI 2	17,791	98	-12%	-5%	-1%	27%	20%
508	Skin Ulcers SOI 3	12,969	110	-6%	-2%	0%	18%	13%
509	Major Skin Disorders SOI 1	946	3	-10%	-5%	-3%	38%	33%
510	Major Skin Disorders SOI 2	3,952	19	-12%	-5%	-4%	29%	22%
511	Major Skin Disorders SOI 3	1,784	15	-4%	-1%	-1%	18%	13%
512	Malignant Breast Disorders SOI 1	160	1	-15%	-8%	-6%	19%	17%
513	Malignant Breast Disorders SOI 2	948	5	-13%	-5%	-6%	21%	16%
514	Malignant Breast Disorders SOI 3	1,063	10	-2%	0%	-2%	11%	7%
515	Cellulitis & Other Bacterial Skin Infections SOI 1	24,953	88	-15%	-6%	-4%	37%	29%
516	Cellulitis & Other Bacterial Skin Infections SOI 2	77,318	357	-13%	-6%	-4%	29%	21%
517	Cellulitis & Other Bacterial Skin Infections SOI 3	36,034	246	-8%	-4%	-4%	19%	13%

Appendix C. Comparative Cost Margins in THEORI Models Based on CS DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 6 Standard Charges	7 Standard Cost	8 HSRV Cost	9 HSRVcc GM CCR	10 HSRVcc Agg. CCR
518	Contusion, Open Wound & Other Trauma to Skin & Subcutaneous Tissue SOI 1	4,888	15	-9%	-5%	-4%	30%	26%
519	Contusion, Open Wound & Other Trauma to Skin & Subcutaneous Tissue SOI 2	15,390	61	-11%	-6%	-5%	23%	17%
520	Contusion, Open Wound & Other Trauma to Skin & Subcutaneous Tissue SOI 3	5,005	30	-8%	-4%	-4%	15%	10%
521	Other Skin, Subcutaneous Tissue & Breast Disorders SOI 1	2,530	8	-12%	-6%	-4%	36%	31%
522	Other Skin, Subcutaneous Tissue & Breast Disorders SOI 2	5,016	21	-10%	-5%	-4%	30%	24%
523	Other Skin, Subcutaneous Tissue & Breast Disorders SOI 3	1,876	13	-4%	-3%	-2%	22%	16%
524	Procedures for Endocrine, Nutritional & Metabolic Disorders SOI 4	807	32	17%	11%	11%	-4%	-3%
525	Pituitary & Adrenal Procedures SOI 1	1,362	12	-5%	-5%	-5%	-22%	-20%
526	Pituitary & Adrenal Procedures SOI 2	713	8	-1%	-4%	-5%	-28%	-26%
527	Pituitary & Adrenal Procedures SOI 3	334	7	3%	2%	1%	-18%	-17%
528	Procedures for Obesity SOI 1	2,426	22	9%	-4%	-4%	-15%	-8%
529	Procedures for Obesity SOI 2	4,850	51	8%	-3%	-3%	-16%	-11%
530	Procedures for Obesity SOI 3	997	17	12%	5%	3%	-14%	-10%
531	Thyroid, Parathyroid & Thyroglossal Procedures SOI 1	10,433	42	3%	-6%	-7%	-13%	-13%
532	Thyroid, Parathyroid & Thyroglossal Procedures SOI 2	5,458	32	1%	-4%	-5%	-8%	-8%
533	Thyroid, Parathyroid & Thyroglossal Procedures SOI 3	723	11	2%	1%	1%	-10%	-11%
534	Other Procedures for Endocrine, Nutritional & Metabolic Disorders SOI 1	600	5	0%	-3%	-1%	-2%	0%
535	Other Procedures for Endocrine, Nutritional & Metabolic Disorders SOI 2	1,432	15	3%	-2%	-1%	-3%	-4%
536	Other Procedures for Endocrine, Nutritional & Metabolic Disorders SOI 3	1,682	29	8%	4%	4%	-3%	-3%
537	Endocrine Diagnoses SOI 4	11,909	173	4%	3%	4%	0%	-3%
538	Diabetes SOI 1	22,669	72	-12%	-6%	-1%	33%	26%
539	Diabetes SOI 2	34,084	137	-10%	-5%	-2%	17%	12%
540	Diabetes SOI 3	23,325	141	-7%	-4%	-2%	7%	3%
541	Malnutrition, Failure to Thrive & Other Nutritional Disorders SOI 1	367	1	-14%	-3%	-3%	25%	19%
542	Malnutrition, Failure to Thrive & Other Nutritional Disorders SOI 2	6,461	29	-15%	-5%	-4%	24%	17%
543	Malnutrition, Failure to Thrive & Other Nutritional Disorders SOI 3	7,551	52	-7%	-2%	-1%	19%	12%
544	Hypovolemia & Related Electrolyte Disorders SOI 1	5,748	17	-13%	-6%	-5%	27%	21%
545	Hypovolemia & Related Electrolyte Disorders SOI 2	81,354	322	-12%	-6%	-5%	21%	15%
546	Hypovolemia & Related Electrolyte Disorders SOI 3	50,429	293	-10%	-5%	-4%	15%	9%
547	Inborn Errors of Metabolism SOI 1	123	0	-12%	-6%	-5%	35%	32%
548	Inborn Errors of Metabolism SOI 2	579	3	0%	3%	4%	23%	20%
549	Inborn Errors of Metabolism SOI 3	502	4	-2%	5%	5%	20%	17%
550	Other Endocrine Disorders SOI 1	5,434	20	-9%	-6%	-5%	29%	24%
551	Other Endocrine Disorders SOI 2	11,372	62	-11%	-6%	-6%	13%	7%
552	Other Endocrine Disorders SOI 3	7,896	62	-8%	-4%	-4%	7%	2%
553	Electrolyte Disorders Except Hypovolemia Related SOI 1	9,423	28	-13%	-6%	-6%	24%	17%
554	Electrolyte Disorders Except Hypovolemia Related SOI 2	44,471	181	-12%	-6%	-5%	19%	13%
555	Electrolyte Disorders Except Hypovolemia Related SOI 3	23,972	147	-10%	-4%	-4%	11%	6%
556	Urinary Tract & Related Procedures Except Kidney Transplant SOI 4	5,659	194	11%	8%	8%	-5%	-4%
557	Kidney Transplant SOI 1	1,416	23	1%	-4%	-3%	-17%	-15%
558	Kidney Transplant SOI 2	3,638	68	1%	-3%	-1%	-14%	-12%
559	Kidney Transplant SOI 3	2,597	71	7%	4%	5%	-7%	-5%
560	Kidney Transplant SOI 4	410	21	13%	10%	11%	-3%	-1%

Appendix C. Comparative Cost Margins in THEORI Models Based on CS DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 6 Standard Charges	7 Standard Cost	8 HSRV Cost	9 HSRVcc GM CCR	10 HSRVcc Agg. CCR
561	Major Bladder Procedures SOI 1	245	2	-11%	-5%	-4%	-9%	-10%
562	Major Bladder Procedures SOI 2	2,185	30	-4%	-2%	-3%	-13%	-13%
563	Major Bladder Procedures SOI 3	3,248	69	-3%	0%	-1%	-17%	-16%
564	Kidney & Urinary Tract Procedures for Malignancy SOI 1	4,908	41	-5%	-5%	-7%	-13%	-12%
565	Kidney & Urinary Tract Procedures for Malignancy SOI 2	6,819	69	-6%	-5%	-6%	-15%	-15%
566	Kidney & Urinary Tract Procedures for Malignancy SOI 3	3,600	60	-3%	-1%	-2%	-14%	-14%
567	Kidney & Urinary Tract Procedures for Non-Malignancy SOI 1	4,140	30	-2%	-5%	-6%	-10%	-8%
568	Kidney & Urinary Tract Procedures for Non-Malignancy SOI 2	6,290	58	-1%	-3%	-3%	-5%	-5%
569	Kidney & Urinary Tract Procedures for Non-Malignancy SOI 3	5,227	86	4%	2%	2%	-2%	-3%
570	Renal Dialysis Access Device Procedure Only SOI 1	4,610	24	10%	-6%	-4%	-5%	-2%
571	Renal Dialysis Access Device Procedure Only SOI 2	12,670	99	6%	-4%	-3%	0%	0%
572	Renal Dialysis Access Device Procedure Only SOI 3	6,839	105	7%	0%	0%	-1%	-1%
573	Other Bladder Procedures SOI 1	4,031	18	-4%	-6%	-7%	-3%	-2%
574	Other Bladder Procedures SOI 2	3,110	23	-2%	-5%	-5%	2%	6%
575	Other Bladder Procedures SOI 3	1,034	13	4%	6%	7%	7%	5%
576	Urethral & Transurethral Procedures SOI 1	10,038	36	0%	-6%	-6%	3%	3%
577	Urethral & Transurethral Procedures SOI 2	17,595	96	-1%	-5%	-6%	3%	1%
578	Urethral & Transurethral Procedures SOI 3	4,480	50	0%	-1%	-1%	1%	-2%
579	Other Kidney, Urinary Tract & Related Procedures SOI 1	7,824	52	10%	-4%	-3%	-7%	0%
580	Other Kidney, Urinary Tract & Related Procedures SOI 2	14,559	120	8%	-2%	-2%	-3%	1%
581	Other Kidney, Urinary Tract & Related Procedures SOI 3	7,709	119	10%	4%	4%	1%	2%
582	Kidney & Urinary Tract Diagnoses SOI 4	28,800	473	5%	5%	5%	2%	0%
583	Renal Failure SOI 1	3,431	13	-2%	-4%	-1%	26%	24%
584	Renal Failure SOI 2	19,337	101	-7%	-4%	-2%	17%	14%
585	Renal Failure SOI 3	128,335	974	-7%	-3%	-2%	9%	5%
586	Kidney & Urinary Tract Malignancy SOI 1	381	1	-5%	-6%	-7%	23%	21%
587	Kidney & Urinary Tract Malignancy SOI 2	2,483	13	-7%	-5%	-5%	19%	15%
588	Kidney & Urinary Tract Malignancy SOI 3	2,429	20	-5%	-2%	-3%	13%	8%
589	Nephritis & Nephrosis SOI 1	128	0	-3%	-6%	-7%	38%	31%
590	Nephritis & Nephrosis SOI 2	571	3	-11%	-3%	-1%	27%	20%
591	Nephritis & Nephrosis SOI 3	775	7	-5%	-2%	-2%	13%	8%
592	Kidney & Urinary Tract Infections SOI 1	15,280	48	-11%	-7%	-4%	31%	25%
593	Kidney & Urinary Tract Infections SOI 2	122,892	516	-11%	-6%	-5%	23%	16%
594	Kidney & Urinary Tract Infections SOI 3	81,821	509	-8%	-5%	-4%	15%	9%
595	Urinary Stones & Acquired Upper Urinary Tract Obstruction SOI 1	4,541	13	-1%	-7%	-4%	19%	19%
596	Urinary Stones & Acquired Upper Urinary Tract Obstruction SOI 2	14,826	58	-2%	-7%	-6%	13%	12%
597	Urinary Stones & Acquired Upper Urinary Tract Obstruction SOI 3	3,516	24	-2%	-5%	-4%	6%	3%
598	Malfunction, Reaction, Complic of Genitourinary Device or Proc SOI 1	842	2	-10%	-7%	-7%	29%	27%
599	Malfunction, Reaction, Complic of Genitourinary Device or Proc SOI 2	15,769	72	-4%	-5%	-2%	23%	20%
600	Malfunction, Reaction, Complic of Genitourinary Device or Proc SOI 3	30,523	241	-1%	-1%	1%	17%	14%
601	Other Kidney & Urinary Tract Diagnoses, Signs & Symptoms SOI 1	14,083	48	-8%	-6%	-5%	31%	27%
602	Other Kidney & Urinary Tract Diagnoses, Signs & Symptoms SOI 2	19,311	94	-8%	-5%	-3%	22%	18%
603	Other Kidney & Urinary Tract Diagnoses, Signs & Symptoms SOI 3	13,250	98	-6%	-3%	-2%	12%	8%

Appendix C. Comparative Cost Margins in THEORI Models Based on CS DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 6 Standard Charges	7 Standard Cost	8 HSRV Cost	9 HSRVcc GM CCR	10 HSRVcc Agg. CCR
604	Male Reproductive System & Related Procedures SOI 4	591	16	10%	9%	10%	-3%	-2%
605	Major Male Pelvic Procedures SOI 1	13,171	87	-3%	-6%	-8%	-15%	-14%
606	Major Male Pelvic Procedures SOI 2	5,410	42	-2%	-5%	-6%	-14%	-13%
607	Major Male Pelvic Procedures SOI 3	547	7	-2%	-1%	-2%	-14%	-13%
608	Penis Procedures SOI 1	1,227	5	-4%	-7%	-6%	2%	2%
609	Penis Procedures SOI 2	2,412	17	11%	-3%	-3%	-1%	8%
610	Penis Procedures SOI 3	257	4	4%	0%	2%	4%	2%
611	Transurethral Prostatectomy SOI 1	29,375	99	-5%	-6%	-7%	-3%	-4%
612	Transurethral Prostatectomy SOI 2	21,243	94	-6%	-6%	-6%	4%	2%
613	Transurethral Prostatectomy SOI 3	2,935	27	-3%	-3%	-4%	0%	-3%
614	Testes & Scrotal Procedures SOI 1	494	2	0%	-4%	-4%	8%	5%
615	Testes & Scrotal Procedures SOI 2	496	4	-2%	-3%	-2%	10%	6%
616	Testes & Scrotal Procedures SOI 3	232	3	1%	1%	5%	5%	2%
617	Other Male Reproductive System & Related Procedures SOI 1	648	2	-2%	-6%	-7%	13%	10%
618	Other Male Reproductive System & Related Procedures SOI 2	2,278	13	7%	-4%	-5%	-3%	1%
619	Other Male Reproductive System & Related Procedures SOI 3	1,307	11	0%	-2%	-3%	5%	5%
620	Male Reproductive System Diagnoses SOI 4	461	6	1%	1%	1%	3%	1%
621	Malignancy, Male Reproductive System SOI 1	277	1	-4%	-7%	-6%	33%	30%
622	Malignancy, Male Reproductive System SOI 2	1,830	9	-9%	-4%	-4%	21%	16%
623	Malignancy, Male Reproductive System SOI 3	1,498	12	-5%	-4%	-4%	12%	8%
624	Male Reproductive System Diagnoses Except Malignancy SOI 1	2,026	6	-8%	-5%	-4%	35%	30%
625	Male Reproductive System Diagnoses Except Malignancy SOI 2	6,534	26	-9%	-6%	-4%	29%	23%
626	Male Reproductive System Diagnoses Except Malignancy SOI 3	2,793	17	-6%	-3%	-3%	19%	14%
627	Female Reproductive System & Related Procedures SOI 4	1,132	37	9%	8%	7%	-9%	-8%
628	Pelvic Evisceration, Radical Hysterectomy & Other Radical Gyn Procs SOI 1	895	6	-1%	-7%	-7%	-8%	-10%
629	Pelvic Evisceration, Radical Hysterectomy & Other Radical Gyn Procs SOI 2	1,131	11	-1%	-3%	-5%	-8%	-10%
630	Pelvic Evisceration, Radical Hysterectomy & Other Radical Gyn Procs SOI 3	400	8	5%	3%	1%	-11%	-11%
631	Uterine & Adnexa Procedures for Ovarian & Adnexal Malignancy SOI 1	574	4	-3%	-6%	-6%	-8%	-10%
632	Uterine & Adnexa Procedures for Ovarian & Adnexal Malignancy SOI 2	2,473	27	-3%	-3%	-3%	-7%	-8%
633	Uterine & Adnexa Procedures for Ovarian & Adnexal Malignancy SOI 3	1,485	28	4%	3%	1%	-9%	-9%
634	Uterine & Adnexa Procedures for Non-Ovarian & Non-Adnexal Malig SOI 1	3,927	22	-6%	-7%	-7%	-7%	-9%
635	Uterine & Adnexa Procedures for Non-Ovarian & Non-Adnexal Malig SOI 2	5,560	43	-6%	-5%	-5%	-7%	-9%
636	Uterine & Adnexa Procedures for Non-Ovarian & Non-Adnexal Malig SOI 3	1,247	18	1%	2%	2%	-7%	-8%
637	Uterine & Adnexa Procedures for Non-Malignancy Except Leiomyoma SOI 1	22,056	102	-6%	-7%	-7%	-10%	-10%
638	Uterine & Adnexa Procedures for Non-Malignancy Except Leiomyoma SOI 2	15,026	87	-6%	-6%	-6%	-6%	-7%
639	Uterine & Adnexa Procedures for Non-Malignancy Except Leiomyoma SOI 3	1,869	21	-2%	-2%	-2%	-7%	-8%
640	Female Reproductive System Reconstructive Procedures SOI 1	19,547	73	-2%	-7%	-7%	-9%	-8%
641	Female Reproductive System Reconstructive Procedures SOI 2	12,364	60	-2%	-6%	-7%	-10%	-9%
642	Female Reproductive System Reconstructive Procedures SOI 3	672	6	-4%	-3%	-4%	-9%	-9%
643	Dilation & Curettage for Non-Obstetric Diagnoses SOI 1	465	2	2%	-7%	-2%	8%	6%
644	Dilation & Curettage for Non-Obstetric Diagnoses SOI 2	847	5	-1%	-5%	-2%	7%	4%
645	Dilation & Curettage for Non-Obstetric Diagnoses SOI 3	326	3	-3%	-1%	1%	5%	2%
646	Other Female Reproductive System & Related Procedures SOI 1	2,339	10	-4%	-6%	-6%	8%	7%

Appendix C. Comparative Cost Margins in THEORI Models Based on CS DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 6 Standard Charges	7 Standard Cost	8 HSRV Cost	9 HSRVcc GM CCR	10 HSRVcc Agg. CCR
647	Other Female Reproductive System & Related Procedures SOI 2	1,380	10	-3%	-3%	-3%	1%	-1%
648	Other Female Reproductive System & Related Procedures SOI 3	498	8	6%	6%	5%	1%	-1%
649	Uterine & Adnexa Procedures for Leiomyoma SOI 1	3,482	16	-4%	-7%	-6%	-6%	-7%
650	Uterine & Adnexa Procedures for Leiomyoma SOI 2	2,264	13	-4%	-6%	-4%	-2%	-4%
651	Uterine & Adnexa Procedures for Leiomyoma SOI 3	254	3	4%	-1%	1%	-6%	-7%
652	Female Reproductive System Diagnoses SOI 4	693	12	7%	5%	5%	8%	5%
653	Female Reproductive System Malignancy SOI 1	423	1	-6%	-5%	-6%	25%	22%
654	Female Reproductive System Malignancy SOI 2	2,053	10	-8%	-5%	-5%	21%	17%
655	Female Reproductive System Malignancy SOI 3	2,541	22	-3%	-1%	-2%	12%	8%
656	Female Reproductive System Infections SOI 1	377	1	-6%	-3%	0%	34%	29%
657	Female Reproductive System Infections SOI 2	1,620	9	-8%	-5%	-4%	24%	17%
658	Female Reproductive System Infections SOI 3	1,521	13	-6%	-3%	-2%	14%	9%
659	Menstrual & Other Female Reproductive System Disorders SOI 1	1,318	4	-3%	-7%	-5%	39%	37%
660	Menstrual & Other Female Reproductive System Disorders SOI 2	1,847	7	-4%	-5%	-2%	32%	28%
661	Menstrual & Other Female Reproductive System Disorders SOI 3	588	3	-2%	-2%	0%	26%	21%
663	Cesarean Delivery SOI 1	1,956	8	-16%	-7%	-4%	20%	13%
664	Cesarean Delivery SOI 2	1,209	6	-11%	-4%	0%	17%	11%
665	Cesarean Delivery SOI 3	445	4	-7%	0%	4%	15%	10%
666	Cesarean Delivery SOI 4	40	1	3%	9%	16%	8%	7%
667	Vaginal Delivery Procedures SOI 1	88	0	-8%	-4%	0%	-9%	-10%
668	Vaginal Delivery Procedures SOI 2	94	0	-21%	-4%	1%	8%	5%
669	Vaginal Delivery Procedures SOI 3	32	0	-8%	-2%	0%	3%	0%
670	Other Procedures for Obstetric Diagnoses Except Delivery Diagnoses SOI 1	165	1	3%	-5%	0%	11%	9%
671	Other Procedures for Obstetric Diagnoses Except Delivery Diagnoses SOI 2	199	1	-6%	-7%	-1%	9%	7%
672	Other Procedures for Obstetric Diagnoses Except Delivery Diagnoses SOI 3	56	0	-6%	-3%	1%	6%	3%
674	Vaginal Delivery SOI 1	2,622	6	-17%	-6%	-3%	12%	7%
675	Vaginal Delivery SOI 2	2,086	6	-20%	-6%	-3%	27%	19%
676	Vaginal Delivery SOI 3	546	3	-14%	-4%	0%	27%	20%
678	Postpartum & Abortion Diagnoses w/o Procedure SOI 1	102	0	-13%	-1%	4%	56%	55%
679	Postpartum & Abortion Diagnoses w/o Procedure SOI 2	205	1	-15%	-5%	-1%	49%	43%
680	Postpartum & Abortion Diagnoses w/o Procedure SOI 3	124	1	-13%	-9%	-5%	25%	19%
681	Antepartum Diagnoses SOI 1	613	1	-20%	-6%	-3%	59%	49%
682	Antepartum Diagnoses SOI 2	1,318	4	-17%	-6%	-2%	43%	35%
683	Antepartum Diagnoses SOI 3	700	3	-12%	-1%	5%	42%	34%
698	Procedures of Blood & Blood-Forming Organs SOI 4	356	15	9%	9%	9%	-6%	-5%
699	Splenectomy SOI 1	394	4	-5%	-2%	-2%	-7%	-4%
700	Splenectomy SOI 2	885	12	1%	1%	1%	-6%	-4%
701	Splenectomy SOI 3	536	13	5%	7%	7%	-6%	-5%
702	Other Procedures of Blood & Blood-Forming Organs SOI 1	887	5	1%	-6%	-7%	-4%	-5%
703	Other Procedures of Blood & Blood-Forming Organs SOI 2	540	5	1%	-3%	-4%	-6%	-7%
704	Other Procedures of Blood & Blood-Forming Organs SOI 3	238	4	6%	2%	3%	-2%	-3%
705	Anemia & Diagnoses of Blood & Blood-Forming Organs SOI 4	4,272	85	10%	10%	10%	7%	6%
706	Major Hematologic/Immunologic Diag Exc Sickle Cell Crisis & Coagul SOI 1	2,307	10	-3%	-3%	-3%	23%	21%

Appendix C. Comparative Cost Margins in THEORI Models Based on CS DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 6 Standard Charges	7 Standard Cost	8 HSRV Cost	9 HSRVcc GM CCR	10 HSRVcc Agg. CCR
707	Major Hematologic/Immunologic Diag Exc Sickle Cell Crisis & Coagul SOI 2	13,336	81	-7%	-3%	-4%	19%	16%
708	Major Hematologic/Immunologic Diag Exc Sickle Cell Crisis & Coagul SOI 3	8,144	85	-1%	3%	2%	15%	12%
709	Coagulation & Platelet Disorders SOI 1	6,331	31	-1%	0%	1%	24%	21%
710	Coagulation & Platelet Disorders SOI 2	6,779	50	0%	0%	2%	16%	15%
711	Coagulation & Platelet Disorders SOI 3	2,800	39	14%	9%	10%	16%	17%
712	Sickle Cell Anemia Crisis SOI 1	4,621	22	-7%	-2%	0%	33%	25%
713	Sickle Cell Anemia Crisis SOI 2	4,171	27	-7%	0%	1%	27%	20%
714	Sickle Cell Anemia Crisis SOI 3	1,338	13	-5%	1%	2%	18%	13%
715	Other Anemia & Disorders of Blood & Blood-Forming Organs SOI 1	29,791	101	-9%	-6%	-4%	26%	22%
716	Other Anemia & Disorders of Blood & Blood-Forming Organs SOI 2	37,714	168	-9%	-5%	-4%	19%	15%
717	Other Anemia & Disorders of Blood & Blood-Forming Organs SOI 3	16,373	105	-7%	-4%	-3%	12%	8%
718	Procedures for Lymphatic/Hematopoietic/Other Neoplasms SOI 4	1,603	71	15%	10%	9%	-1%	0%
719	Major O.R. Procedures for Lymphatic/Hematopoietic/Other Neoplasms SOI 1	935	9	-6%	-5%	-6%	-13%	-12%
720	Major O.R. Procedures for Lymphatic/Hematopoietic/Other Neoplasms SOI 2	2,706	37	-1%	-1%	-2%	-9%	-9%
721	Major O.R. Procedures for Lymphatic/Hematopoietic/Other Neoplasms SOI 3	1,796	44	4%	4%	2%	-8%	-8%
722	Other O.R. Procedures for Lymphatic/Hematopoietic/Other Neoplasms SOI 1	2,592	15	2%	-5%	-6%	-7%	-7%
723	Other O.R. Procedures for Lymphatic/Hematopoietic/Other Neoplasms SOI 2	4,227	38	1%	-2%	-2%	-1%	-2%
724	Other O.R. Procedures for Lymphatic/Hematopoietic/Other Neoplasms SOI 3	2,288	42	6%	4%	3%	3%	2%
725	Leukemia, Lymphoma, Myeloma, Chemotherapy & Radiotherapy SOI 4	5,932	194	14%	12%	11%	9%	9%
726	Acute Leukemia SOI 1	558	4	0%	5%	2%	25%	23%
727	Acute Leukemia SOI 2	2,474	25	9%	11%	10%	25%	23%
728	Acute Leukemia SOI 3	3,136	64	14%	15%	13%	19%	18%
729	Lymphoma, Myeloma & Non-Acute Leukemia SOI 1	2,059	12	-2%	-4%	-6%	19%	17%
730	Lymphoma, Myeloma & Non-Acute Leukemia SOI 2	9,416	75	-3%	-2%	-3%	13%	10%
731	Lymphoma, Myeloma & Non-Acute Leukemia SOI 3	9,607	122	0%	2%	0%	7%	5%
732	Radiotherapy SOI 1	637	3	5%	-5%	-6%	22%	19%
733	Radiotherapy SOI 2	1,731	19	-1%	-2%	0%	0%	2%
734	Radiotherapy SOI 3	307	5	6%	6%	6%	17%	15%
735	Chemotherapy SOI 1	4,462	21	8%	-2%	-3%	36%	37%
736	Chemotherapy SOI 2	19,781	125	3%	-2%	-3%	28%	28%
737	Chemotherapy SOI 3	4,678	75	11%	11%	9%	25%	24%
738	Lymphatic & Other Malignancies & Neoplasms of Uncertain Behavior SOI 1	1,063	4	-3%	-5%	-5%	31%	28%
739	Lymphatic & Other Malignancies & Neoplasms of Uncertain Behavior SOI 2	6,423	37	-4%	-3%	-3%	19%	15%
740	Lymphatic & Other Malignancies & Neoplasms of Uncertain Behavior SOI 3	6,877	65	-2%	0%	-1%	11%	8%
741	Lymphatic & Other Malignancies & Neoplasms of Uncertain Behavior SOI 4	1,300	23	9%	6%	4%	3%	2%
742	Infectious & Parasitic Diseases w O.R. Procedure SOI 4	9,927	415	11%	9%	9%	-5%	-4%
743	Infectious & Parasitic Diseases Including HIV w O.R. Procedure SOI 1	279	3	2%	1%	1%	4%	3%
744	Infectious & Parasitic Diseases Including HIV w O.R. Procedure SOI 2	3,096	45	-1%	0%	0%	-1%	-3%
745	Infectious & Parasitic Diseases Including HIV w O.R. Procedure SOI 3	8,677	198	5%	4%	4%	-2%	-3%
746	Post-Op, Post-Trauma, Other Device Infections w O.R. Procedure SOI 1	2,540	21	-7%	-3%	-4%	5%	2%
747	Post-Op, Post-Trauma, Other Device Infections w O.R. Procedure SOI 2	6,392	74	-2%	0%	-1%	3%	1%
748	Post-Op, Post-Trauma, Other Device Infections w O.R. Procedure SOI 3	4,626	105	5%	7%	6%	1%	0%
749	Infectious & Parasitic Diseases SOI 4	61,037	1,049	10%	7%	8%	1%	0%

Appendix C. Comparative Cost Margins in THEORI Models Based on CS DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 6 Standard Charges	7 Standard Cost	8 HSRV Cost	9 HSRVcc GM CCR	10 HSRVcc Agg. CCR
750	Septicemia & Disseminated Infections SOI 1	2,494	11	-12%	-5%	-2%	28%	21%
751	Septicemia & Disseminated Infections SOI 2	60,745	370	-11%	-5%	-3%	14%	9%
752	Septicemia & Disseminated Infections SOI 3	95,114	887	-4%	-2%	0%	6%	3%
753	Post-Operative, Post-Traumatic, Other Device Infections SOI 1	7,159	35	-15%	-6%	-6%	28%	21%
754	Post-Operative, Post-Traumatic, Other Device Infections SOI 2	17,640	110	-9%	-4%	-4%	23%	17%
755	Post-Operative, Post-Traumatic, Other Device Infections SOI 3	9,188	93	-3%	0%	-1%	14%	10%
756	Fever SOI 1	1,888	7	-7%	-6%	-7%	20%	15%
757	Fever SOI 2	10,038	45	-8%	-5%	-6%	18%	13%
758	Fever SOI 3	4,940	33	-6%	-2%	-3%	14%	10%
759	Viral Illness SOI 1	1,278	4	-7%	-6%	-6%	20%	15%
760	Viral Illness SOI 2	5,722	20	-11%	-6%	-6%	20%	15%
761	Viral Illness SOI 3	3,036	19	-8%	-2%	-3%	15%	10%
762	Other Infectious & Parasitic Diseases SOI 1	4,307	26	-9%	-5%	-6%	15%	10%
763	Other Infectious & Parasitic Diseases SOI 2	6,893	60	-7%	-3%	-4%	9%	5%
764	Other Infectious & Parasitic Diseases SOI 3	3,011	31	-3%	0%	0%	9%	6%
765	Mental Illness Diagnosis w O.R. Procedure SOI 1	117	1	0%	-3%	-1%	13%	15%
766	Mental Illness Diagnosis w O.R. Procedure SOI 2	357	4	-6%	1%	1%	7%	5%
767	Mental Illness Diagnosis w O.R. Procedure SOI 3	261	7	-1%	10%	9%	6%	4%
768	Mental Illness Diagnosis w O.R. Procedure SOI 4	35	1	15%	4%	5%	-3%	-4%
769	Major Depressive, Schizophrenia & Bipolar Disorders SOI 1	19,619	101	-32%	-3%	6%	71%	50%
770	Major Depressive, Schizophrenia & Bipolar Disorders SOI 2	38,525	222	-30%	-3%	5%	59%	41%
771	Major Depressive, Schizophrenia & Bipolar Disorders SOI 3	4,303	34	-23%	-1%	2%	32%	21%
772	Major Depressive, Schizophrenia & Bipolar Disorders SOI 4	681	11	-28%	-1%	-1%	17%	7%
773	Organic Mental Health Disturbances SOI 1	4,510	19	-15%	-5%	-5%	24%	15%
774	Organic Mental Health Disturbances SOI 2	12,449	62	-18%	-6%	-6%	19%	11%
775	Organic Mental Health Disturbances SOI 3	4,253	29	-13%	-4%	-4%	14%	7%
776	Organic Mental Health Disturbances SOI 4	253	3	-6%	-4%	-3%	0%	-5%
777	Other Mental Health Disorders SOI 1	7,321	23	-17%	-6%	-4%	29%	23%
778	Other Mental Health Disorders SOI 2	10,312	44	-22%	-6%	-5%	24%	16%
779	Other Mental Health Disorders SOI 3	2,984	18	-17%	-4%	-4%	14%	8%
780	Other Mental Health Disorders SOI 4	177	2	-3%	3%	2%	1%	-2%
781	Drug & Alcohol Abuse or Dependence, Left Against Medical Advice SOI 1 & 2	4,032	8	-21%	-4%	4%	64%	53%
782	Drug & Alcohol Abuse or Dependence, Left Against Medical Advice SOI 3 & 4	331	1	-13%	-2%	5%	33%	27%
783	Drug Abuse & Dependence Diagnoses SOI 1	9,954	32	-30%	-5%	3%	48%	36%
784	Drug Abuse & Dependence Diagnoses SOI 2	29,147	113	-21%	-4%	4%	43%	32%
785	Drug Abuse & Dependence Diagnoses SOI 3	7,411	45	-14%	-3%	-1%	18%	11%
786	Drug Abuse & Dependence Diagnoses SOI 4	714	13	1%	4%	4%	-7%	-9%
787	O.R. Procedure for Other Complications of Treatment SOI 1	3,306	21	-6%	-4%	-5%	0%	-1%
788	O.R. Procedure for Other Complications of Treatment SOI 2	7,776	71	-3%	-1%	-1%	1%	0%
789	O.R. Procedure for Other Complications of Treatment SOI 3	4,044	69	2%	4%	3%	-3%	-4%
790	O.R. Procedure for Other Complications of Treatment SOI 4	1,507	60	11%	11%	11%	-5%	-4%
791	Injuries, Poisonings & Toxic Effects of Drugs Diagnoses SOI 4	5,011	83	5%	6%	7%	-6%	-6%
792	Allergic Reactions SOI 1	1,850	4	-14%	-7%	-4%	27%	23%

Appendix C. Comparative Cost Margins in THEORI Models Based on CS DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 6 Standard Charges	7 Standard Cost	8 HSRV Cost	9 HSRVcc GM CCR	10 HSRVcc Agg. CCR
793	Allergic Reactions SOI 2	2,811	8	-12%	-6%	-5%	17%	13%
794	Allergic Reactions SOI 3	911	6	-7%	-4%	-3%	-3%	-5%
795	Poisoning of Medicinal Agents SOI 1	3,761	10	-17%	-7%	-5%	16%	11%
796	Poisoning of Medicinal Agents SOI 2	17,868	62	-15%	-7%	-5%	15%	10%
797	Poisoning of Medicinal Agents SOI 3	10,413	62	-10%	-5%	-4%	1%	-2%
798	Other Complications of Treatment SOI 1	6,339	21	-13%	-6%	-7%	25%	22%
799	Other Complications of Treatment SOI 2	13,711	65	-10%	-5%	-5%	18%	15%
800	Other Complications of Treatment SOI 3	6,671	55	-4%	0%	-1%	11%	8%
801	Other Injury, Poisoning & Toxic Effect Diagnoses SOI 1	1,967	6	-2%	-6%	-2%	24%	22%
802	Other Injury, Poisoning & Toxic Effect Diagnoses SOI 2	4,552	17	-9%	-6%	-3%	20%	15%
803	Other Injury, Poisoning & Toxic Effect Diagnoses SOI 3	2,482	16	-7%	-3%	-1%	4%	1%
804	Burn Procedures SOI 4	239	21	15%	13%	18%	-1%	-1%
805	Extensive 3rd Degree or Full Thickness Burns w Skin Graft SOI 1	130	1	-12%	-6%	-3%	4%	-2%
806	Extensive 3rd Degree or Full Thickness Burns w Skin Graft SOI 2	537	9	-6%	1%	5%	4%	-1%
807	Extensive 3rd Degree or Full Thickness Burns w Skin Graft SOI 3	397	16	5%	11%	15%	3%	1%
808	Burn Diagnoses SOI 4	205	6	13%	14%	18%	8%	8%
809	Extensive 3rd Degree or Full Thickness Burns w/o Skin Graft SOI 1	72	0	-12%	-4%	4%	42%	32%
810	Extensive 3rd Degree or Full Thickness Burns w/o Skin Graft SOI 2	361	2	-15%	-3%	2%	36%	28%
811	Extensive 3rd Degree or Full Thickness Burns w/o Skin Graft SOI 3	338	3	-1%	2%	6%	21%	16%
812	Partial Thickness Burns w or w/o Skin Graft SOI 1	534	3	-17%	-3%	3%	42%	34%
813	Partial Thickness Burns w or w/o Skin Graft SOI 2	940	6	-5%	2%	6%	33%	26%
814	Partial Thickness Burns w or w/o Skin Graft SOI 3	522	5	-6%	4%	6%	20%	15%
815	Procedure w Diag of Rehab, Aftercare or Oth Contact w Health Service SOI 1	1,438	8	0%	-2%	-2%	0%	4%
816	Procedure w Diag of Rehab, Aftercare or Oth Contact w Health Service SOI 2	801	8	1%	1%	1%	0%	4%
817	Procedure w Diag of Rehab, Aftercare or Oth Contact w Health Service SOI 3	221	3	-1%	0%	0%	-3%	-3%
818	Procedure w Diag of Rehab, Aftercare or Oth Contact w Health Service SOI 4	38	1	-2%	6%	5%	-4%	-5%
819	Rehabilitation/Aftercare/Convalescence Except Neonatal Aftercare SOI 4	798	11	-16%	5%	9%	17%	10%
820	Rehabilitation SOI 1	1,206	8	-48%	-6%	0%	21%	11%
821	Rehabilitation SOI 2	3,410	28	-49%	-6%	-1%	20%	9%
822	Rehabilitation SOI 3	2,234	25	-40%	-1%	5%	17%	8%
823	Signs, Symptoms & Other Factors Influencing Health Status SOI 1	5,109	15	-10%	-6%	-5%	27%	22%
824	Signs, Symptoms & Other Factors Influencing Health Status SOI 2	22,375	84	-12%	-6%	-6%	19%	13%
825	Signs, Symptoms & Other Factors Influencing Health Status SOI 3	5,754	34	-9%	-4%	-5%	12%	7%
826	Other Aftercare & Convalescence SOI 1	592	2	-34%	-6%	-10%	30%	24%
827	Other Aftercare & Convalescence SOI 2	1,084	5	-25%	-3%	-6%	26%	23%
828	Other Aftercare & Convalescence SOI 3	258	2	-4%	3%	-1%	19%	15%
829	HIV Diagnoses SOI 4	2,822	66	19%	10%	14%	9%	9%
830	HIV w Multiple Major HIV Related Conditions SOI 1 & 2	191	2	1%	-2%	3%	17%	13%
831	HIV w Multiple Major HIV Related Conditions SOI 3	1,423	21	14%	7%	10%	17%	14%
832	HIV w Major HIV Related Condition SOI 1 & 2	1,520	10	5%	-1%	4%	25%	20%
833	HIV w Major HIV Related Condition SOI 3	4,145	44	12%	4%	7%	18%	15%
834	HIV w Multiple Significant HIV Related Conditions SOI 1 & 2	1,405	12	11%	2%	5%	22%	18%
835	HIV w Multiple Significant HIV Related Conditions SOI 3	973	12	13%	5%	7%	18%	14%

Appendix C. Comparative Cost Margins in THEORI Models Based on CS DRGs

DRG	Description	Cases	Total Cost ($Mils)	THEORI Models 6 Standard Charges	7 Standard Cost	8 HSRV Cost	9 HSRVcc GM CCR	10 HSRVcc Agg. CCR
836	HIV w One Signif HIV Cond or w/o Signif Related Cond SOI 1	797	3	6%	-3%	1%	33%	28%
837	HIV w One Signif HIV Cond or w/o Signif Related Cond SOI 2	4,756	26	7%	-2%	2%	26%	22%
838	HIV w One Signif HIV Cond or w/o Signif Related Cond SOI 3	1,836	16	10%	3%	5%	20%	16%
839	Multiple Significant Trauma Procedures SOI 4	1,668	75	9%	9%	12%	-6%	-4%
840	Craniotomy for Multiple Significant Trauma SOI 1 & 2	55	1	3%	-3%	-2%	-22%	-20%
841	Craniotomy for Multiple Significant Trauma SOI 3	138	4	6%	7%	8%	-12%	-11%
842	Extensive Abdominal/Thoracic Procedures for Mult Significant Trauma SOI 1 & 2	44	1	-2%	-3%	-1%	-14%	-12%
843	Extensive Abdominal/Thoracic Procedures for Mult Significant Trauma SOI 3	255	6	8%	8%	12%	-5%	-4%
844	Musculoskeletal & Other Procedures for Multiple Significant Trauma SOI 1 & 2	1,454	18	-3%	-2%	-2%	-9%	-7%
845	Musculoskeletal & Other Procedures for Multiple Significant Trauma SOI 3	2,213	49	1%	3%	5%	-10%	-8%
846	Multiple Significant Trauma w/o O.R. Procedure SOI 1 & 2	1,647	12	-8%	-4%	-2%	1%	-2%
847	Multiple Significant Trauma w/o O.R. Procedure SOI 3	2,065	26	-3%	1%	2%	-4%	-5%
848	Multiple Significant Trauma w/o O.R. Procedure SOI 4	700	20	5%	7%	9%	-8%	-7%
987	Extensive Procedure Unrelated to Principal Diagnosis SOI 1	921	10	-1%	0%	-2%	-8%	-5%
988	Extensive Procedure Unrelated to Principal Diagnosis SOI 2	5,012	78	3%	0%	-1%	-8%	-7%
989	Extensive Procedure Unrelated to Principal Diagnosis SOI 3	10,087	250	4%	3%	2%	-7%	-7%
990	Extensive Procedure Unrelated to Principal Diagnosis SOI 4	6,455	291	9%	7%	7%	-8%	-7%
991	Non Major Procedure Unrelated to Principal Diagnosis SOI 4	8,952	316	11%	6%	6%	-7%	-6%
992	Moderately Extensive Procedure Unrelated to Principal Diagnosis SOI 1	2,531	19	4%	-3%	-3%	-1%	3%
993	Moderately Extensive Procedure Unrelated to Principal Diagnosis SOI 2	11,034	124	2%	-2%	-3%	-4%	-3%
994	Moderately Extensive Procedure Unrelated to Principal Diagnosis SOI 3	14,456	277	4%	1%	0%	-6%	-5%
995	Nonextensive Procedure Unrelated to Principal Diagnosis SOI 1	4,379	22	-2%	-5%	-4%	4%	3%
996	Nonextensive Procedure Unrelated to Principal Diagnosis SOI 2	11,143	98	-1%	-4%	-4%	0%	-1%
997	Nonextensive Procedure Unrelated to Principal Diagnosis SOI 3	11,314	178	1%	-1%	-1%	-4%	-4%

Submitter : Dr. Deborah Longo-Malloy **Date:** 06/12/2006

Organization : Dr. Deborah Longo-Malloy

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.

Sincerely,

Deborah Longo-Malloy, DO

Submitter : **Mr. David Burd** **Date: 06/12/2006**

Organization : **Nebraska Hospital Association**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1606-Attach-1.DOC

#1606

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 Nebraska Hospital Association (NHA), its 85 member hospitals, and the 36,000 individuals we employ, 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.

While the NHA is supportive of many of the provisions in the proposed rule, we have some serious concerns related to the proposed changes to the DRG weights and classifications, long-term care hospital DRGs, quality reporting requirements, outlier threshold, occupational mix adjustment, hospital wage index, and critical access hospital relocations. We have also included comments in regard to health information technology and hospital-acquired infections. Our concerns and recommendations are explained below.

DRG Changes

In response to payment recommendations from the Medicare Payment Advisory Commission (MedPAC) to address the proliferation of physician-owned, limited service hospitals, the Centers for Medicare & Medicaid Services (CMS) proposed the biggest changes to the calculation of diagnosis-related group (DRG) relative weights since the creation of the prospective payment system (PPS). These changes would significantly redistribute payments among the DRGs and among hospitals. Specifically, CMS proposes 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. CMS also proposes an alternative patient classification system called consolidated severity adjusted DRGs (CS-DRGs), with implementation likely in FY 2008.

NHA member hospitals support meaningful improvements to Medicare's inpatient PPS. We believe that refining the system to create an equal opportunity for return across DRGs will provide an equal incentive to treat all types of patients and conditions. We also believe the system should be simple, predictable, and stable over time. One of the fundamental values of a

prospective payment system is the ability of providers to reasonably estimate payments in advance to inform their budgeting, marketing, staffing and other key management. Another core feature of the PPS is clinically cohesive and meaningful DRGs that are somewhat intuitive for providers and coders to follow, and that reflect similar resource use within DRGs. Ultimately, the inpatient PPS should foster innovation and best practice in care delivery. The NHA believes these are essential characteristics of a well-functioning PPS.

New DRG Weights: HSRVcc

CMS proposes an alternative to MedPAC's approach to HSRVs and cost-based weights that could be characterized as a short cut. CMS asserts that this combined methodology, known as the HSRV cost center methodology (HSRVcc), achieves similar results in a more administratively feasible manner. But that is not the case. Specifically, the CMS proposal involves two major steps.

1. Develop, on a charge-basis, hospital-specific relative weights for each DRG. CMS established 10 cost center categories based on broad hospital accounting definitions: routine day costs; intensive care day costs; and eight ancillary cost centers. CMS calculated DRG relative weights for each of the 10 cost centers by DRG for each hospital and then used those hospital-specific weights for calculating national DRG weights. CMS' current process aggregates charges for all hospitals at the DRG level to calculate weights. CMS believes the new approach removes the variation introduced by hospital characteristics such as teaching, disproportionate share, location and size, among others.

2. "Scale" the charge-based DRG weights to "costs" using the national cost center cost-to-charge ratios (CCRs) developed from the cost report data (as opposed to using hospital-specific CCRs at the claim level). CMS believes this approach will remove the effect of different CCRs across departments within hospitals. CMS chose this methodology because the use of national average rather than hospital-specific departmental CCRs is administratively easier.

The NHA supports the move to cost-based weights but has some concerns regarding CMS' proposed method. More time and work is needed to develop a sound approach to create cost-based weights and to understand their potential impact. Hospitals are willing to work with CMS in a process to develop consensus around the right way to make this change.

When the American Hospital Association analyzed the proposed rule, a series of data errors were uncovered. Further analyses showed that small changes in method lead to large changes in DRG weights, which indicates that the proposed changes are highly unstable.

CMS chose to use *charges* to initially calculate the relative weights at the DRG level and then a national scaler to make the conversion to "cost-based" weights. The national scaler converts the 10 cost center charge-based weights to one national weight using the actual share of costs across departments. CMS maintains that this adjusts for differential mark-ups across hospital departments. In contrast, MedPAC estimated *costs* at the claim level to calculate relative weights. CMS provided no validation of the methodological shortcut they propose.

CMS aggregates charges into 10 cost centers for each DRG, then applies a cost-center level CCR (derived from the cost reports) to charge figures (from claims data). But because hospitals often

report charges on the cost reports differently than charges on the claims, the cost-center level CCRs are calculated based on a different set of charges than the charges to which the CCRs are later applied. We believe this may materially distort the DRG weights and needs to be thoughtfully considered and accounted for in any methodology. If CMS is going to move to cost-based weights, regardless of the methodology, hospitals will need time to align their mapping of cost centers into departments or cost categories for purposes of cost reporting with that of claims reporting.

CMS provided no analysis to validate that the proposed changes result in better payment policy. While measuring improved payment accuracy is difficult, the large degree to which the weights fluctuate given methodological changes alone indicates the need for further analysis and study. CMS should construct a process to test the sensitivity of weights to various methodological assumptions and publicly share the results. This analysis will help determine the most effective and administratively feasible approach for a shift to cost-based weights in FY 2008.

NEW PATIENT CLASSIFICATION: SEVERITY OF ILLNESS

CMS also proposes moving to an entirely new patient classification system beginning in FY 2008 *or earlier*. Currently, Medicare uses 526 DRGs to classify all Medicare patients. CMS considered use of 3M's all-patient refined DRGs (APR-DRGs) as an alternative to its current DRGs, which would increase the number of categories to 1,258. However, CMS ultimately proposed refining the APR-DRG system by consolidating APR-DRGs into fewer categories. This would result in a new DRG system with 861 consolidated severity-adjusted DRGs, or CS-DRGs.

The NHA believes that the need for and best approach to changing the patient classification system has not been concretely and objectively demonstrated. More careful analysis is needed, along with greater access to the specifics of CMS's methodology.

It is unclear whether there is a need for a new patient classification system. More work is needed to assess the proposed system and others that might be considered. As with the HSRVcc proposal, CMS provided no analysis that shows that the proposed changes result in an improved hospital payment system compared to the existing DRG system or APR-DRGs.

Today's DRG system was created to distinguish the resource use required among patients. It has been modified over time to reflect changes in clinical practice and technology. The APR-DRG system is based on severity of illness, not necessarily the resource use required. The implications of moving from a resource-based system to a severity-based payment system must be more fully explored and understood.

CMS suggests in the proposed rule that it would reduce payments to hospitals by instituting a budget neutrality adjustment to offset the fact that case mix may increase because of improved coding rather than actual changes in acuity. However, CMS did not propose an adjustment or even a methodology for determining an adjustment. We recommend that CMS hold off on such an adjustment until there is evidence that one is needed.

The proprietary nature of the proposed CS-DRG GROUPER is of concern. The current DRG GROUPER logic has been in the public domain since the inception of the PPS. Without the new GROUPER logic, it is virtually impossible for anyone to thoroughly analyze the system and comment. Without access to the new GROUPER, we have no understanding of how and why

patients fall into certain CS-DRGs and cannot evaluate whether it represents policy improvement. We urge CMS to make any new classification system widely available to the public and non-proprietary.

We are concerned that CMS' GROUPER does not use all diagnoses and procedures that affect a patient's severity of illness and/or the resources utilized. The current DRG GROUPER only considers nine diagnoses and up to six procedures. Hospitals submit claims to CMS in an electronic format. The HIPAA compliant electronic transaction 837i standard allows up to 25 diagnoses and 25 procedures. Many fiscal intermediaries are ignoring or omitting the additional codes submitted by hospital providers since these additional diagnoses and procedures are not needed by the GROUPER to assign a DRG.

Capturing all diagnoses and procedures meeting the definitions of reportable secondary diagnoses and procedures will provide a more complete picture of patient complexity. As CMS considers methodologies for refining the patient classification system, the number of secondary diagnoses may be an important factor in determining differences in patient characteristics. This is particularly true of patients with many chronic illnesses that add to the complexity of treating them.

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. The validity of CMS' proposals versus potential alternatives to improve the DRG weights and classification system is uncertain. Moving forward requires thoughtful change. Specifically, the NHA supports the following:

- **One-year Delay:** The NHA supports a one-year delay in the proposed DRG changes given 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 have some concerns with CMS' proposed HSRVcc method.

- **A New Classification System Only if the Need Can Be Demonstrated:** The NHA does not support a new classification system at this time, 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. We recommend that CMS provide a three-year transition with a blend of the old DRG weights and the new DRG weights. In the first year, hospitals would be paid based on an

average of DRG weights: 75 percent of the old weights and 25 percent of the new weights. The second year would be 50 percent of each, and the third year would be 25 percent of the old weights and 75 percent of the new weights. Another method of transition is dampening the reduction for DRGs with significant decrease in relative weights similar to the dampening of APC weights in the outpatient PPS. Dampening could be more feasible – especially if a significant change to the classification system is made – because it does not require CMS to calculate payments using two different systems.

We further believe that a stop loss should be instituted as part of this transition. This would be similar to the approach currently used under the inpatient psychiatric PPS whereby no hospital can receive less than 70 percent of what they would otherwise have been paid under the old system. In combination with the DRG blend or dampening, this would result in less significant losses in the first year than in the last year of the transition. To avoid having to run all claims under both DRG weights, CMS could establish a payment-to-cost ratio for each hospital in FY 2006 and use that as a base against which to compare payments under the new system.

Long-term Care Hospital (LTCH) DRGs

The NHA is very concerned about the proposed reweighting of the long-term care hospital (LTCH) DRGs for FY 2007. The projected payment cut resulting from the reweighting – 1.4 percent – in combination with the payment cut resulting from the recent LTCH PPS final rule for 2007 – 7.1 percent – will cause substantial volatility for LTCH providers, and ultimately restrict access for patients needing long-term acute care services. It would be extremely difficult for any provider group to withstand an 8.5 percent cut in one year. By pursuing these changes, CMS is misinterpreting MedPAC's estimate of 2006 Medicare margins for LTCHs and creating an extremely unstable regulatory environment for LTCHs. MedPAC projected a 7.8 percent Medicare margin for LTCHs in 2006 and recommended no market basket update for FY 2007. However, this MedPAC projection does not include two major policy changes that also decrease Medicare margins for LTCHs: the projection excludes the impact of the "25% Rule" limiting payments to co-located LTCHs and the new reductions associated with the LTCH short-stay outlier policy.

Given these considerations, we urge the agency to forgo the proposed 1.4 percent cut and instead implement the reweighting in a budget-neutral manner.

This would appropriately redistribute allocated funds among the payment categories to reflect current costs and omit the inappropriate modification of total payments due to unrelated considerations. **The NHA believes the LTCH PPS should be treated the same as other Medicare payment systems by reweighting the LTCH PPS in a budget-neutral manner.**

Hospital Quality Data

The Deficit Reduction Act of 2005 (DRA) expands quality reporting requirements for hospitals to be eligible to receive a full market basket update. The proposed rule states that to qualify for their full market basket update, hospitals would have to pledge to submit data on all 21 measures currently part of the Hospital Quality Alliance's (HQA) public reporting on www.HospitalCompare.hhs.gov for patients discharged on or after January 1. Hospitals failing to submit data for the first calendar quarter of 2006 by August 15 would receive an inpatient

update equal to the market basket minus two percentage points. Hospitals that fail data validation tests for data submitted for the first three calendar quarters of 2005 would also lose the two percentage points from the market basket update.

As a partner in the HQA, the NHA and its member hospitals support the HQA's effort to make more information on hospital quality available to the public, and we join with CMS in wanting to make it happen quickly and accurately. However, as written, the proposed rule 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.**

The DRA gave the Secretary of the Department of Health and Human Services (HHS) the authority to further expand the measures that must be reported to qualify for full market basket update in future years. **We strongly urge CMS to select measures only from those used by the HQA for public reporting.** To choose different measures would thwart efforts to streamline quality reporting, add to the "babble" of quality measurement that currently exists in health care and dilute efforts to create a single source to share solid reliable information with the public. In addition, whenever the Secretary intends to expand the set of measures linked to payment, **CMS should consider publishing the proposal at least one full year prior to the start of the fiscal year.** This will enable hospitals and their vendors to put the needed data collection processes in place to be able to provide the requested data.

Further, we agree with CMS that it is critical that the collected data be validated. The process used to validate the HQA data was reviewed by the Government Accountability Office, which concluded that there was "a high overall baseline of accuracy," but recommended several changes to improve the validation process. CMS proposes to look at the validation results for data submitted on patients who were discharged during the first three calendar quarters of 2005. CMS has hired a contractor to randomly select five patient records per quarter. That contractor selects the patients, asks the hospital to send a copy of the medical record for the hospitalization of the patients that occurred during that period, and then reabstracts the same data that the hospital abstracted from the medical record. A comparison is made between the data the hospital submitted and the data the contractor abstracted, and if there is at least an 80 percent agreement, the hospital is said to have passed validation. In the proposed rule, the hospital would have to have at least 80 percent agreement across the 15 medical records that the contractor reabstracted. This methodology assumes that the contractor has correctly reabstracted the data and that discrepancies must mean erroneous data submission on the part of the hospital. However, that is not always the case. This validation process is still in its infancy and seems to be working to correctly validate the information submitted by many, but unfortunately not all, hospitals.

In Nebraska there have been at least two situations when the hospital had submitted information correctly, and in a timely fashion, only to discover that problems on the part of the vendor, caused them to be in jeopardy of not being in compliance. Both were resolved with no penalty to the hospital. However, this points out how tenuous the process is and the risk it places on

hospitals whom have every intention of participating in the HQA and making this information available to their patients and potential patients.

Some data validation problems have actually begun with the data submission process. Hospitals and their data collection vendors submit data to the Quality Improvement Organization (QIO) data warehouse in a good-faith effort to get the information submitted in the right format, with all of the right labels and coding. An "error report" is generated that is supposed to alert the hospital if it appears data were received in a way that is not consistent with the requirements. The hospital is supposed to receive this report in time to make any necessary corrections. However, the report can be hundreds of pages long with a multitude of meaningless notations. A significant problem in data transmission might have occurred, but the indications of it are buried in this voluminous report and may not be discovered until it is too late for the hospital to make a correction.

Another common problem results when the contractor has asked for the medical record pertaining to a particular patient, but has not specified which admission it wanted. Since it is not uncommon for heart failure patients to be readmitted for care, the omission of the specifics on which admission was being reabstracted has inevitably led to the hospital copying and submitting data on one admission, and the contractor trying to make that match up with the data for a different admission – and the data simply will not match up.

CMS was made aware of these problems with the validation process and it has begun to work to improve the process reliability so it can be used to support payment decisions. However, in the first three calendar quarters of 2005, the validation process did not have sufficient integrity to warrant hospital payments being withheld based on the validation results. At this juncture, we firmly believe that the problems with the validation process itself need to be resolved before any payment decisions are made solely on the basis of the contractor's work. **We strongly urge CMS to review, on a case-by-case basis, any incidence where a hospital's payment would be put in jeopardy as a result of the validation process. It should allow the hospital to submit information showing that it made a good-faith effort to supply the data warehouse with accurate information so that the public could be informed about the quality of its care. If the hospital has made a good-faith effort, it should receive full payment regardless of whether the data are deemed accurate enough for public display.** In addition, CMS should instruct its QIO data warehouse to accept any significant corrections so that the public can have a full and accurate picture of hospital quality.

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. This is an 8.2 percent increase from the FY 2006 payment threshold of $23,600. We are very concerned that the threshold is too high. It is estimated that the actual outlier payments for FY 2006 will 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.

The NHA appreciates 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. The NHA strongly opposes using this methodology to estimate the outlier threshold.** The NHA supports the methodology proposed by the AHA that incorporates both cost inflation and charge inflation. We believe the use of more than one indicator will make the threshold calculation more accurate and reliable. **The estimated fixed-loss amount that would result in 5.1 percent outlier payments under this methodology is $24,000.**

The NHA strongly urges CMS to adopt this methodology, which is applicable regardless of what DRG changes are made or not made in FY 2007. We estimate that the fixed-loss threshold necessary to achieve 5.1 percent in FY 2006 should have been set at $21,275 as compared to the $23,600 actually utilized. We believe CMS underspent the funds set aside for outliers by an estimated $3 billion over FYs 2004, 2005 and 2006. **This is a real cut in payments to hospitals that cannot be recouped. If CMS leaves the threshold at $25,530, rather than dropping it to $24,000, we believe that CMS will again significantly underspend by over $300 million.**

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.

The NHA urges CMS to allow hospitals to turn in first quarter corrections in August. This recommendation is being made due to the rushed collection process to ensure that accurate data has been obtained.

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. The results of the survey could be material. 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 urge CMS to publish the occupational mix adjustment changes as an interim-final rule in August with an associated comment period.**

Geographic Reclassifications

As a result of changes in the labor market area definitions made in response to the results of the 2000 census, counties in which a number of Critical Access Hospitals (CAHs) are located became "treated" as urban instead of rural under the inpatient PPS because of a statutory provision modifying the status of rural counties with certain commuting patterns to metropolitan areas. In its FY 2005 final rule, CMS interpreted this provision as applying to CAHs located in these counties (known as "Lugar counties" after the Senate sponsor of the provision) and allowed these facilities a grace period to seek reclassification as rural in order to retain their CAH status.

While accommodating CAHs in this manner, the agency also took the position that any CAH being reclassified would no longer be eligible for pass-through payments for the services of certified registered nurse anesthetists (CRNAs). It's reasoning was that the facility was no longer "located in a rural area (as defined for purposes of section 1886(d) of the Social Security Act)" as the pass-through statute requires, but were only reclassified as rural.

In response to comments received on the FY 2006 proposed rule, CMS announced a policy change in the final rule for FY 2006 stating that Lugar county designation would not affect a CAH's rural status because the statutory provision creating such counties only applies to hospitals paid under the inpatient PPS (CAHs are paid under a separate, cost-based system). This policy change had the effect of eliminating the need for these CAHs to seek either geographic reclassification or a waiver of the Lugar statute (which CMS has maintained it has no authority to do). **In effect, under this new reading of the law, the provision creating Lugar counties does not apply *at all* for purposes of CAH eligibility.**

Despite this policy change, CMS continues to maintain that a CAH located in a Lugar county cannot qualify for CRNA pass-through payments. This position is at odds with the agency's view that *it is geographic reclassification that renders a CAH ineligible for such payments* – since, under CMS' revised policy, a CAH located in such a county need not seek geographic reclassification to be a CAH. Apparently, it is CMS' view that these CAHs can never qualify for CRNA pass-through payments, whether they have sought reclassification (under the old policy) or not (under the new policy). **We believe that all CAHs located in a Lugar county should receive pass-through payments, regardless of whether they sought reclassification, and urge CMS to revise its regulations accordingly.**

Wage Index Budget Neutrality

CMS eliminates the CAH data from the wage index file it uses to compute the national average hourly wage (NAHW). Nationally for FY 2007, 1,191 CAHs representing approximately 24 percent of all inpatient PPS hospitals (as of FY 2000) – 55 percent of all rural hospitals in FY 2000 – have been eliminated from the file. Nebraska currently has 65 critical access hospitals. Because CAHs have lower average hourly wages (AHWs) than the average PPS hospital, the elimination of this data results in an overstated NAHW. While the NAHW has been increasing,

the systematic withdrawal of low-wage hospitals has artificially inflated the NAHW to some extent. This artificial increase is included in the negative budget neutrality adjustment that consequently reduces payment, resulting in the national inpatient PPS operating payments being understated by an estimated $1.52 billion over five years (2003-2007). **We believe that CMS should apply a positive budget neutrality adjustment in FY 2007 to compensate for the underpayments.** The understatement increases each year as more hospitals become CAHs and more data are eliminated from the wage index data. However, we believe that this could be a one-time adjustment as we expect very few hospitals to convert to CAH status now that the necessary provider designation is no longer an option.

SCH/MDH Changes in Qualification Status

The proposed rule would require an approved sole community hospital (SCH) or Medicare dependent hospital (MDH) to notify the appropriate CMS Regional Office of any change affecting its classification as such. To date, it has been the FIs responsibility to evaluate hospitals' continuing qualification for SCH or MDH status. CMS expects the hospital to now self-disclose any material changes in circumstances or potentially face a retroactive cancellation of their designation once an FI discovers its ineligibility.

This appears to be an inappropriate shift of the burden from the FIs to hospitals. For instance, hospitals are neither involved in, nor have any control over, the building of new roads or new hospitals and thus should not be accountable to report such changes. It also would be very difficult for hospitals to know when and for how long there were prolonged severe weather conditions that closed area roads, or to note changes to posted speed limits and traffic patterns. In addition, some of the qualifying criteria, such as inpatient admissions at other regional hospitals, would be hard to monitor, as the hospitals do not have this sort of data on their competitors. Requiring hospitals to constantly monitor whether they continue to meet these requirements would impose a tremendous and unreasonable administrative burden on hospitals. **The NHA recommends that this function remain a responsibility of the FIs, who are in a better position to monitor these circumstances. If CMS requires hospitals to report changes in circumstances, then the specific types of situations should be noted and should only include aspects of their operation that are within their control (e.g., number of beds).**

CMS' proposal to retroactively withdraw SCH or MDH status if a hospital does not appropriately self-report a change in circumstances could be financially devastating. CMS should at minimum give consideration to whether the hospital had knowledge of the disqualifying circumstance. Hospitals should not have to repay CMS based on the difference between the inpatient PPS or outpatient PPS payment and the SCH or MDH payment when they did not know that they no longer qualified for the program. Instead CMS should develop a prospective process for withdrawing the hospitals' SCH or MDH status. We believe that a 30-day timetable for losing SCH/MDH status is unrealistic given the financial implications of such a change and the inability for a hospital to plan for this outcome. **CMS should re-evaluate the proposed timetable for canceling SCH/MDH status when a hospital is found to be disqualified or self-reports disqualification and consider revoking the hospitals' status as of the following cost-reporting period.**

SCH/MDH Volume Decrease Adjustment

A SCH or MDH may apply for special payments if it experiences a decrease of 5 percent or more in its total number of inpatient discharges that was out of its control from one cost-reporting

period to another. If the hospital qualifies, it must demonstrate that it took measures to scale back its nursing force commensurately. The adjustment is intended to cover the fixed costs that the hospital is unable to reduce in the year following the volume decrease. CMS believes that only "core staff and services" should be covered by these special payments. To date, CMS has used the AHA's HAS/Monitrend Data Book to compare the hospital's staffing to other similar hospitals in the area to determine if the hospital is staffing its routine and intensive care units appropriately. However, the Data Book has not been updated since 1993. CMS has been using the 1989 publication. Thus, CMS proposes using the occupational mix adjustment data currently being collected for wage index purposes to calculate nursing hours per inpatient day for a hospital in question and local peer hospitals.

The occupational mix adjustment was only partially implemented in its first three years, primarily due to the questionable data and results. The current collection, which is occurring again under rushed circumstances, may also result in questionable data. **We do not believe that it should be assumed that the occupational mix adjustment data would be appropriate for this use. The NHA believes that the data within the AHA annual survey should be sufficient for CMS to determine the nursing levels per patient day.**

Critical Access Hospitals (CAHs)

On November 14, 2005, CMS issued interpretive guidelines on the relocation of CAHs as a follow-up to the FY 2006 inpatient PPS final rule that established the "75% test" – serving 75 percent of the same population, providing 75 percent of the same services and employing 75 percent of the same staff – for necessary provider CAHs. The guidelines not only extended the 75% test to *all* CAHs, but it also altered the definitions of "mountainous terrain" and "secondary road."

We believe that these guidelines go well beyond the regulations included in the FY 2006 rule that provoked numerous critical responses from individual CAHs, associations and congressional representatives. The "mountainous terrain" and "secondary road" definitions are overly prescriptive and the 75% test does not provide reasonable flexibility based on natural variation in demographics, patient needs distribution patterns, normal employee and board attrition, and necessary changes in services to meet community needs. **Rural hospitals that move a few miles are clearly the same providers serving the same communities.**

Many CAHs are planning to rebuild in the near future to improve site safety and quality of care by adding fire and smoke barriers, upgrading infrastructure to support utilities and air handling, modernizing telecommunications to support health information technology, or making other essential upgrades. Facilities expect to relocate when they rebuild for a multitude of reasons: to be closer to a highway, to connect to municipal water and sewer, because of seismic safety concerns, or other similar concerns. **Such improvements will undoubtedly result in higher quality care, better patient outcomes and more efficient service, yet CMS' guidelines discourage these improvements.**

CMS' guidelines will not only impose an unnecessary burden on CAHs, but will preclude many of them from securing financing for needed capital improvements. The hospitals themselves, their hospital districts and their lenders cannot risk investing in a hospital that will be unsure of its status until a year after moving. **CMS should create a preliminary approval process to give assurances to those involved in the project that the CAH relocation will be approved if it meets the assertions made in the attestation submitted to CMS.**

Again this year, almost 60 congressional representatives signed a letter to CMS showing their support for their CAHs and urging changes to these guidelines. We agree with their recommendations and reiterate our suggestion from last year that a safe harbor be established for hospitals relocating within five miles of their existing locations. These providers are not only clearly serving the same communities, but are trying to improve the quality of and access to needed health care services. A safe harbor will reduce the administrative burden on not only the hospitals, but CMS and the state survey agencies as well. **We urge CMS to create a safe harbor for CAHs moving within five miles of their current location.**

Emergency Medical Treatment and Active Labor Act (EMTALA)

The NHA supports CMS' proposal to modify the definition of "labor" at 489.24(b) to allow a certified nurse-midwife or other qualified medical personnel operating under their scope of practice, as defined in hospital medical staff bylaws and in state law, to certify that a woman is in false labor. This change recognizes that licensure and scope of practice should remain under the purview of state law and regulation. Further, this change provides hospitals with the staffing flexibility needed to maintain access to and the efficiency of vital obstetrical services, particularly in hospitals located in areas of the country that may find it difficult to attract and retain physicians, such as rural areas.

Under the proposed rule, a hospital with "specialized capability" is required to accept appropriate transfers under EMTALA regardless of whether it has a dedicated ED. **Guidance is still needed on the definition of specialized capability.** In addition to questions related to the availability of on-call physicians and inpatient psychiatric resources, this proposed regulation calls into question application to inpatient rehabilitation facilities and long-term acute care hospitals.

The NHA agrees that a physician-owned, limited-service hospital should be treated as a hospital "with specialized capability or facilities" under EMTALA without regard to whether it has an ED. However, in the DRA-mandated HHS interim report to Congress on its development of a strategic plan regarding physician investment in specialty hospitals, the Secretary suggested that this interpretation of EMTALA "may result in an increase in the number of specialty hospitals accepting transfers of emergency patients on nights and weekends." (CMS uses "specialty" to mean the hospitals covered under Congress's moratorium, i.e., physician-owned, limited-service hospitals providing primarily cardiac, surgical or orthopedic services.) **We believe it is unlikely this will result in improved access for patients to the specialty care they need.**

It is important to separate the capabilities of the practicing physicians from the capabilities of the facility in which they are practicing. While the physician expertise housed in the physician-owned, limited-service facility could be capable of meeting the needs of community hospital patients, the facility is seldom designed or operated in a manner to support this level of practice. Although physician-owned, limited-service hospitals hold themselves out as "hospitals," many of these facilities actually have a range of capabilities more similar to a hospital department or ambulatory surgical center. These hospitals often do not have emergency capabilities, as they are geared toward elective cases of minor severity. Their capabilities are typically limited to a single major diagnostic category, and they staff for minimal inpatient capacity. Many of these facilities minimize resource consumption by being almost a Monday through Friday operation.

For these reasons, it generally would not be in the best interests of community hospital patients to be transferred to these facilities.

At the same time, many physician-owned, limited-service hospitals have withdrawn specialist services from the community at-large. As their physicians maintain an increasing amount of their practice at these hospitals or other sites outside the community hospital (e.g., ambulatory surgical centers), they are much less willing to accept on-call responsibility for the broader community's emergency needs. While withdrawing specialist services from on-call coverage, these same physician-owned, limited-service hospitals presume to rely on the community hospital for back-up in the event of complications requiring around-the-clock access to emergency care and inpatient admission to the community hospital. With the change in physician practice patterns and the increased number of physicians requesting only courtesy admitting privileges at community hospitals, relying only on the professional obligations attached to admitting privileges is not sufficient to assure appropriate transfer arrangements and the availability of physicians to provide emergency specialty capacity. **Every physician-owned, limited-service hospital that relies on the community's emergency services capacity should be obligated to support it.**

In addition, this policy does not address the problem of patients at physician-owned, limited service hospitals who suffer from complications appearing in a hospital ED with no warning call, no medical history, no operative report, no information on the anesthesia used and, often, no ability to reach the treating surgeon for consultation. **Physician-owned, limited-service hospitals should be required to have agreements with the community hospitals they plan to rely on in the event that they do not have the capacity to treat a particular patient.**

Specifically, the NHA recommends the following:

- **A physician-owned, limited-service hospital should be required to have a pre-existing agreement with the community hospital(s) it intends to rely on for emergency back-up services.**

- **The Secretary should establish the terms that must be addressed by an agreement, including:**

    - **Procedures for an appropriate transfer for patients not covered under EMTALA** (e.g., inpatient or outpatient whose condition develops into an emergency beyond the capability of the limited-service hospital and consequently needs to be transferred to a full-service hospital);
    - **Continuity of care** (e.g., telephone consultation with the receiving hospital and physician, sending the patient's medical records along when transferred, etc.); and
    - **Support for maintaining full-time emergency capacity at the community hospital, including on-call coverage** (e.g., physician-owned, limited-service hospital physicians serve in on-call panels at the community hospital, or the physician-owned, limited-service hospital provides financial support to the community hospital to maintain on-call coverage).

New Technology

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

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

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

The National Committee on Vital and Health Statistics (NCVHS) and Congress, in committee language for the MMA, recommended that the Secretary undertake the regulatory process to upgrade ICD-9-CM to ICD-10-CM and ICD-10-PCS. Congress' call for action recognized that procedure classification codes serve to identify and support research and potential reimbursement policies for inpatient services, including new health technology, as required under the *Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.*

To date, despite these recommendations, as well as the recommendations of several federal health care agencies and offices and health care trade and professional associations, HHS has not yet moved forward to adopt the ICD-10 classification upgrades. We believe that absent a switch to ICD-10 soon, there will be a significant data crisis in the U.S. This coding crisis will affect the efficiency of the current coding process, adding significant operational costs. In addition, failure to recognize this looming problem will only impede the efforts to achieve President Bush's goal for an electronic health record by 2014.

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

Category 00 is now full, and the C&M committee is entertaining proposals for codes in category 17. At the April C&M meeting a proposal was presented that would in effect leave only 80 codes available in this category. Many of the specific body system chapters are already filled

(e.g., cardiac and orthopedic procedures). In recent years, as many as 50 new procedure codes were created in a single year. This means that it is possible for ICD-9-CM to completely run out of space in one-and-a-half years. We concur with the NCVHS recommendation to issue a proposed rule for adoption of ICD-10. We also would support an implementation period of at least two years following issuance of a final rule.

The NHA strongly recommends that the Secretary undertake the regulatory process to replace ICD-9-CM with ICD-10-CM and ICD-10-PCS expeditiously. HHS should take the necessary steps to avert this crisis and avoid being unable to create new diagnosis or procedure codes to reflect evolving medical practice and new technology. It is easier to plan for this migration than respond to a crisis that will likely result in unreasonable implementation timeframes. It is imperative that the rulemaking process starts immediately.

OTHER FUTURE CONCEPTS

Health Information Technology (IT)

The proposed rule states that it "supports the adoption of health IT as a normal cost of doing business to ensure patients receive high quality care." It also notes that the quality and efficiency benefits of health IT may provide a policy rationale for promoting the use of health IT through the Medicare program. Consequently, CMS asks for comments on:

- The appropriate role of IT in any value-based purchasing program; and
- The desirability of including use of certified health IT in hospital conditions of participation.

The NHA strongly believes that health IT is a very important tool for improving the safety and quality of health care, and our members are committed to adopting IT as part of their quality improvement strategies. Hospitals also view IT as a public good that requires a shared investment between the providers and purchasers of care. Health IT is a very costly tool, requiring both upfront and ongoing spending. Hospital administrators tell us the upfront and ongoing costs of IT are the greatest barriers to further adoption.

Hospitals have not seen financial returns greater than the costs of implementing clinical IT systems, particularly in the short term. They adopt clinical IT because it is the right thing to do for improving patient safety and quality of care, not because it saves them money. While IT may be a "normal cost of doing business," it systematically raises those costs.

The proposed rule highlights the anticipated benefits of health IT as laid out by the RAND Corporation. However, it overlooks another of the study's major findings – that the financial benefits of IT investments accrue more to the payers and purchasers of care than the hospitals and health systems that pay for them. **Given that they reap many of the financial benefits of IT, the NHA believes that the payers should share in the costs of IT.**

Finally, we learned through the Nebraska SNIP and HIPAA process that efficient health information exchange requires all parties to upgrade their systems and work from a common set of standards. As we move toward implementation of health IT in hospitals, payers – including

the federal government – must modify their own systems to accept electronic data and accept uniform interpretations of the standards.

Value-based Purchasing. The NHA believes that any value-based purchasing program should not be punitive. **With regard to IT, only programs that add new funds to the inpatient PPS should be pursued because IT is costly, requiring both upfront and ongoing expenditures.** Decreasing payments to those that have not been able to afford IT further limits their ability to invest. A budget-neutral approach also ignores the reality that health IT systematically increases hospitals' costs.

The NHA also believes that value-based purchasing programs should build off the consensus measures endorsed by the broad spectrum of organizations – including CMS – that participate in the HQA. In general, the HQA favors measures that address quality outcomes, rather than the tools used to get there.

Health IT can play a role in reducing the burden of quality reporting. Presently, electronic health records (EHRs) and other clinical IT systems do not automatically generate quality measures. Most hospitals still require special calculations – including expensive manual chart abstraction and use of third-party contractors – to submit quality data. CMS could advance the quality agenda by investing in the development of algorithms for the calculation of the quality measures it wants reported from EHRs and encouraging vendors to include them in their products.

Rather than including health IT in a value-based purchasing program, **CMS could support adoption of health IT through a payment adjustment funded with new money.** For example, it could increase payments to hospitals that use health IT that improves the safety and quality of care by 1 percent. This kind of payment adjustment represents Medicare's share of the necessary investment to achieve this goal and would recognize the greater costs of a "wired" health care system. The NHA will pursue legislation authorizing such a payment adjustment. Other mechanisms, such as loan guarantees and grant funds, are needed to help hospitals finance the upfront costs of implementing health IT.

Conditions of Participation. The NHA firmly believes that **CMS should not include health IT in the Medicare conditions of participation (COP) for hospitals.** The COPs address the basic, essential infrastructure needed to ensure patient safety and must be clearly understood. Successful implementation of quality-enhancing IT requires careful planning and changes to work processes. The hospital field is still developing its understanding of how to implement these systems correctly.

While the NHA appreciates the efforts of the Certification Commission on Health Information Technology (CCHIT) to provide the market with better confidence in vendor product, we do not believe those efforts are sufficiently advanced to warrant inclusion in any adoption incentives CMS might pursue. CCHIT is only at the beginning stages of looking into certification of hospital inpatient products. CCHIT's work on ambulatory products is more advanced but, while it shows promise, has not yet proven itself in the marketplace.

Hospital-acquired Infections

In the proposed rule, CMS has asked for ideas about how to effectively implement the DRA provision requiring the agency to identify instances in which the reliable application of science and appropriate processes of care should prevent infections, and to ensure that Medicare does not

pay more for the hospital care of patients who becomes infected as a result of their care than it does for patients who are infection free.

It is difficult to identify the confluence of known science and effective care processes to prevent infections. **We believe that until a broad array of expertise is brought together to consider what conditions, procedures and circumstances should be targeted for this change, it is impossible to know how to most effectively implement the provision.**

We believe that the right starting point for this work is to build off CMS' substantial investment in the Surgical Care Improvement Project (SCIP). Surgical wound infections are among the most common and hazardous hospital-acquired infections. There is a readily available community of expertise among the broad group of organizations involved in SCIP, including the American College of Surgeons, the American Society of Anesthesiologists, the Association of periOperative Registered Nurses and the Centers for Disease Control and Prevention, among others. The existing SCIP partners' expertise can help identify a few surgical procedures that might be most appropriate for the change Congress envisioned. We believe these are likely to be relatively "clean" surgeries, meaning surgeries on patients whose conditions or wounds have not already put them at higher risk for infection, and patients who do not already have a variety of complicating conditions that would place them in higher paying DRGs. Additional expertise on coding and the DRG GROUPER also is needed for these discussions to help address questions of what data are helpful and readily available to determine which infections were acquired in the hospital versus the community, and which codes actually lead to enhanced payments.

In addition, there is good evidence to suggest that even when reliable science and appropriate care processes are applied in the treatment of patients, not all infections can be prevented. Therefore, we suggest that by utilizing the SCIP program as the basis for responding to the congressional mandate, CMS could choose not to penalize a hospital if, despite their best efforts, an infection occurs. For example, if a hospital's performance on the SCIP surgical wound infection prevention measures show that it reliably performs the necessary infection prevention steps all or nearly all of the time, CMS might not make any change to the current payment system for that hospital.

The NHA appreciates the opportunity to submit these comments on the proposed rule. If you have any questions about these comments, please feel free to contact David Burd, Director of Finance, at (402) 458-4900 or dburd@nhanet.org.

Sincerely,

Laura J. Redoutey, FACHE
President

Submitter : **Dr. Peter Coggan** **Date: 06/12/2006**

Organization : **Henry Ford Health System**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1607-Attach-1.DOC

#1607

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June 12, 2006

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

Attention: **CMS-1488—P "GME Payments"**

Dear Administrator McClellan:

Henry Ford Health System welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' 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.

While it is difficult, if not impossible, to separate patient care from teaching in the daily care of individual patients in the hospital or clinic, didactic teaching is more easily distinguished. Didactic sessions clearly have an impact on patient care since their purpose is to enhance the resident's knowledge and skills. They, therefore, enhance expertise and improve the quality of care of individual patients. Furthermore didactic sessions are often case-based using individual patients as examples from which the residents learn.

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,

Peter Coggan

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

Organization : **Doylestown Hospital**

Category : **Hospital**

Issue Areas/Comments

DRGs: MCVs and Defibrillators

DRGs: MCVs and Defibrillators

June 12, 2006

The Honorable Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8011
Baltimore, MD 21244-1850

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

Dear Dr. McClellan:

I am the Director of Cardiovascular Services at Doylestown Hospital in Doylestown Pennsylvania. We are a 200 bed hospital serving suburban Philadelphia approximately 30 miles north of the city. One of our premier service lines is our Heart Center which includes a busy cardiac catheterization lab, electrophysiology lab and cardiac surgery. My role at Doylestown Hospital is to oversee much of the cardiac product line.

Thank you for the opportunity to comment on the Centers for Medicare and Medicaid Services proposed changes to the Hospital Inpatient Payment Systems and Fiscal 2007 Rates (CMS-1488-P).

As a cardiac service line administrator I am very concerned about the proposed payment changes, in particular to the cardiovascular services we provide to our patients. I entirely agree cardiac DRG reimbursement should be based on both the acuity of the patient and accurate costs of supplies and devices provided to our patients. However, I strongly feel CMS is collecting inaccurate costs of these supplies and devices when based on cost to charge ratios.

Furthermore, I am absolutely certain most hospitals are incorrectly charging for cardiac devices in order to reflect accurate costs when the cost to charge ratio is applied by CMS. I would estimate up to 80% of all hospitals implanting cardiac devices have incorrect charges creating what has been termed charge compression . I base this opinion on 27 years of experience working in several institutions ranging from urban university based setting to community hospitals. As you know when the cost to charge ratio is applied to incorrect charges the result is erroneous cost data ultimately resulting in inaccurate and inappropriate payment rates.

If the proposed changes as stated were to be adopted, the reduction in payment would not in some cases even cover the cost to our hospital for the cardiac device alone. This in and of itself may, in fact, preclude our community hospital from offering this proven life saving therapy given the razor thin financial margins at which we presently operate.
I would emphatically urge CMS to delay the 2007 proposed changes until more accurate and extensive study of the actual costs of devices such as BiV ICD s, pacemakers and drug-eluting stents can be completed. I would also urge CMS to proactively develop an accurate system to collect actual costs from hospitals. This could be accomplished through either data registries such as the ICD registry or perhaps even directly into a modified UB-92 form.

In conclusion, I can certainly appreciate as a tax payer the efforts of CMS to improve the inpatient payment system. It is certainly incumbent upon both CMS and healthcare providers to work together to both control the costs of healthcare and to provide the best quality care to our patients. However, the present proposed changes are rooted in a highly flawed charge based system which does not accurately reflect the cost of very expensive medical devices to healthcare providers. To change the inpatient payment system based on this data would both bankrupt healthcare providers and/or seriously reduce the availability of life saving therapies for our patients.

Sincerely

John M. Mitchell
Director Cardiovascular Services
Doylestown Hospital
595 West State Street
Doylestown, PA 18901

Submitter : **Dr. Dana Ann Mann** **Date: 06/12/2006**

Organization : **Tufts University Family Medicine Residency**

Category : **Physician**

Issue Areas/Comments

GME Payments

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.

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,
Dana D. Mann M.D.

Submitter : **Mr. Denis Conroy** **Date: 06/12/2006**

Organization : **Northeast Hospital Corporation**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

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, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Proposed Rule.

Dear Mr. McClellan:

On behalf of Northeast Hospital Corporation, I appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the fiscal year (FY) 2007 inpatient propsective payment system (PPS) and occupational mix adjustment proposed rules.

HSRV Weights
The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc).

I strongly support the change from the current charge based DRG weighting system to the proposed HSRVcc system in FY07. While I understand that other parties are commenting on imperfections in the cost weighted system poposed by CMS, we should not lose sight of the greater imperfections in the current charge-based system. The proposed DRG weights under the HSRVcc methodology more closely represent the cost of providing services that the current charge-based system. Hospitals that provide more routine medical admissions as opposed to high-end, high-margin (especially cardiac) surgeries and services have been disadvantaged for years under the current charge-based system. The move to a cost-based system should be effective in FY07 regardless of whether perfected. Even as proposed it is more reflective of the costs of providing servcies which should be the foundation for payment under the Medicare system.

If I can provide you with any additional information regarding our comments, please do not hesitate to contract me at (978) 922-3000, x7979.

Sincerely,
Denis Conroy
Chief Financial Officer

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Office of Strategic Operations & Regulatory Affairs

1,611

CMS-1488-P-1611 **Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates**

Please note that electronic comment CMS-1488-P-1611 is a duplicate of CMS-1488-P-1610. To view this comment, please see CMS-1488-P-1610.

Submitter : **Mr. R. Scott Huennekens** **Date: 06/12/2006**

Organization : **Volcano Corporation**

Category : **Device Industry**

Issue Areas/Comments

DRG Weights

DRG Weights

Volcano Corporation is pleased to provide the attached comment letter relating to proposed changes to the Medicare hospital inpatient prospective payment systems and fiscal year 2007 rates. We thank you for the opportunity to comment on the Proposed Rule.

CMS-1488-P-1612-Attach-1.PDF

#1612

June 12, 2006

Via Electronic Mail

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

File Code CMS-1488-P: Comments Related to Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates

Dear Dr. McClellan:

Volcano Corporation (hereinafter referred to as "Volcano") is pleased to provide this comment letter relating to proposed changes to the Medicare hospital inpatient prospective payment systems and fiscal year 2007 rates ("Proposed Rule"). We thank you for the opportunity to comment on the Proposed Rule.

About Volcano

Volcano is a manufacturer of intravascular ultrasound (IVUS) and functional measurement (FM) guidewire products, and is headquartered in Rancho Cordova, California. We develop, manufacturer, and commercialize a broad suite of products that enhance the diagnosis and treatment of vascular and structural heart disease. Our Company is dedicated to investing in technologies and products that provide superior care and improve cardiac and vascular health, for Medicare and other patients. In recent years, we have made important technical and medical advancements, which we are confident will have a significant impact on the quality of cardiac care.

Overview of Comment

Volcano supports and welcomes CMS' goal of improving the accuracy of payments as a means of assuring beneficiary access to care. We do not believe, however, that the hospital specific relative value cost center (HSRVcc) cost-based system for calculating DRG relative weights as outlined in the Proposed Rule is an efficient, accurate, or patient-focused solution.

The Proposed Rule would change Medicare DRG payment to use hospital cost reports from FY 2003 to calculate the cost-to-charge ratios (CCR) used in determining DRG relative weights. The time lag between the cost report period and the payment year means that new medical technologies or technologies whose use has increased recently will not be reflected in relative weight calculations. In fact, the Proposed Rule has the potential to *systematically* bias payment (and -- hence -- use) against the very medical advances that have elevated the quality of care in this country.

Volcano Corporation • 2870 Kilgore Road • Rancho Cordova, CA 95670
Phone: 800-228-4728 • Fax: 916-638-8812

Implementing the Proposed Rule could severely discourage the utilization of new technologies that both improve patient outcomes and enable more efficient use of healthcare resources. Volcano's IVUS and FM products are used in a number of DRGs, but the most important include DRGs 556 and 558 for Percutaneous cardiovascular procedures with drug eluting or non-drug eluting stents. CMS' proposal would cut payment by over 30% to hospitals.

Because of the importance of improving the accuracy of the payment rates, reflecting actual resources for innovative medical technologies, and encouraging high quality care, Volcano recommends the following:

1. Maintain the current methodologies for assigning DRG relative weights in FY 2007;
2. Any changes should only be phased in over a three to five year period with yearly assessments of the impact of payment reductions on patient access;
3. CMS institutes a special payment transition for certain DRGs like 556 and 558, that would protect hospitals from radical payment reductions, since these DRGs utilize diagnostic and imaging procedures that enhance the efficacy of the primary procedure within the DRG (stents, ICDs, etc.)—procedures whose products may not be captured in cost data reports.

Volcano also has significant reservations about the proposed severity of illness modifications in the DRGs. As proposed, these severity adjusted DRGs fail to accurately distinguish patients with various cardiac conditions, and requiring specialized services. This system should be deferred until further analysis and refinements can be made that support high quality care for Medicare patients.

About IVUS

IVUS allows the direct visualization of vascular anatomy during percutaneous diagnostic and therapeutic procedures and is used in conjunction with angiography.

During an IVUS procedure, an imaging catheter is placed inside an artery to produce a cross-sectional image of the size and shape of the artery's lumen and provides information concerning the composition and density of plaque or lesions and the condition of the layers of the surrounding arterial walls.

IVUS imaging is based on the same principles employed in sonar. High frequency ultrasonic waves are generated by a transducer and directed at the tissue to be imaged. When the sound waves encounter the tissue, they are reflected back to the transducer. Harder substances reflect the ultrasonic waves more strongly than softer substances, which absorb more of the wave's energy. Analysis of the time delay and strength of the returned signal determines the distance to and composition of the tissue.

Unlike angiography, which depicts a silhouette of the lumen, IVUS displays continuous real-time longitudinal and cross-sectional perspectives of the artery. Since angiographic images are grayscale and two-dimensional, they provide limited information about the lesion and artery and also make it difficult to assess complex artery anatomy and bifurcations. In addition, angiography lacks the ability to provide any information about plaque and its composition.

In conjunction with angiography, IVUS is used both prior to percutaneous intervention to assess the artery and determine the appropriate therapy and after therapy to assess the result. IVUS is used in both coronary and peripheral artery percutaneous interventions as well as for structural heart disease.

Volcano's IVUS products consist of consoles, single-procedure disposable catheters and advanced functionality options.

Trends in IVUS Utilization

With Volcano's recent innovation of integrating IVUS components directly into the lab, the IVUS technology is always available and always on.

Historically, clinicians had to take several manual measurements in order to calculate critical vessel and lumen measurements. Also, IVUS historically could only be viewed in grayscale images which provided limited information about plaque composition.

Volcano has recently made available its VH™ IVUS functionality that offers automatic real-time drawing of lumen and plaque borders, automatic vessel sizing, and color-coded identification of plaque composition. By providing greater decision-making information to clinicians can more effectively manage the therapeutic options.

About Functional Measurement

FM devices measure the pressure and flow characteristics of blood around the lesion (or plaque build-up) thereby allowing physicians to gauge the lesion's impact on blood flow and pressure. FM devices produce a simple, reliable and reproducible measurement of a lesion's blood flow limiting characteristics and are used in conjunction with angiography. This physiological measurement provides physicians with specific clinical guidance on appropriate treatment.

With growing numbers of patients with acute coronary syndromes, or ACS, undergoing diagnosis and treatment and the increasing numbers of patients with multi-vessel CAD, complementary physiologic lesion assessment for directing revascularization is of increasing value.

An FM product includes a console and a single-procedure disposable guidewire. FM consoles are designed to be mobile and moved among cath labs or integrated and installed in both new and replacement cath labs. Historically, consoles were not integrated into the cath labs' data management systems or work flow. The recent introductions of FM consoles that are smaller and integrate into the cath lab for the first time represent a significant improvement in ease of use.

In addition, FM products offer the opportunity to physiologically assess lesion severity and determine whether expensive drug-eluting stents are needed, and can be used to appropriately rationalize use of drug-eluting stents only in flow-limiting lesions.

Our FM products consist of pressure and flow consoles and single-procedure disposable pressure and flow guidewires. We believe we are the only company that offers a full line of pressure and flow guidewires as well as a guidewire that can measure both pressure and flow.

Our consoles are mobile, proprietary and high speed electronic systems with different functionalities and sizes designed and manufactured to process the signals received from only our guidewires.

Importance of Minimally Invasive Procedures

Interventional procedures are performed in a hospital where real-time angiography provides visualization which enables physicians to insert and navigate tools such as catheters, guidewires, stents and other devices into the vasculature or chambers of the heart to diagnose and deliver therapy.

Although great strides have been made in improving percutaneous interventional techniques, significant challenges remain that reduce the effectiveness of current treatments and limit the number of complex procedures and the types of diseases that can be diagnosed and treated. These challenges primarily involve limitations of angiography as the primary means for diagnosing and guiding percutaneous interventions.

IVUS and FM Usage Could Improve Patient Outcomes and Reduce Overall Healthcare Costs

Volcano's IVUS products provide the interventionalist the information to optimize stent sizing and placement.[1] This can help eliminate the need for additional stents or the use of accessory products like balloons to correct for inaccurate stent deployment and apposition issues.

A key determinant of positive therapeutic results in percutaneous interventions is having sufficient information about plaque or lesions. Clinical data has shown that use of IVUS, in conjunction with angiography during percutaneous interventional procedures, can result in better outcomes.[2] Numerous studies have shown the acute and long-term benefits of IVUS guidance in stent deployment.[3] For example, studies have demonstrated that physicians change their percutaneous interventional strategies in 20% to 40% of cases and that 50% of stent deployment issues detected by IVUS are not visible with angiography. **These products provide clinically significant information that improves the outcomes of current and increasingly complex percutaneous interventional procedures.**

While atherosclerosis is often characterized by narrowing of the lumen, or stenosis, it can also take the form of plaque or lesions that are not stenotic but are more likely to rupture and cause blood clots that may block the lumen. Based on clinical studies, 86% of heart attacks and 88% of strokes may be caused by these non-stenotic lesions known as vulnerable plaque. Vulnerable plaque can occur in the coronary or peripheral arteries and has the ability to rupture at any time, without warning, causing a heart attack or stroke.

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[1] Lui H, Brodie, B. The Perfect Fit: Getting the Most Out of Your Coronary Stent. *Cath Lab Digest* October 2005: 20-26.
[2] Colombo A, Hall P, Nakamura S, et al. Intracoronary stenting without anticoagulation accomplished with intravascular ultrasound guidance. *Circulation* 1995;91:1676-88.
[3] Fitzgerald PJ, Oshima A, Hayase M, et al. Final results of the Can Routine Ultrasound Influence Stent Expansion (CRUISE) study. *Circulation* 2000;102:523-30.

Physicians today cannot diagnose and therefore treat vulnerable plaque. Because our technologies address many of these current limitations, we believe our products provide the potential to enable these diseases to be diagnosed and optimally treated through percutaneous interventions. In selected patients with coronary artery stenosis, the detection of vulnerable plaques with a catheter-based test followed by their treatment with a drug-eluting stent could be a more effective strategy than current practice.

Additionally, Volcano's FM products have the potential to reduce the number of devices deployed, thereby by lowering treatment costs. FM products offer the opportunity to physiologically assess lesion severity and determine whether expensive drug-eluting stents are needed, and can be used to appropriately rationalize use of drug-eluting stents only in flow-limiting lesions.

Clinical studies have demonstrated the usefulness of fractional flow reserve, which is measured by FM, for the assessment of intermediate lesions in single-vessel and multi-vessel disease. In addition, the use of FM during angioplasty and after stent deployment has prognostic value for major adverse cardiac events after percutaneous intervention.

FM assessment can be used to direct intervention only to those lesions that can best be treated by expensive drug-eluting stents, thereby resulting in significant cost savings.

Volcano's Concern with the Proposed Rule

While we appreciate CMS' goal of more closely aligning hospital payments to actual costs incurred, we do not support the implementation of the Proposed Rule for two primary reasons:

1. The method for calculating costs in the Proposed Rule is based on incomplete and inaccurate data.

    - The use of estimated costs does not capture the true costs incurred by hospitals. Under prospective payment systems, providers' payments are not based on their actual costs. Thus, there is less incentive for hospitals to report their actual costs incurred for providing services. As such, the estimated costs are incomplete.
    - Under the Proposed Rule, CMS uses hospital cost reports from FY2003. Newer medical technologies or those whose use is growing would not be accurately included in cost-based calculations. There would be an inherent lag with relative weights playing "catch up" to actual medical trends. This will create reduced accuracy in determining DRG weights under the Proposed Rule.

    The result would be to systematically bias payment against use of important new medical advances – many of which have the clear potential to lower the total overall cost of care system wide (although these savings may not always be realized or captured at the time of care delivery).

2. The immediate implementation of the Proposed Rule could have unintended effects.

- In attempting to mitigate the effects of reduction in surgical procedure payments, hospitals may move to cut supply costs across the board without considering the direct patient benefits of many medical products and devices.
- Additionally, hospitals may move to immediately reduce the utilization of diagnostic and imaging procedures that enhance the efficacy of the primary procedure within the DRG (stents, ICDs, etc.)
- While the proposed changes are designed to be revenue-neutral across all Medicare payments, a 30% reduction in key stent DRGs appears disproportionate to all the other payment changes.
- The proposed rule, if finalized, might improperly incentivize hospitals not to use IVUS or FM to assess a lesion at PCI, as the cath lab is attempting to minimize supply costs to offset reduced payments under the Proposed Rule. Not using IVUS or FM might appear to result in short term cost savings. However, not using IVUS may also result in inappropriate stent deployment (stents not fully apposed / expanded) – and could result in costly future re-admission for correction or for management of a myocardial infarction caused by stent thrombosis. Likewise, not using FM may result in stenting a lesion that is not flow-limiting.
- In this hypothetical scenario, costs are reduced at the initial visit, but not over the continuum of care. In fact, costs could be increased significantly as a result of this type of short term behavior which may be encouraged by a cost based DRG system which fails to accurately capture new technology costs.

Summary

Volcano believes the use of estimated costs to determine weights as reflected in the Proposed Rule is an inaccurate method for calculating DRG payments, and could have a negative effect on the utilization of new technology or technology whose use is growing—technologies that improve patient care and enable more efficient use of healthcare resources.

We have hopefully demonstrated that, as with Volcano's IVUS and FM technology, cost report data that is three years behind the fiscal year will not accurately identify current trends in physician practice. The cost of the technology used will not be accurately identified and included in the cost-based system described in the Proposed Rule.

We thank CMS for the opportunity to comment, and we welcome the opportunity to provide any additional supporting information to CMS for use in its evaluation of the Proposed Rule.

Sincerely,

R. Scott Huennekens
President and Chief Executive Officer
Volcano Corporation

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Submitter : **Mr. Robert Monroe** **Date: 06/12/2006**

Organization : **Murer Consultants**

Category : **Attorney/Law Firm**

Issue Areas/Comments

Hospitals-Within-Hospitals

Hospitals-Within-Hospitals

Thank you for the opportunity to comment on the proposed regulations relative to hospitals within hospitals (HWHs). Murer Consultants works with a number of HWHs and several that are grandfathered pursuant to 42 C.F.R. 412.22(f) from the HWH requirement. Our comments are put forth to call attention to some of the ambiguity relative to the current and proposed grandfathering provisions.

The proposed rule changes for grandfathered excluded hospitals do fall short of anticipating the realities of hospital operation. CMS has taken the position that grandfathered HWHs are locked in place in and must 'operate under the same terms and conditions... in effect on September 30, 2003.' Notwithstanding the new provisions relative to square footage and bed size decreases and possible square footage increases, the contemplated grandfathering provisions leave a significant amount of ambiguity for HWHs. For example:

1. If a grandfathered HWH renovates a floor, it usually must comply with new construction standards under the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities.
a. Does the fact that the HWH is subject to new laws as a result of the renovation allow the hospital to construct a new physical plant and expand?
b. Does application of new construction standards equate to 'changes in Federal, State, or local law affecting the physical facility' even if the new construction standards have been in existence for some time and are only now being applied?

2. May square footage be reallocated? For instance, is it permissible to allocate inpatient square footage to outpatient (or other cost centers)? Some HWHs are of significant size (usually they are separate buildings within 250 yards of another hospital) and must frequently upgrade and renovate and that will necessarily impact square footage allocation.
a. May outpatient square footage be decreased and inpatient increased as long as there is no net increase?
b. Similarly may inpatient space be decreased (but the total be numbers remain the same) and the outpatient space be increased in size?

3. What other 'terms and conditions' must remain in place?
a. May a HWH provide a new service such as MRI or is that a change in the terms and conditions?
b. May a HWH cease providing some types of services, i.e. outpatient surgery?
c. May a HWH change ownership or is that a change in the terms and conditions?

CMS' requirement that grandfathered HWHs continue to operate under the same 'terms and conditions' presents hospitals with a significant degree of uncertainty. Must every construction project be presented to the applicable CMS Regional Office to be determined whether it constitutes a changed term or condition? Furthermore, the prohibition on most square footage increases and all bed increases is impractical. Renovating facilities does not result in square footage decreases and hospitals must be able to respond to community need. The revised regulations continue to be ambiguous and overly-broad from the stated purpose of reducing the frequency and expansion of nominal hospitals.

Thank you for your attention to these comments.

Lyndean Lenhoff Brick, J.D.
Senior Vice President

Robert L. Monroe, J.D., LL.M.
Vice President

CMS-1488-P-1613-Attach-1.RTF

CMS-1488-P-1613-Attach-2.RTF

#1613

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Lyndean Lenhoff Brick, J.D.
Senior Vice President

Robert L. Monroe, J.D., LL.M.
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Lyndean Lenhoff Brick, J.D.
Senior Vice President

Robert L. Monroe, J.D., LL.M.
Vice President

Submitter : **Mr. Jerry Stringham** **Date: 06/12/2006**

Organization : **Medical Technology Partners, Inc.**

Category : **Other Health Care Professional**

Issue Areas/Comments

CC List

CC List

See attached file.

Jerry Stringham
Nancy Young
Medical Technology Partners, Inc.
Rockville, Maryland
301-296-4334

CMS-1488-P-1614-Attach-1.DOC

#1614

IPPS COMMENT

We appreciate that CMS will make changes to the payment for infections by October 1, 2007. CMS asked for comments on which infections were of high frequency and/or high cost. We feel particularly strongly that UTI (urinary Tract Infections) should be removed from the CC list.

We recently (12/05) published an article in Perspectives in Health Information Management which indicated that 9% of all Medicare admissions have a UTI included in the claim. The article shows how Medicare pays more for like patients, when one patient acquires a UTI and one does not. It is available online at: http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_028894.html. The article is entitled "MedPAR as a Measure of Urinary Tract Infection Rates: Implications for the Medicare Inpatient DRG Payment System". We believe that this poor quality payment add-on has slowed adoption of infection reducing strategies.

Furthermore, our interest in this subject was initiated when a hospital official told us "we get paid for UTIs" as an argument for not adopting an infection reducing strategy. By maintaining a truly prospective system for patients with a UTI as a non-admitting diagnosis, hospitals will maintain maximum incentive to reduce UTIs, and that is great news for patients. In addition to UTIs, it is our belief that CMS should err on the side of the patient when including an infection as a cc item. Therefore, any non-primary diagnosed infection that might have been prevented by superior care should no longer result in an additional payment for the hospital. In the long run, this will help hospitals better manage the cost of care and reward those who practice better medicine.

The most common counter argument to such a change is that hospitals will lose money if they do not capture the income that comes from the more intense stays and higher DRG payments. We disagree emphatically with this argument. Since patients with this condition will be moved to a different DRG, the relative weight of the DRGs will change. The total payment to US hospitals is fixed, so it's just a matter of when they get paid. Payments for cases with an infection will go down, but payments without an infection will go up. Overall, hospitals will have the same total amount of money to use. The ones with lower infection rates will do better than those with high infection rates.

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If the number of nosocomials is reduced in any way, this cost savings will inure to the hospital's bottom line. So patients and hospitals will benefit from this change. In an era when CMS is exploring making small percentage increases in payments (<1%) for quality improvements, it is pleasing to note that CMS is beginning to eliminate the poor quality bonus to hospitals when preventable infections occur.

Jerry Stringham
Nancy Young
Medical Technology Partners, Inc.
Rockville, Maryland
301-296-4334

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Submitter : **Dr. Daniel Paulson** **Date: 06/12/2006**

Organization : **Springfield Family Physicians**

Category : **Individual**

Issue Areas/Comments

GME Payments

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.

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,

Daniel K. Paulson, MD

Submitter : **Mr. Gary Flansburg** **Date: 06/12/2006**

Organization : **Memorial Health System**

Category : **Hospital**

Issue Areas/Comments

DRGs: Severity of Illness

DRGs: Severity of Illness

In response to the FY 2007 IPPS Proposed Rule, please accept this response as the comments of Memorial Health System, Colorado Springs,CO to the proposed rule. We wish to respond and object to this section of the proposed rule.

The proposed rule revises the DRG weighting system by basing DRG weights on cost data instead of charge data. While Memorial Health System does not disagree with moving to a cost based DRG system, there are two major flaws in the proposed CMS weighting methodology. First, national cost to charge ratios are used to convert charges to cost. This methodology does not take into account local or regional variations in cost nor does it take into account the differing cost and charge structures of hospitals. The example of DRG 558 used in the proposed rule is a good indicator of the problems national cost to charge ratios can cause. DRG 558 is being converted to cost in part by using a 20% cost to charge ratio for cardiology services. However, from Memorial Health System's 2004 audited Medicare cost report, cardiology costs are 36.4% of charges. Adoption of the proposed weight for DRG 558 will seriously understate the true cost to Memorial Health System of providing this service.

The second flaw in the weighting methodology is that there are technical errors in the proposed DRG weighting. The American Hospital Association (AHA), in its June 8, 2006 comments to this proposed rule, submitted data from a Moran Associates analysis of the proposed rule. The Moran analysis pointed out several technical flaws in the weighting of the DRGs. Most notably, CMS hospital weighted as opposed to charge weighting the new proposed rates. That is, smaller hospitals with high routine costs received the same weighting as larger hospitals with greater ancillary costs. As a result, the weights for the routine service intensive DRGs are overstated and the weights for the ancillary service intensive DRGs are understated. Memorial Health System agrees with the AHA recommendation that the implementation of the new cost-based DRG system be delayed one year in order to refine the data elements of the new system. At the very least, correction of the technical errors raised by the Moran analysis should be made before the final rule is published.

Our analysis of the FY 2007 proposed rule shows that Memorial's Medicare reimbursement will decrease by about 3% or $2.2 million if this proposed rule is adopted. Approximately $1.3 million of this decrease is concentrated in DRGs 124,125,515,556,and 558, the five DRGs experiencing the largest percentage weight decrease under the proposed rule. Conversely, the five DRGs experiencing the largest weight increases, DRGs 87,88,89,174, and 277 only yield about $350,000 of offsetting additional reimbursement to Memorial Health System.

In conclusion, the proposed rule as currently written results in a significant financial hardship to Memorial Health System. Adoption of the recommendations made in this letter will mitigate the effects of the proposed rule and allow Memorial Health System to continue to provide the highest quality of care to its Medicare population.

Submitter : **Ms. Terry Cole** **Date: 06/12/2006**

Organization : **Ascension Health**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Please see attached comments.

CMS-1488-P-1617-Attach-1.DOC

#1617

ASCENSION HEALTH

4600 Edmundson Road
Saint Louis, Missouri 63134-3806

Post Office Box 45998
Saint Louis, Missouri 63145-5998

Phone: 314-733-8000
www.ascensionhealth.org

June 9, 2006

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

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

Dear Sir or Madam:

I represent Ascension Health, the nation's largest Catholic and nonprofit health system, serving patients through a network of 63 acute hospitals and their related health facilities. We appreciate the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed fiscal year 2007 changes to the inpatient prospective payment system.

During the most recent fiscal year our facilities were responsible for the care associated with over 295,000 Medicare admissions. Our facilities cover a broad spectrum of providers and include Critical Access Hospitals as well as Level One Trauma Centers and tertiary referral centers. Our care represents the entire range of services including adult medicine, cardiac care, orthopedics, emergency medicine, pulmonary medicine, oncology, neurosciences and transplants, just to name a few.

DRG Revisions

Ascension Health fully supports the goal of CMS to create an equitable return across all DRGs to provide equal incentives to treat all patients and conditions. However, we have serious concerns about many of the changes as currently proposed.

The American Hospital Association (AHA) has submitted comments with regard to the specific calculations and methodologies utilized to arrive at the revised DRG weights. We fully concur with all of their comments and would like to add some additional observations and comments of our own.

We understand that CMS is responding to recommendations from the Medicare Payment Advisory Commission (MedPAC) in developing the revisions to DRG weights based upon costs rather than the current charge-based system. However, the proposed methodology contains many assumptions that have not been tested. And while MedPAC (and Ascension Health) believes that significant redistribution may appropriately occur as a result of the changes, it is extremely important to understand the shifts and why they have occurred in

order to assess the appropriateness of them. With that in mind, we strongly support the AHA's recommendation to delay for one year the proposed DRG changes.

It is our understanding that at least a portion of CMS' objective is to eliminate the incentives for specialty hospitals inherent in the current DRG system; however, all hospitals with significant cardiology, orthopedic and/or neurosurgery programs will suffer significant reductions in payment as a result of the proposed changes. For example, because of their high concentration of cardiac patients one of our hospitals alone will experience an $11.5 million reduction in their payments, or nearly 10%, due solely to the revision to the DRG weights. For a hospital that is currently in a break-even situation time is critical to be able to respond to this type of change. Major cost restrictions will be necessary including personnel layoffs, departmental restructuring, etc.

Many hospitals map charges on their cost reports to different cost centers than are reflected through the revenue codes on submitted claim forms. They do this so that the cost report will appropriately match costs and charges to calculate cost to charge ratios. Medicare data is mapped accordingly by the hospital and will not match strict revenue code mapping on the claims filed. Because CMS applied cost-center level cost to charge ratios (CCRs) derived from the cost reports to charges from claims data, a material distortion of the DRG weights may occur. As an example, at least one of our hospitals reports medical supply costs and charges in the Operating Room on their cost report. However, the revenue codes on submitted claims will reflect these charges as medical supplies. Applying the current CMS methodology will improperly apply the incorrect CCR to the supply costs in this example.

In addition, the methodology utilized by CMS assumes a standard markup is applied to all costs within a particular cost center. While we realize averages must be used, an exception should be considered for items such as implants and devices. It is common industry practice to utilize significantly lower mark-up percentages for high cost items such as implantables and devices than the mark-up applied to routine chargeable supplies. However, CMS' proposed methodology does not account for the fact that the supply CCR utilizes the average of all supplies and not just those higher-cost, lower mark-up supplies utilized in some instances. The result materially underestimates the true cost of many high-resource-utilization DRGs. In order to mitigate such drastic changes, major cost reductions including FTE layoffs will be necessary. Therefore, we propose a delay in the implementation of the proposed changes to DRGs to allow for time to fully understand the implications of these changes and the complexities surrounding them. If a delay is not granted, we respectfully request a minimum three-year transition and a stop-loss provision so that our hospitals have time to assess the impact (particularly the unintended effects) and react to changes that are necessary to appropriately mitigate at least a portion of them.

The current DRG system is based upon the premise of resource use. CMS has proposed revising the DRG methodology to base payments upon severity of illness, however, there has not been sufficient research or testing to validate the assumption that severity of illness is an appropriate measure for payment. As highlighted in our example above, severity of illness does not necessarily correlate to resource usage. We believe the impact of moving to a severity-based payment system must be fully explored, validated and understood prior to making such a drastic change. For this reason, as previously stated, we fully support a one-

year delay in implementation of proposed DRG changes and a minimum three-year transition period with a stop-loss provision. If implementation moves forward we support adoption of severity-based payments simultaneously with the change to cost-based weighting.

Hospital Quality Data

Ascension Health is committed to healthcare that is safe and fully supports the move to reporting additional quality indicators. CMS has proposed expanding the reporting of quality indicators from the current 10 indicators to 21 indicators in total. Hospitals must submit data on all 21 indicators to avoid a two percentage point reduction in reimbursement. In and of themselves we believe the 21 indicators are not a problem. However, CMS has proposed making the reporting requirement retroactive to discharges beginning January 1, 2006. In addition, the reporting requires submission of this data by August 15th and the final regulations will not be issued until approximately August 1st, giving the hospitals only 15 days to retroactively recreate the data CMS is requesting. More importantly, the vendor utilized by the majority of the Ascension Health hospitals requires submission of data to them by June 30 in order to meet the August 15 deadline for submission of core measures. It will be impossible for all of this to occur in order to meet the deadlines associated with this information collection. Many hospitals will also need time to renegotiate contracts with their clinical data warehouse vendors in order to add the additional indicators. We strongly recommend that CMS revise the proposal so that in order to receive a full market basket increase, hospitals be required to submit the relevant data beginning with discharges on or after July 1, 2006.

Occupational Mix Adjustment

As with many areas of the proposed changes to the IPPS payments, the Occupational Mix Adjustment stands to have significant financial impact on many hospitals. We understand that CMS is under intense pressure to fully implement these changes as a result of the Bellevue Hospital Center v. Leavitt decision. However, we are very concerned about the potential impact of these changes on our facilities and the resulting risk to patient access to care. We believe that because of the extremely short timeframe and the other reporting pressures, many hospitals have not had adequate time to collect and understand the appropriate data. Ascension Health strongly recommends that CMS allow hospitals to submit comments after the initial results of the survey are tabulated and released. This will allow CMS an opportunity to make corrections for those unintended changes resulting from rushed submissions and lack of understanding of the specific requirements of the data.

Graduate Medical Education Payments

Each year it seems CMS releases further "clarification" of the rules surrounding the counting of residents for purposes of calculating medical education payments. Many of these "clarifications" result in complete changes to previously understood, and sometimes previously "clarified", reporting requirements. Often times the "clarifications" are retroactively applied to

periods where reporting was compliant with previously issued "clarifications". These proposed regulations are no exception. CMS has issued a "clarification" excluding time spent by a medical resident in didactic activities from the calculation of both direct and indirect medical education reimbursement under the rationale that it is not related to patient care.

As with any field, and particularly in the training of medical residents, educational seminars, classroom lectures, and presentations of research results to other residents are part of the education being provided. They are an integral component of the patient care activities engaged in by residents. Ascension Health asks CMS to recognize the integral nature of these activities and eliminate the change related to the counting of didactic time for the purposes of calculating medical education payments.

Outlier Payments

CMS proposes an increase in the outlier threshold, from $23,600 to $25,530. Based on an AHA analysis, this threshold will not allow expenditure of the 5.1 percent of funds withheld to fund the outlier payments. The increase in outlier threshold represents a real cut in payments to hospitals without any means for recouping underpayments. In their comments, the AHA has proposed an alternative to CMS' methodology for determination of the outlier threshold. We request that CMS give serious consideration to adopting the methodology proposed by the AHA in their comments.

Conclusion

In conclusion, the proposed changes if implemented combined with the recent DRA changes will significantly impair many of our facilities' ability to operate at current or sustainable levels. We request that CMS please give serious consideration to our comments in order to allow us to continue serving the needs of the Medicare, Medicaid and indigent populations we serve.

We appreciate the opportunity to submit our comments on these very important proposed changes and appreciate your serious consideration of them. If you should have any questions about our comments, please do not hesitate to contact me at 314-733-8270.

Sincerely,

Terry L. Cole
Director of Reimbursement and Government Programs
Ascension Health

CC: Anthony Speranzo, Senior Vice President & Chief Financial Officer, Ascension Health
Susan Levy, Senior Vice President of Advocacy and External Relations, Ascension Health
Kathy Arbuckle, Vice President of Finance, Ascension

Submitter : **Dr. David Thom** **Date: 06/12/2006**

Organization : **University of California, San Francisco**

Category : **Individual**

Issue Areas/Comments

GME Payments

GME Payments

As a faculty member at the University of California, San Francisco Family Medicine Residency, 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.

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.

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, 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.

David Thom, MD, PhD
Associate Professor
Family and Community Medicine
UCSD

Submitter : **Dr. Martin Seltman** **Date: 06/12/2006**

Organization : **Forbes Family Practice**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

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. 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 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,

Martin Seltman, MD
Residency Director
Forbes Family Practice

2566 Haymaker Road
Monroeville, PA 15146

Submitter : **Dr. Mark Boyd** **Date: 06/12/2006**

Organization : **St. Elizabeth**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

Financial Stability is Important in Graduate Medical Education funding. Over 50% of Familiy Medicine Residency training programs operate in the red despite current direct and indirect GME funding. Elimating or decreasing this component of financial support will jeaopardize the training of medical students and residents in th US and lead to diminished quality of care for our patients. This would be the biggest risk for future medical mistakes and patient untoward effects in the last 40 years in this country. It would also place the health care of the unservered and underserved at the highest risk. Please maintain current GME funding. If change is necessary, then more support should be given to primary medical care (Family Meidicine, IM and Peds) who see the majority of patients in the US and are on the front lines to help decrease over all cost of medical care and improve the quality of health care delivered in the US.
Thank you for your time.

Mark A. Boyd, MD, FAAFP
413 South Loop drive
Edgewood, Ky 41017

(859) 578 - 9137

Submitter : **Mr. Stephen Frayne** **Date: 06/12/2006**

Organization : **Connecticut Hospital Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

 #1621

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. Lisa McGiffert** **Date: 06/12/2006**

Organization : **Consumers Union**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

We are commenting on several of these issues. See attachments (3)

CMS-1488-P-1622-Attach-1.RTF

CMS-1488-P-1622-Attach-2.RTF

CMS-1488-P-1622-Attach-3.RTF

#1622

June 12, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
P. O. Box 8011
Baltimore, Maryland 21244-1850

RE: **CMS-1488-P**, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and FY2007 Rates: DRGs Severe Sepsis; Hospital Quality Data; Value-Based Purchasing (Incentive Methodology, Public Reporting; 5. Considerations Related to Certain Conditions, Including Hospital-Acquired Infections).

Dear CMS:

Consumers Union[1], the independent, non-profit publisher of *Consumer Reports,* appreciates the opportunity to comment on the "Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates."

Consumers Union has a history of health care quality work in the states and at the national level. Most recently, we are conducting a campaign encouraging legislatures to enact state laws requiring public disclosure of hospital infection rates (www.StopHospitalInfections.org). To date, such laws have been considered in 35 states, and adopted in whole or part in 10. We expect additional states to require such reporting once proposals approved by the legislatures in four states are signed by their respective governors. There has been widespread support for publishing this very basic quality measure – the rate at which certain infections occur in hospitals – and we see no sign of the demand for information slowing down at the state level.

Field Code Changed

We have undertaken this campaign because these mostly preventable infections affect at least two million Americans every year. An estimated 90,000 of these patients die each year, costing our health care system at least $5 billion annually. For the most part, the public has been left in the dark about their local hospital's record on infections. Public disclosure of the rate of infection will allow consumers to make more informed health care decisions and will create strong incentives for hospitals to improve care and make infection prevention a high priority. The mere fact of disclosure being debated in state

[1] Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance. Consumers Union's income is solely derived from the sale of Consumer Reports and ConsumerReports.org, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, **Consumer Reports and ConsumerReports.org, with approximately 6.5 million combined paid circulation,** regularly carry articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions that affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

houses around the U.S. has stimulated action within hospitals as they realize their infection record could soon be available. There is much hospitals can do that they are not doing to address this serious and costly problem. Public disclosure is a key component to making that happen.

The data that is being developed in the various states with mandatory reporting argues for a similar, aggressive effort at the national level, to ensure that in the near future all residents of the United States will have the information necessary to reward quality hospitals and avoid dangerous hospitals.

Summary:
Our comments will concentrate in support of:

--expanding the number of quality measures to be reported as a condition of receiving the full Medicare update, with particular attention to hospital-acquired infection process and outcomes measures;

-- identifying the procedures for which Medicare and beneficiary/consumers do not pay the added cost of hospital acquired infections;

--planning for a quality purchasing system that rewards hospitals for quality and efficiency, including the use of scientific evidence-based measures in their Pharmacy and Therapeutics (P&T) Committees.

While many states have been acting to reduce the rate of hospital-acquired infections (HAI), it is particularly appropriate that Medicare do more in this area given the data in the March 2006 MedPAC Report to Congress which shows an increased rate of 'infection due to care' and 'postoperative sepsis' between 1998 and 2004.[2] Further, the Pennsylvania Health Care Cost Containment Council (PHC4), the first state agency to issue reports on hospital-acquired infections, found that 76 percent of the infections identified by hospitals as being acquired in their facilities were billed to Medicare and Medicaid, with Medicare paying for most (67%). [3]

SPECIFIC COMMENTS

DRGs: Severe Sepsis
We strongly oppose the proposal of the commentator that a single new DRG be given to "all cases in which severe sepsis is present on admission, as well as those cases in which it develops after admission (which are currently classified elsewhere)…." [emphasis added]

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[2] MedPAC Report to Congress, March, 2006, p. 54.
[3] "Reducing Hospital-acquired Infections: The Business Case ," PHC4 Research Brief , Issue No. 8, November 2005.

We do not understand how the new payment adjustment provision provided by DRA section 5001(c) can work if there is only one code for sepsis, including hospital acquired infections. Indeed, to help providers understand the extent of the infection problem and the many avenues to infection in an institution, it is important that there be more 'granularity,' not less in the classification of sepsis. Rather than one DRG code, we need more detailed descriptions so that we can measure the extent of the problem and the success of a hospital in solving the problem.

Hospital Quality Data

We strongly support the expansion of the quality items that must be reported in order to receive the full payment update (i.e., not face a reduction of 2 percentage points), and there are a number of examples of additional measures to encourage better prevention of hospital-acquired infections and other medical errors that have been tested or are currently being tested, such as the Institute for Healthcare Improvement's 100,000 Lives Campaign. We appreciate that the mandatory expanded quality items include the two Surgical Infection Prevention (SIP) procedures that may currently be voluntarily reported (prophylactic antibiotic received within one hour prior to surgical incision and prophylactic antibiotics discontinued within 24 hours after surgery end time). Clearly, voluntary reporting without payment incentives did not yield enough information to be useful to consumers.

We urge that the SIP-2 measure (appropriate antibiotic selection for surgical prophylaxis) be added to the list immediately. In the July 2005 announcement of the suspension of this measure, CMS and JCAHO indicated it was a temporary suspension, and that the data would continue to be collected without public disclosure. This measure is a critical element to the SIP bundle. What good is it if the antibiotics are started and stopped in a timely manner if the wrong antibiotic is being given? The evidence on the effectiveness of these measures in preventing surgical site infections includes all three elements, yet the public is unable to see them all. The agencies have had almost a year to resolve the suspension statement and should report the measure.

Following the above-mentioned suspension, almost 2200 people signed Consumers Union's petition calling for CMS to report this third measure. (See Attachment 1)

We further urge that CMS make it clear that process measures are an interim step prior to the reporting in the near future of the actual rates of common hospital acquired infections (HAI).

The law clearly provides for the updating and replacing of the existing reporting requirements and we strongly encourage moving to new measures once most hospitals integrate the measured practices most of the time. The law also requires reporting on measures of outcome as well as process and structure. We urge CMS to include outcome measures based on the best available science and consensus, rather than permanently focus on the current process measures. Ultimately, consumers want to see the results of

hospital practices, i.e., whether the processes measured actually yield higher quality care as indicated by results such as better mortality rates and fewer infections.

Our multi-state effort (www.StopHospitalInfections.org) has focused on public reporting of the HAI rate, as determined by the best available science. The CMS proposal, on the other hand, is for the voluntary reporting of two process questions—and may or may not tell the public much about the actual rate of infection in a hospital. Therefore, we again urge CMS to move to outcomes reporting as soon as possible. While process measures can provide information on what hospitals should be doing, actual results are far more useful to consumers.

Field Code Changed

As the regulation discussion notes, the reporting/update provision does "not apply to hospitals and hospital units excluded from the IPPS...." We hope the Administration will propose and the Congress approve an expansion of this reporting/payment update program, particularly the infection provisions, to all providers who receive Medicare and Medicaid reimbursement. Different measures may be appropriate for small or rural hospitals, but consumers still need some quality of care information about these hospitals. An expression of intention in this area will send a strong message to all providers that there is no excuse for the current level of institution acquired infections, deaths, and costs.

In the HCAHPS patient survey proposed for October, 2006, we urge that the question be added, "Did you get an infection while you were in the hospital or after any surgery or other procedure?" Most patients will know about the existence of an infection and this would be a more precise way to identify significant problems than the more general and subjective HCAHPS question about the "cleanliness and quietness of the hospital."

We strongly support the provision that "hospitals attest to the completeness and accuracy of the data submitted to the QIO Clinical Warehouse in order to improve aspects of the validation checks." The reporting requirement is tied to reimbursement and any falsification of the data should be considered a false claim subject to the full range of anti-fraud rules and laws. While we do not have the expertise to comment on the specifics of the process, validation is a critical element to ensuring public confidence in the reports and we encourage continued scrutiny and upgrading of the validation techniques as the program continues.

We support electronic medical records data submission. As the impact statement makes clear, CMS is spending about $1.5 million a year for the copying and mailing of these case files. Not only should providers be encouraged to send such data electronically, but we urge CMS to state that by a date certain such transmittals must be by electronic means, consistent with the interoperability standards being developed through the ONCHIT.

Value-Based Purchasing We strongly support the movement to value based purchasing and urge CMS to include hospital pharmaceutical use in the calculation of quality.

Specifically, we hope that the issue of whether a hospital P&T committee uses an evidence-based system to establish its first tier formulary becomes one of the criteria used to determine quality hospital services.

In recent years, Consumers Union has developed a public education service called Consumer Reports Best Buy Drugs. This program uses the drug safety and effectiveness work of the Drug Effectiveness Review Project (DERP), which is based at Oregon Health and Science University. Three Agency for Healthcare Research and Quality-sponsored Evidence-Based Practice Centers (at OHSU, UNC, and California Rand) are involved in preparing systematic reviews of the comparative effectiveness of drugs for DERP. These systematic reviews are prepared by the EPC's on behalf of DERP, and review the comparative effectiveness and safety of drugs in various therapeutic categories. They are used by member states to help guide selection of effective, safe, and affordable drugs for their Medicaid programs. (It is of note that the state Medicaid programs that consulted or used the DERP process generally avoided use of Vioxx, thus saving lives and millions of dollars in health care costs.)

Consumer Reports Best Buy Drugs translates the systematic reviews into user-friendly language, and adds information on relative price, and presents these reports to the public in an easy-to-read format (at www.CRBestBuyDrugs.org). By combining the best pharmaceutical science with pricing data, Consumer Reports Best Buy Drugs information can save consumers hundreds and thousands of dollars while encouraging the use of the safest, most effective medicines.

DERP, combined with research conducted to date under Section 1013 of the Medicare Modernization Act, have demonstrated the power of systematic review to help improve the quality of health care and get better value for health care dollars.

A similar system should be used by hospitals and their P&T Committee to ensure that the safest, most effective, and most reasonably priced drugs are promoted within hospitals. Of course, there would be allowance for exceptions and going off-formulary. But in general, a hospital's drug use should be based as much as possible on science, and not on the persuasiveness of pharmaceutical company sales representatives.

We urge therefore that CMS develop a specific measurement to encourage hospitals to move to evidence based formularies as part of the FY 2009 system of hospital value-based purchasing.

We support efforts to address timeliness of data. In order for this information to be truly useful to consumers, it has to be published closer to real time in order to reflect what is happening in our hospitals now, not what happened two years ago. Clearly, electronic information is the key and it seems to make sense to attempt to tie the billing submissions with equally timely quality data whenever possible. Almost universally, hospitals dismiss billing forms as a possible method of collecting data by claiming the information on them is inaccurate – we find this to be unacceptable. It is their professional

responsibility to accurately complete the forms. While many have criticized the Pennsylvania efforts in using this format, we believe the state's agency (Pennsylvania Healthcare Cost Containment Council) is blazing a trail by testing the use of billing forms to collect clinical data AND thus having the clinical data directly connected to other characteristics of the patient that can assist in more comprehensive and timely quality of care assessments. This could also allow for tracking patient readmissions due to infection or other complications. Whatever the methods, we must move more quickly to electronic submission of data in order to improve the timeliness of quality assessments.

To comment more specifically, we support requiring monthly submission of data and reducing the time the hospitals have to submit the data (4.5 months). We recommend a rolling publication of data with at least quarterly updates. For example the measures would reflect a year's worth of data to ensure that there is enough data to give a clear picture of the hospital's performance, with the reports representing the previous 12 months of data, rather than a particular calendar year. Do not sacrifice validation process in the name of more timely data. Validation is absolutely essential for the public to have any confidence in the information.

Incentive Methodology – developing composite scores

While it can be useful to combine a number of measures to create a single rating (such as in the AHRQ, patient safety indicators), this score should not be the only information available. Our fear with attempting to help consumers understand the complex performance indicators by combining measures into a single score will compromise the meaning of the data and leave many who want more extensive information in the dark. It is best to present quality measures in a manner that includes various ways to view the information: a composite score, the individual scores that go into that composite score, the statistics or data backing up the scoring, graphics such as bar charts to allow for visual comparisons, links to research that provides the evidence that these are measures that determine quality, and links to benchmarks and goals (for example, simply benchmarking hospital infection scores can lead the public to believe that the average, the status quo, is acceptable when in the case of hospital-acquired infections, it certainly is not.)

Public Reporting

To get more consumers engaged in using quality of care information will require continuous promotion to remind the public that reports are available. Ideally, analyses of the data should assume an intelligent audience that is seeking reliable information. Often discussions about quality data are either extremely elementary or written for medical experts – surely there is something in the middle. Be more descriptive about what the data means – put it in context. We encourage development of tools that enable consumers to view the comparisons in various ways – let them choose how to arrange the comparisons, for example, by measures, by region, by rank and by individual hospital (e.g., enable consumers to pull up all measures for a single hospital at one time). Finally, the information must be updated more frequently than once a year or it will not be relevant to the patient or fair to the hospital.

5. Considerations Related to Certain Conditions, Including Hospital-Acquired Infections.

Generally, we are very supportive of these strong hospital-acquired infection proposals. They should be strong, given the extent of this problem, the devastating results in human costs, the financial drain on our health care system, and the utter failure of hospitals to address the problem over the past three decades. We anticipate that hospitals will push back on these proposals and we urge CMS to resist weakening or delaying them. In addition, there must be strong consumer protections attached to this proposal to prohibit providers billing patients when Medicare does not cover a particular treatment resulting from a hospital-acquired infection. Further, protections should prohibit any activities by the hospital that indicate they are avoiding patients they perceive at risk for infection.

We strongly support Section 5001 (c) which

> ...requires the Secretary to identify, by October 1, 2007, at least two conditions that are (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines.

In separate communications, we are urging the Administration and Congress to apply this provision to more than just two in the initial phase. The death, injury, and cost associated with HAI is simply too high to limit this provision to just two conditions. We urge CMS to apply this non-payment provision to all HAIs. If you decide not to apply it to all HAIs, then we recommend starting with the top ten conditions based on the highest cost and highest volume. Then we urge adding to this list each year.

Thank you for your consideration of these comments.

Sincerely,

Lisa McGiffert
Project Director
www.StopHospitalInfections.org
Consumers Union
506 W. 14th Street
Austin, TX 78701

Field Code Changed

William Vaughan
Senior Policy Analyst

Consumer Petition to the Centers for Medicare and Medicaid Services: Relating to the Suspension of Public Release of SIP-2 Measure (appropriate antibiotic selection for surgical prophylaxis:

I was disturbed to learn that CMS will not release all of the data collected on surgical site infection prevention to the public According to a recent study, surgeons give a preventive antibiotic before surgery in only about half of cases. Hospitals can address this with pre- and post-operative policies and procedures. I want to know which hospitals in my community excel in preventing surgical site infections using the three measures that experts have said are effective.

It sets a bad precedent to stop the release of this information at a time when the public is demanding more information about hospital infections in this country, not less.

I urge you to release information about all three infection prevention measures you have collected to the public.

1.	Renee	Cunnings	CMR 475 Box 1285	APO AE	AE	09036-1012
2.	Deirdre	Holzweiler	PO Box 22012	Juneau	AK	99802-2012
3.	prem	parinito	6170 old rich hwy	salcha	AK	99714-9725
4.	Marilyn	wright	1411 Oxford Dr.	Anchorage	AK	99503-6943
5.	barbara	williams	po box 4146	kodiak	AK	99615-4146
6.	Christian	Blankenship	PO Box 1783	Palmer	AK	99645-1783
7.	David L.	Smith, MD	500 Spanish Fort Blvd. #96	Spanish Fort	AL	36527-5006
8.	Carla	Hull	3405-E Arnold Ave.	Opelika	AL	36801-5346
9.	Ed	Jackson	673 Larkin Lane	Montgomery	AL	36109-4613
10.	J.	Whitson	3652 Clairmont Ave,	Birmingham	AL	35222-3517
11.	Rex	Sanders	2628 Boykin Place	Montgomery	AL	36117-4660
12.	Dennis	Tribble	1808 Chapman Avenue	Huntsville	AL	35811-2204
13.	Walter	Templeton	101 Royal Drive	Madison	AL	35758-1780
14.	Glenn	Hunter	809 Linda St	Albertville	AL	35950-2165
15.	Albert	Hardaker	216 Westmeade Court	florence	AL	35630-6704
16.	Deborah	Eldridge	810 Inverness Lane	Birmingham	AL	35242-3807
17.	AMANDA	TURNER	POST OFFICE BOX 152	Graysville	AL	35073-0152
18.	David	Dreitzler	658 Tenth Street Ne	Arab	AL	35016-1660
19.	Sylvia	Ross	950 Sitton Road	Hayden	AL	35079-8531
20.	Eugene A.	Mangieri, M.D.	2510 Hospital Drive	Northport	AL	35476-0839
21.	Dan	Fulton	1440 Alford Avenue	Hoover	AL	35226-3130
22.	Martha	Shirley	10081 US Highway 31	Hope Hull	AL	36043-4831
23.	Michael	Cline	7242 Napa Valley Lane Apt.#101	Springdale	AR	72762-0793
24.	Frances	Bridges	808 Center Street or box # 309	Bald Knob	AR	72010-3114
25.	Brenda	Breckenridge	511 A Lisa Ln.	Bono	AR	72416-9686
26.	Larry	Onstott	P.O.box 66	Edgemont	AR	72044-0066

27.	Judith	Urich	PO Box 24667	Little Rock	AR	72221-4667
28.	kenneth	boyle	1701 w olive apt 48	rogers	AR	72756-3487
29.	Robert	Sharkey	2764 Old Military Rd.	Mountain Home	AR	72653-6340
30.	jerry	berry	6014 geoege dr	north little rock	AR	72118-1909
31.	Deane	Willey	32 Meadowview Drive	Texarkana	AR	71854-2445
32.	Brock	Johnson	421 NW 3RD ST	Corning	AR	72422-1819
33.	Maria L.	Gomez	144 Northpointe Drive	Mountain Home	AR	72653-8124
34.	Robert	Wilson	3101 Overcup Drive	Sherwood	AR	72120-3706
35.	Eric Lee Elliott	Elliott	68 Carol Lane	Batesville	AR	72501-8023
36.	Dorothy	Stephens	333 Kimpel Hall	Fayetteville	AR	72701
37.	James	Oakley	1304 Magnolia Ave	Mena	AR	71953-2953
38.	John A.	Hickman	23 Hambleton Drive	Bella Vista	AR	72714-4310
39.	Barbara	Fitzpatrick	2500 W. Valley Dr.	Fayetteville	AR	72703-1146
40.	H F	Youngs	8900 N Cahill Way	tucson	AZ	85742-8868
41.	Diane	Jordan	14209 W. Meadowood Dr.	Sun City West	AZ	85375-5531
42.	Paul and Carole	Dyer	1401 South Avenue 66 East	Dateland	AZ	85333
43.	Bob	Fischella	6219 E. Via De La Yerba	Tucson	AZ	85750-1150
44.	Robert	Lloyd	8729 E. Tether Trl.	Scottsdale	AZ	85255-1492
45.	Marilyn	Waltasti	4893 W. New Shadow Way	Marana	AZ	85653-4293
46.	Bradford	West	416 S Chase Street	Sierra Vista	AZ	85635-8218
47.	elyse	benson	po box 7114	mesa	AZ	85216-7114
48.	Elizabeth	Mondschein	P.O.Box 2056	Lake Havasu City	AZ	86405-2056
49.	Scott	Lefler	510 E Huntington Dr #2	Tempe	AZ	85282-3787
50.	Harlan	Scott	805 W Glenn Dr.	Phoenix	AZ	85021-8638
51.	George	Shrewsbury	4786 Arizona Road	Prescott	AZ	86303-8117
52.	Alexandria	Lupu	P O Box 1704	Lake Havasu City	AZ	86405-1704
53.	Patty	Diana	4937 W. Myrtle	Glendale	AZ	85301-2137
54.	Marvin	George	1233 E Katherine Drive	Sierra Vista	AZ	85635-4975
55.	Jana	Shiloh	100 El Camino rd	sedona	AZ	86336-5116
56.	Shauna	Holt	2051 E. Stanford Dr.	Tempe	AZ	85283-2431
57.	Cassandra	Johnson	6713 e kiami street	tucson	AZ	85715-3325
58.	Phillip	Schaffer	770 Gordon Dr.	Kingman	AZ	86401-2917
59.	Howard	Curtiss	2380 S. Flying Q Lane	Tucson	AZ	85713-6728
60.	Harlan	Reed	483-A E. Ft. Lowell Road	Tucson	AZ	85705-3926
61.	BILLY	WILLEY	1262 W. PALMER AVE.	FLAGSTAFF	AZ	86001-8856
62.	Dennis	Jensen	13087 N 100th Ave.	Sun City	AZ	85351-2854
63.	Richard	Pasichnyk	1007 W Main St	Mesa	AZ	85201-7121
64.	Laura	Hayes	2942 S. Marvin Ave.	Tucson	AZ	85730-1755
65.	William	Kendig	4866 Comanche Trail	Prescott	AZ	86301-5756
66.	Colleen	Davey	18240 N 21st ST #07	Phoenix	AZ	85022-1443

67.	Edward	Crogan	20669 N. 105th Drive	Peoria	AZ	85382-6100
68.	Brian	Stevens	1696 E. Laredo St	Chandler	AZ	85225-5346
69.	Sue	Holmes	9157 W. Paradise Ln.	Peoria	AZ	85382-3567
70.	Scott	McDaniel	15836 E. Primrose Dr.	Fountain Hills	AZ	85268-3602
71.	Lonnie	Hailey	1685 E. Ganymede Dr.	Tucson	AZ	85737-3429
72.	lynette	allen	1764 great oak dr.	tucson	AZ	85746-3212
73.	Wayne R	Porter	222 E. Indianola Ave.	Phoenix	AZ	85012-4027
74.	Bob	Oakes	PO Box 1429	Arizona City	AZ	85223-1429
75.	lisa	reed	p o box 295	green valley	AZ	85622-0295
76.	Ben	Stoken	1991 Meadowbrook Rd.	Prescott	AZ	86303-5635
77.	Laura	Steckman	5484 N. Bramble Brook Lane	Tucson	AZ	85704-1737
78.	Jerry	Calhoun	po box 345	bridgehampton	AZ	85929-0345
79.	Bruce C.	Flanagan	678 N. Hayden Dr.	Tucson	AZ	85710-2476
80.	Mary Lou	Reck	4355 N. Calle Santa Cruz	Prescott Valley	AZ	86314-5414
81.	Eva	Vangi-Stern	54 Avenida Pastor	Rio Rico	AZ	85648-8001
82.	Robert D.	Jandacek	6111E Evergreen St	Mesa	AZ	85205-5934
83.	Darrell	Ziegler	4334 E. Desert Marigold Dr.	Cave Creek	AZ	85331-7822
84.	Clyde	Robinson	5151 N. Kain #18	Tucson	AZ	85705-1246
85.	Diana	Miller	8539 E. McDonald Drive	Scottsdale	AZ	85250-6328
86.	Jeff	Meyer	338 E Vaughn Avenue	Gilbert	AZ	85234-9300
87.	Gerald	Wheatley	7301 W. Sweetwater Ave	Peoria	AZ	85381-5085
88.	Linda	Taylor	2521 W. Vereda De Las Flores			Tucson
89.	Janet	Strecher	617 Filaree Dr	Prescott	AZ	86301-5776
90.	Monique	King MD	5424 N. Via Sempreverde	Tucson	AZ	85750-5974
91.	pamela	mitchell	11242 E. Hash Knife Circle	Tucson	AZ	85749-9553
92.	Christine	Kasten	5386 North Via Papavero	Tucson	AZ	85750-6055
93.	Dee	Achin	10911 E Oak St	SCOTTSDALE	AZ	85256-4905
94.	Kenneth	Molinkiewicz	14007 N 57th Street	Scottsdale	AZ	85254-3015
95.	Shirley	Kosek	9231 N Kanawha St	Tucson	AZ	85742-9682
96.	Duane	Tendick	6206 W Zoe Ella Way	Glendale	AZ	85306-2933
97.	Sherry	Howard	1521 Gettysvue Way	Prescott	AZ	86301-5525
98.	Celia M	Hodges	8032 W Montebello Ave	Glendale	AZ	85303-4502
99.	Brian B	Coley	3386 E. Mesquite Trail	Camp Verde	AZ	86322-6562
100.	Mary	Wilson	3551 N. Palmer Drive	Tucson	AZ	85716-1111
101.	Alexandra	Fette	2310 W. Del Campo	Mesa	AZ	85202-2600
102.	Mary	Etheridge	5745 E Decatur St	Mesa	AZ	85205-6615
103.	Jennifer	Young	6622 West Maya Way	Phoenix	AZ	85085-6511
104.	Tania	Malven	2228 E. Kleindale Rd.	Tucson	AZ	85719-2441
105.	SanDee	Fry	9867 N. Stone Creek	Tucson	AZ	85742-9585

			Place			
106.	jason	gerepka	2123 East Kirkland Lane #2	Tempe	AZ	85281-4464
107.	Barbara	Regulinski	3553 W Royal Palm Rd	Phoenix	AZ	85051-5826
108.	Shell	Lavender	370 Snowflake Heights Blvd	Snowflake	AZ	85937-5701
109.	James	Burdick	5857 E. Nance St.	Mesa	AZ	85215-1483
110.	Ila	Swan	552 Redwood Drive	Vacaville	CA	95687-6224
111.	Glenn	Head	8787 Crimson Clover Lane	Longmont	CO	80503-8777
112.	Carolyn	Freedman	1607 E. 25th Ave	Denver	CO	80205-5350
113.	Debi	Desgalier	10532 Julian Street	Westminster	CO	80031-2242
114.	Karen	Schiller	11247 Cimarron St.	Firestone	CO	80504-6408
115.	Jamesb	Button	3195 Redstone Lane	Boulder	CO	80305-7172
116.	Mary S.	Fussner	3024 Stout St. #3	Denver	CO	80205-3075
117.	Rudolph	Greis	1429 E Columbia St.	Colorado Springs	CO	80909-3613
118.	Paulette	Whitcomb	9085 W. 95th Avenue	Westminster	CO	80021-4313
119.	Jan	Kochmeister	12587 West Dakota Avenue #1-111	Lakewood	CO	80228-3274
120.	ray	mckinney	444 e. briarwood dr.	centennial	CO	80122-1006
121.	Christopher	Aamot	4663 16th St.	Boulder	CO	80304-2262
122.	Lawrence	Harrison	1987 S. Deframe Way	Lakewood	CO	80228-4518
123.	John	Pinezich	4617 Highland Drive	Longmont	CO	80503-9399
124.	Cathy	Cole	1640 Kirkwood Dr Q 39	Fort Collins	CO	80525
125.	Sabrina	Montoya	6301 w. hampden ave #8-105	Lakewood	CO	80227-5474
126.	Gerald	Riley	2000 W 92nd Ave Lot 416	Federal Heights	CO	80260-5357
127.	Philip	Zahn	22 Desert Willow Ln	Littleton	CO	80127-3549
128.	Arnold	Schultz	1137 S. Oakland St.	Aurora	CO	80012-4259
129.	Ken	Tharp	601 Birky Place	Fort Collins, CO 80526	CO	80526-1905
130.	Michael	Shinbein	3025 Vance St	Wheat Ridge	CO	80033-8071
131.	Allie	Carpenter	3384 Williamsburg Street	Loveland	CO	80538-5548
132.	Mr. Derek B.	Clark	P.B. Box 824	Greeley	CO	80632
133.	Dennis	Caldwell	1197 N Wilson #B205	Loveland	CO	80537-3115
134.	Star	Seastone	1121 #2 Laporte	Fort Collins	CO	80521-2421
135.	John	Brogan	8090 Bannock Dr	Larkspur	CO	80118-8505
136.	Leland	Long	736 East 10th Avenue #2	Denver	CO	80203-5237
137.	Steven	Frangos	1680 S. Dahlia St.	Denver	CO	80222-3818
138.	Brant Matthew	Tate	7485 Quartz Street	Arvada	CO	80007-7943
139.	jon	jenkins	0177 County Road 48	Howard	CO	81233-9660
140.	Carl	Edquist	14 Pinyon Pine Rd	Littleton	CO	80127-3505
141.	Ellie	Collinson	1030 N. Custer Ave.	Colorado Springs	CO	80903-2647
142.	Bobbie	Moore	7251 S Quintero St	Foxfield	CO	80016-1659
143.	Jean	Dennis	874 Aster Way	Golden	CO	80401-9201

144.	mark	rush	9020 e. nassau ave.	denver	CO	80237-1917
145.	Eric	Richards	1409 fleetwood ct.	Fort Collins	CO	80521-4057
146.	helen	barker	154 hillside drive	silverthorne	CO	80498-9500
147.	J. A.	Dionigi	PO Box 389	Golden	CO	80402-0389
148.	Kathy	Tolman	4735 Reed St.	Wheat Ridge	CO	80033-3546
149.	Rebecca	English	11 2nd St	Colorado Springs	CO	80906-3152
150.	Frances L.	Stearns	5600 Dover St.	Arvada	CO	80002-2341
151.	Judi	Aden	1290 Walnut Ave	Grand Junction	CO	81501-4235
152.	Verlene	White	2047 36th Avenue	Greeley	CO	80634-3953
153.	Trudi	Nelson	2224 Balsam Street	Lakewood	CO	80214-5533
154.	Nina	Keefer	1029 Terry Street	Longmont	CO	80501-4316
155.	richard	hajek	10223 roterwood cir	highlands ranch	CO	80130-8891
156.	Monica	Koziol	13192 West Cross Place	Littleton	CO	80127-2133
157.	Susan B.	Evans	2765 Lafayette Drive	Boulder	CO	80305-7104
158.	Kevin	Prager	PO Box 1133	Washington	CT	06793-0133
159.	Joshua	Angelus	67 Hillside Avenue	Waterbury	CT	06710-2220
160.	Dorothy	Dankanyin	85 Sherman Rd	Enfield	CT	06082-4128
161.	Kevin	Brodie	147 Dunn Rd	Coventry	CT	06238-1113
162.	Edward	Dypa	666 Congdon St. W.	Middletown	CT	06457-1993
163.	Joanna	Mrozek	270 Oak Street	Manchester	CT	06040-5563
164.	Leah	Rubenstein	193 Dogwood Lane	Stamford	CT	06903-4532
165.	James	Tatum, Jr.	65 Noroton Avenue	Darien	CT	06820-5215
166.	George	Hakkila	466 Norwich Rd.	Plainfield	CT	06374-1625
167.	mel	hathorn	164 woodland dr	Cromwell	CT	06416-1161
168.	Nathan	Rosenbaum	55 Pondview Ave.	Trumbull	CT	06611-2905
169.	Marguerite Joan	Galimitakis	4 Fieldbrook Ave	Clinton	CT	06413-1427
170.	skelley27@snet.	carbone	225 kate lane	tolland	CT	06084-3529
171.	Paula	Moriarty	18 N Moodus Rd	Moodus	CT	06469-0433
172.	marilina	imperati	48 frost dr	North Haven	CT	06473-3733
173.	Emanuel	Pallant	126 Morningside CT	Shelton	CT	06484-4344
174.	David	barboza II	227 Olivia St.	Derby	CT	06418-1529
175.	Stephen	Newberg	146 Granville Road	North Granby	CT	06060-1301
176.	Greg	Teschendorf	101 Hunting Lodge Rd.	Storrs Mansfield	CT	06268-1538
177.	Wilfred	Jordan	131 Lakewood Cir N	Manchester	CT	06040-7090
178.	Mary	Cheney	37 Scarborough Rd.	Manchester	CT	06040-5430
179.	Henry	Colbert	38 Littlebrook Crossing	Farmington	CT	06032-3323
180.	edward	ripp	3 tomahawk la.	westport	CT	06880-5636
181.	Margaret	Sawyer	100 York Street	New Haven	CT	06511-5620
182.	Jo-Anne	O'Boy	4 Olmsteaad Place	Norwalk	CT	06855-1318
183.	Allan	Crystal	788B Heritage Village	Southybury	CT	06488-5323
184.	Martin	Ritter	58 Star Farms Drive	Manchester	CT	06040-6373
185.	ROBERT	GENNARINI	19 SCHOOL ST.	MONROE	CT	06468-2131
186.	Denise	Nelson	178 Sixth Avenue	Stratford	CT	06615-7730
187.	Emily	Davis	1601 18th NW	Washington	DC	20009-2529

188.	Scott	Haskett	223 O ST SW APT 31	WASHINGTON	DC	20024-2932
189.	Karissa	Silver	5415 Connecticut Ave., NW, #320			Washington
190.	Edward	Miller	10 Coventry La.	Lewes	DE	19958-9027
191.	David	Haslett	117 Delrem Dr.	Newark	DE	19711-7400
192.	Lester	Morganstein	2514 Justin Lane	Wilmington	DE	19810-2224
193.	Alfred	Mac Leod	398 Ronald Lane	Smyrna	DE	19977-1042
194.	Maura	O'Connor	124 Jeandell Drive	Newark	DE	19713-2959
195.	Charles	Yembrick	19 Drummond Drive	Wilmington	DE	19808-1312
196.	Philip V.	Jennings	174 Fairhill Dr.	Wilmington	DE	19808-4309
197.	Ann	Dunkelberger	33 Hill Road	Wilmington	DE	19806-2009
198.	Lisa	Lasher	P.O. Box 1717	Millsboro	DE	19966-5717
199.	Richard	Keene	328 Schooner AVe.	Edgewater	FL	32141-5971
200.	Henry	Stevens	3333 NE 34 Steet	Ft. Lauderdale	FL	33308-6911
201.	Irving	Lillien	10181 S. W. 198 STreet	Miami	FL	33157-8622
202.	Charles	Solly	504 Willow Walk Place	Saint Augustine	FL	32086-5416
203.	Marlynn Marcks	Joe McKinney	667 SW Treasure CV	Fort Pierce	FL	34986-3438
204.	Stanley	Pauer	20401 NE 30th Av. #104	Aventura	FL	33180-1522
205.	Melissa	Hamel	750 Ellwood Ave	Orlando	FL	32804-7320
206.	Robert	Jordan	11951 SE 57th Street	Morriston	FL	32668-3523
207.	stanley	pierce	7412 mandarin drive	boca raton	FL	33433-7418
208.	Chris	Craven	1200 West Ave #703	Miami Beach	FL	33139-4316
209.	Angela	Congdon	4271 Arrow Court	Sarasota	FL	34232-2514
210.	Bob & J.B.	Bennett	18 SE 917 St	Old Town	FL	32680-4351
211.	Rene	Sexton	11711 Springflower Pl	Boca Raton	FL	33428-1175
212.	Glenn	Crane	4561 Fairway Drive	North Port	FL	34287-6109
213.	William	Purcell	1416 Thrasher Dr	Punta Gorda	FL	33950-7697
214.	Michael R.	Duffey	1671 SW 16 St.	Miami	FL	33145-1515
215.	Janis	Watkins	14050 Miramar Avenue	Madeira Beach	FL	33708-2215
216.	William	Collier	11 Golden Gate Circle	Port Orange	FL	32129-4113
217.	Richard	Keck	703 Hilltop Street	Fruitland Park	FL	34731-2049
218.	Patrick	Garner	1602 SW 16 street	Gainesville	FL	32608-1159
219.	sherrie	gill	4010 n ola ave	Tampa	FL	33603-3510
220.	G.	Swordsma	P.O. Box 14826	Jacksonville	FL	32238-1826
221.	Steve	Okes	p o box 2470	windermere	FL	34786-2470
222.	Deborah	Burns O'Hara	5983 Cedar Lake Dr	Cocoa	FL	32927-4975
223.	Barbara	Henderson	907 W. Branch Street	Lantana	FL	33462-4311
224.	Irene	Radke	4648 sw 38 Ter	Dania Beach	FL	33312-5412
225.	Paula	Dodson	246 River Hills Dr.	Jacksonville	FL	32216-8925
226.	Daniel	Oaks	2970 Robins Nest Ct	Saint Cloud	FL	34772-8182
227.	Marion	Blumenstock	23411 Water Circle	Boca Raton	FL	33486-8547
228.	Kevin	Whartnaby	1044 NE 8th Ave	Fort Lauderdale	FL	33304-4946
229.	Cliff	Leonard	1318 Windsor Place	Jacksonville	FL	32205-7961
230.	Erich	Komdat,Jr.	2080 Embarcadero Way	N. Ft. Myers	FL	33917-6780
231.	Robert	Norton	1462 E St. James Lp.	Inverness	FL	34453-3639

232.	Joseph	Meury	691 Hudson Bay DR	Palm Beach Gardens	FL	33410-2193
233.	Eugene	Stern	8989 Shoal Creek Lane	Boynton Beach	FL	33437-2508
234.	Tom	Houchin	2622 Englewood Drive	Melbourne	FL	32940-7183
235.	Christopher	Lizarraga	791 Crandon Blvd Apt 1106	Key Biscayne	FL	33149-2203
236.	dk	major	po bx 880888	tampa	FL	33600
237.	Laurette	Roy	402 Fernandina St	Ft Pierce	FL	34949-3578
238.	anna	collins	Us Hwy 301	Waldo	FL	32694
239.	Nellie	Lee	6666 SW 115 Court , Apt. 203			Miami
240.	Kay	Kershman	2039 Gulf of Mexico Dr. #212	Longboat Key	FL	34228-3237
241.	Maura	Hart	6150 NW 62 ST APT 207	TAMARAC	FL	33319-6247
242.	Norman	Epstein	1222D NW Sun Terrace Circle			Saint Lucie West
243.	Robert	Jamerson	2655 Le Jeune Road	Coral Gables	FL	33134-5832
244.	Claude	Tatarowicz	14409 Estrella Dr	Orlando	FL	32837-4756
245.	Maria	Fisher	901 Stone Creek Court	Longwood	FL	32779-2338
246.	John	Stockton	2230 Royal Ln	Naples	FL	34112-5323
247.	Arthur	Frey	8873 SE 136th Lane	Summerfield	FL	34491-9630
248.	Elizabeth	Horvath	98 Hickorywood Dr.	Crawfordville	FL	32327-2562
249.	Patsy	Shafchuk	5316 Macoso Ct.	New Port Richey	FL	34655-4347
250.	Brenda	Knapp	12552 116th St N	Largo	FL	33778-2501
251.	Virgil	Koning	7236 Crystal Lake Drive	West Palm Beach	FL	33411-5713
252.	Melissa	Judge	1711 W. Aileen St.	Tampa	FL	33607-2019
253.	Suzanne	Kiffmann	10265 Ulmerton Rd Lot 170	Largo	FL	33771-4109
254.	Martin	Werman	9202 Vineland Ct Apt F	Boca Raton	FL	33496-4221
255.	Mary	Secord	10771 Crooked River Road, #103			Bonita Springs
256.	David	Marcella	90 Leyte Drive	Pensacola	FL	32507-2084
257.	Robert	Wilson	1321 Highland Greens Drive	Venice	FL	34285-5667
258.	Jim	Loveland	1410 Freemont St.	St. Petersburg	FL	33707-3327
259.	James	Arrington	743 N. Shine Ave.	Orlando	FL	32803-4107
260.	Lillian	Cripps	2665 Middle River Drive, #2	Ft. Lauderdale	FL	33306-1433
261.	Tracy	Ward	3441 S. Pine Ave. Lot 78	Ocala	FL	34471-6663
262.	Kimberly	Acquaro	480 Ventura Pl.	Indian River Shores	FL	32963-4262
263.	Howard	Bergman	2340 Columbia	Weston	FL	33326-2322
264.	Gene	Tamborini	1403 Silver Lake Dr.	Melbourne	FL	32940-1953
265.	Wayne	Harris	7642 49th Ave. E.	Bradenton	FL	34203-7941
266.	Warren	Souders	3357 Grove Rd	Palm Beach Gardens	FL	33410-2445

267.	Ronee	Jacobson	12856 SW 67th Terrace	Miami	FL	33183-1336
268.	Dean	Nagle	4705 Ocean Beach Blvd.	Cocoa Beach	FL	32931-3609
269.	Nadja	Whalen	819 Crenshaw Lk Rd	Lutz	FL	33548-6108
270.	Sam	Caruso	9747 Oakwood Hills Ct.	New Port Richey	FL	34655-1167
271.	Carol	Hamilton	4586 W Ranger St	Beverly Hills	FL	34465-4680
272.	Philip	Tritschler	4317 Hidden Lakes Dr.	Niceville	FL	32578-4196
273.	Amilcar	Blake	303 Pine Rd	Nokomis	FL	34275-3946
274.	Derek	Monroe	383 Hidden Pines Circle	Casselberry	FL	32707-3366
275.	Kenneth	Koenig	500 Ocean Drive #W7A	Juno Beach	FL	33408-1945
276.	Sumner	Peirce	1501 NW 42nd Street	Fort Lauderdale	FL	33309-4527
277.	William	Popowicz	1490 San Roy Drive	Dunedin	FL	34698-4352
278.	Richard	Eckley	711 22nd St. S.W.	Largo	FL	33770-2951
279.	Linda	Kalter	381 E. Sandpiper St.	Apopka	FL	32712-3614
280.	Arthur	Binz	3707 Borden Lane	Green Cove Springs	FL	32043-8071
281.	John	Foley	1618 East La Rua	PENSACOLA	FL	32501-4346
282.	Shirley J	Ward	5685 S. Highway A1A,	Melbourne Beach	FL	32951-3309
283.	Mack	Jones	329 Eldredge Road	Fort Walton Beach	FL	32547-1308
284.	Nancy	Busch	19875 sw 127 Ave	Miami	FL	33177-4805
285.	Effie	O'Day	2910 SE 13th Street	Ocala	FL	34471-2752
286.	j.a.	hoffman	6399 heronwalk dr.	gulf breeze	FL	32563-7013
287.	Dorothy	McCauley	12 Clarendon Ct S	Palm Coast	FL	32137-8352
288.	Denise	Jeffreys	332 SW 22nd St	Fort Lauderdale	FL	33315-2511
289.	Michael	Krause	5 Newport Drive	Crestview	FL	32539-5203
290.	Melvin	Halpern	3600 Mystic Pointe Dr.	Aventura	FL	33180-2565
291.	June Jaye	Logie	6740 Pansy Drive	Miramar	FL	33023-4863
292.	Kevin	Duffy	206 Waterbury Lane	Indian Harbour Beach	FL	32937-5308
293.	Elvira	Morgan	PO Box 1716	Clearwater	FL	33757-1716
294.	Cathy	Bullock	18 Aston Cir	Ormond Beach	FL	32174-9006
295.	paul	mars	3863 burlington	stoetr	FL	33713
296.	Homer	Fontaine	4970 Britni Way	Zephyrhills	FL	33541-7312
297.	Teresa	Jaeger	604 Trinidad Court	Winter Park	FL	32792-4907
298.	MICHAEL	RYAN	1054 6TH LN N	NAPLES	FL	34102-8101
299.	Julie	Dinsmore	8303 SE Cumberland Circle	Hobe Sound	FL	33455-4057
300.	Walter	Graue	205 Mosley Drive	Lynn haven	FL	32444-5603
301.	Laura	Weissman	5119 Ventura Drive	Delray Beach	FL	33484-8383
302.	Rachael	Harrison	376 SW 62nd Blvd Apt 10	Gainesville	FL	32607-2046
303.	William	Manzini	2209 S.W. Crocus Lane	Port St. Lucie	FL	34953-5711
304.	Werner	Munzer	3759 Pebblebrook Ct.	COCONUT	FL	33073-2221

				CREEK		
305.	Keth	Luke	5438 Tennessee Ave	New Port Richey	FL	34652-2932
306.	Joe	Castello	P.O. Box 290589	Tampa	FL	33687-0589
307.	Ralph	Alfano	3273 Sunnyhill Dr	Brooksville	FL	34602-8318
308.	Dimitria	Gatzia	3764 59th ave. west	Bradenton	FL	34210-3537
309.	Ken	Wardlaw	279 Capri Avenue	Lauderdale-By-The-Sea, Fl. 33308	FL	33308-5036
310.	Raymond	Shaw	2441 Del Webb Blvd. E.	Sun City Center	FL	33573-6972
311.	Elizabeth	Allen	901 Live Oak Ave NE	St. Petersburg	FL	33703-3178
312.	WALTER	HEBERLEIN	5 GATESHEAD DR	DUNEDIN	FL	34698-8536
313.	Scott	Cody	15714 Iona lakes drive	fort myers	FL	33908-1878
314.	gerald	sandler	4832 heron run circle	leesburg	FL	34748-7819
315.	David	Neral	444 Island View Cir	St. Augustine	FL	32095-9631
316.	gilbert	beach	3264 s.e. monte vista st.	port st. lucie	FL	34952-6113
317.	Robert	Turel	510 39th Avenue	St. Pete Beach	FL	33706-2606
318.	Kathleen	Scott	506 Honeysuckle Ln	Vero Beach	FL	32963-1809
319.	Sarah	Danner	6661 Fairmont St.	Navarre	FL	32566-8135
320.	Peter	Quinonez	7040 Hemlock Course	Ocala	FL	34472-2138
321.	GAYLE	Hassinger	1786 BOCA RATON CT.	PUNTA GORDA	FL	33950-5137
322.	Sue	Jones	790 Bayside Lane	Weston	FL	33326-3337
323.	Dorothy G	Eingold	15163 SW 15 ST	Pembroke Oines	FL	33027-2330
324.	Robert	de Graffenried	4728 ARROW ROAD	ORLANDO	FL	32812-8207
325.	Thomas	Bryant	4908 Cypress Trace Drive	Tampa	FL	33624-6908
326.	Lois	Kraus	3301 Bayshore Blvd	Tampa	FL	33629-8875
327.	Jorge	Mera	540 NW 47th Ter	Coconut Creek	FL	33063-6738
328.	Eugene	Skalsky	4545 Pine Tree Drive	Pace	FL	32571-8928
329.	Jay	Litt	7056 Falls Rd E	Boynton Beach	FL	33437-6317
330.	Marco	Lurati	1506 N Saturn Ave.	Clearwater	FL	33755-2921
331.	Joyce	De Vries	5777 SW 89th Way	Cooper City	FL	33328-5162
332.	Russel	Murray	10403 SE 177th Pl	Summerfield	FL	34491-7457
333.	Robert	Lappin	52 Bermuda Lake Drive	Palm Beach Gardens	FL	33418-4584
334.	Nancy	Graham	3157 Tipperary Drive	Tallahassee	FL	32309-3328
335.	Denise	Minarchick	202 NW Archer Ave	Port St Lucie	FL	34983-1178
336.	Patricia	Antoine	7700 Ventura Lane	Parkland	FL	33067-2327
337.	Rob	Gonzalez	8840 Lake Park Circle N.	Davie	FL	33328-7011
338.	Charles A	BAKER III	209 SOLDIERS CREEK	PLACE		LONGWOOD
339.	Marlene	Adams	2520 N E 1st Court	Boynton Beach	FL	33435-2047
340.	Susan	Chandler	321 Monarch Ln	Fort Pierce	FL	34946-6443
341.	Valerie	Starkman	2514 Taylor Street, #3	Hollywood	FL	33020-4375
342.	Jack	Robins	223 Lake Meryl Drive	West Palm Beach	FL	33411-3392
343.	Lisa	Felt	12564 Strickland	Perry	FL	32348-7752

			Landing Ct.			
344.	Joseph	Breitenbach	3333 N.E.34th St. Apt. 1601	Fort Lauderdale	FL	33308-6916
345.	Tiffany	Scott	279 ne 40th St	Pompano	FL	33064-3533
346.	Sandi	Fehr	1125 15th ave. no. 6B	lake Worth	FL	33460-1859
347.	Emily	Fueger	325 Woodstead Circle	Longwood	FL	32779-3727
348.	Donna	Fowley	4749 SE Binnacle Way	Stuart	FL	34997-1932
349.	Robert	Greenfield	1650 Landings Blvd	Sarasota	FL	34231-3223
350.	Desiree	Gimse	P.O.Box 582	Key Largo	FL	33037
351.	C G	Herrington	4411 Windlake Drive	Niceville	FL	32578-4812
352.	Kirk	Butler	2705 armenia court	tampa	FL	33614-4305
353.	Patricia	Capobianco	1288 Balboa Ct	Marco Island	FL	34145-5008
354.	michael	reik	580 W Tropical Way	Plantation	FL	33317-3346
355.	Leon	Puterbaugh	220 Washington Rd.	Sebring	FL	33870-8101
356.	Roberta	Richardson	PO Bx. 1304	Melbourne	FL	32902-1304
357.	Sarah	Cullen	2987 bridgeport ave.	Miami	FL	33133-3607
358.	robert	wolf	1705 Gordon Dr	Naples	FL	34102-7553
359.	James	Richardson	683 Sheridan Woods Dr	Melbourne	FL	32904-3304
360.	Kris	Pagenkopf	7625 SW 7th Place	Gainesville	FL	32607-1580
361.	Wayne	Kelly	6305 Spyglass lane	Bradenton	FL	34202-1706
362.	JANET	IANNELLI	389 W Hillmoor Ln	Beverly Hills	FL	34465-4781
363.	Steve	Rostan	2285 Marsh Hawk Ln Apt 2104	Orange Park	FL	32003-6370
364.	Joe	Serpico	4215 East Bay Dr 1507A	Clearwater	FL	33764-6972
365.	Laurie S.	Waldron	6929 W University Av. 3G	Gainesville	FL	32607-1650
366.	Margaret	Gervais	100 ne 8 ave #515	gainesville	FL	32601-2357
367.	Harris	Graber	7122 Grassy Bay Drive	West Palm Beach	FL	33411-5725
368.	Leonard	Moss	PO Box 160538	Hialeah	FL	33016-0009
369.	Stephen	Jones	790 Bayside Lane	Weston	FL	33326-3337
370.	George	Locke	10734 Richmond Place	Cooper City	FL	33026-4913
371.	William	West	812 Atwood Ave. North	St. Petersburg,	FL	33702-6614
372.	Howard	Usher	10173 NW 66 Drive	Parkland	FL	33076-2907
373.	Carl	Gerig Jr	12613 Lakewood Court	Fort Myers	FL	33908-2852
374.	JIM	Mankowski	5212 creekside tr.	Sarasota	FL	34243-3887
375.	Mary	Magill	944 Sunridge Dr.	Sarasota	FL	34234-2805
376.	Rosemary	Hagen	645 Linden Drive	Englewood	FL	34223-7170
377.	Robert	Parkinson	1542 SW 18th Terrace	Ft. Lauderdale	FL	33312-4131
378.	Jerry	Keller	103 Lucerne Ave.	Lake Worth,	FL	33460-3913
379.	GRACE	LULEJIAN	5108 ST. ALBANS AVE	Sarasota	FL	34242-1532
380.	Ronald	Hines	9730 N Armenia Ave	Tampa	FL	33612-7539
381.	barbara	jacques	2460 persian dr #4	clearwater	FL	33763-1920

382.	Darren	Puorro	2980 Haines Bayshore Road #155			Clearwater
383.	Ted	Bahn	PO Box 1931	Anna Maria	FL	34216-1931
384.	John	Hadder	489 Captains Circle	Destin	FL	32541-5307
385.	Rebecca	Mercer	2727 DuPont Ave	Jacksonville	FL	32217-2654
386.	Meri-Lynn	Britz	2109 San Sebastian Drive	Big Pine Key	FL	33043-5108
387.	rg	odom	4261 West Palm Aire Drive	Pompano Beach	FL	33069-4068
388.	Patti	Brown	805 Sschoolway	New Smyrna Beach	FL	32169-3865
389.	Linda	George	5415 Rustic Pine Ct	Orlando	FL	32819-7129
390.	Jack	Feder	7703 Great Glen Circle	Delray Beach	FL	33446-3604
391.	Donna	Adkins	1099 McMullen Booth Rd	Clearwater	FL	33759-3453
392.	Sidney	Dratch	7589 Diamond Pointe Circle	Delray Beach	FL	33446-3344
393.	Anne	Maxson	4014 Saxon Dr	New Smyrna Beach	FL	32169-3849
394.	Thomas	Bartt	2531 Country Club Dr	Titusville	FL	32780-5234
395.	julian	hart	1520 fort duquesna dr	sun city center	FL	33573-5045
396.	Sally	Coupal	4118 W. Obispo St.	Tampa	FL	33629-6737
397.	Janet	Clayton	P. O. box 895418	Leesburg	FL	34789-5418
398.	ALBERT	DOBSON	6106 Sourwood Way	Bartow	FL	33830-9761
399.	Stephen	Sleeper	24716 Carnoustie Ct.	Bonita Springs	FL	34135-7623
400.	Charlotte	Thomas	RR 1 Box 406	Lake Butler	FL	32054-9801
401.	R.C.	Farr	47 fARR cIRCLE	rYDAL	GA	30171-1627
402.	ALICIA	SMITH	104 Gettysburg Place	Atlanta	GA	30350-3030
403.	Anne	Genova	803 Cumberland Road NE	Atlanta	GA	30306-3211
404.	Terri	Drummond	120 Highview Road SE	Milledgeville	GA	31061-9508
405.	E. Victor	Mereski	1132 Meridian Drive	Savannah	GA	31406-2058
406.	Russell	Harris	110 Knob Hill Dr	Evans	GA	30809-6684
407.	Gene	Newton	3007 Weaver Ct	Augusta	GA	30906-4327
408.	Paul	Jamieson	1895 Country Crest Way	Dacula	GA	30019-1589
409.	PHILIP	MCDADE	PO BOX 128`	UVALDA	GA	30473-3021
410.	Robert	Davis	510 Park Ln SE	Marietta	GA	30067-5006
411.	Stephen	Marsh	320 Woodbury Way	Alpharetta	GA	30022-6506
412.	Stephen	Lykins	3318 Wheeler Dr	Doraville	GA	30340-3236
413.	D.	Magee	PO Box 25506	Atlanta	GA	30322-0032
414.	Bob	Jochums	4118 Centennial Trail	Duluth	GA	30096-4245
415.	Rob	Sinyard	1265 Crystal Springs Trail	Hampton	GA	30228-2675
416.	Janice	Alford	3780 London Dr	Decatur	GA	30032-2359
417.	Hezikiah	Johnson III	600 Longbow Drive	Albany	GA	31721-8920
418.	Eugene	Mansour	5504 Sandy Hollow	Norcross	GA	30093-4242
419.	Paul	Osman	3141 Burnt Hickory Rd NW	Marietta	GA	30064-1203
420.	Anisha	Hyers	2035 Sparrow Lane	Blackshear	GA	31516-4677
421.	Beverly	Schumacher	832 Buck Swamp Rd	Brunswick	GA	31523-7014

422.	Bruce	Couter	56 Buck Creek Drive	Jackson	GA	30233-6572
423.	Pamela	Foley	1607 Ellington Rd SE	Conyers	GA	30013-2185
424.	Ashley	Pietrzykowski	2525 Forrest Ave NW	Atlanta	GA	30318-1114
425.	Sandra	Usery	537 Greenwood St.	Barnesville	GA	30204-1552
426.	Andrea	Fowler	83 Dartmouth Ave.	Avondale Estates	GA	30002-1412
427.	Fred Nadelman,	Lmsw	1825 East Gwinnett St.	Savannah	GA	31404-1852
428.	Gary	Lefmann	385 Avian Forest Dr	Stockbridge	GA	30281-7268
429.	Ruth	Yurchuck	986 Arlington Drive	Tucker	GA	30084-1566
430.	nicole	patterson	101 ridgewood trl	stockbridge	GA	30281-7138
431.	Kathleen	McNulty	3978 Palisades Main	Kennesaw	GA	30144-6165
432.	M. Margaret	Chandler	2706 Chancellor Way	Duluth	GA	30096-3679
433.	A. S.	Worthington	4824 Oak Arbor Dr.	Valdosta	GA	31602-4905
434.	Donna	Marshall	2728 Northwoods Lake Court	Duluth	GA	30096-4895
435.	Pamela	Howard	1448 Grant Dr NE	Atlanta	GA	30319-3528
436.	Georgii	Billiris	1723 Adolphus St NE	Atlanta	GA	30307-2201
437.	Queen	Ekanem	4298 Cedar Ridge Trail	Stone Mountain	GA	30083-5710
438.	Cheryl	Schmidt	154 Lamar Drive	Ellijay	GA	30540-7229
439.	Robert	Lann	1120 Lea Drive	Roswell	GA	30076-4626
440.	Aron	Clark	80 Meadow Ridge Ln.	Murrayville	GA	30564-2658
441.	Edward	Gresham	2243 meadow Dr.	Snellville	GA	30078-2623
442.	William	Stone	154 Timberland St.	Woodstock	GA	30188-3927
443.	Bernard	Wilms	3500 Miller Farms Lane	Duluth	GA	30096-2973
444.	Josephine	Gallagher	331 Grandiflora Dr.	McDonough	GA	30253-8010
445.	Philip	McKenna	1920 Low Gap Road	Lakemont	GA	30552-3407
446.	R.	Robeson	307 E Breckinridge	Macon	GA	31210-2189
447.	P C	Johnson	1359 Michael Way	Marietta	GA	30062-6270
448.	Karl	Clarke	4113 ridgecrest trail	Hiawassee	GA	30546-4540
449.	George	Vokey	3281 Amesbury Way	Duluth	GA	30096-4671
450.	Suzanne	Waldron	5195 S. Chestatee, Dahlonega, GA 30533-6136			DAHLONEGA
451.	James	White	45-179F Lilipuna Rd	Kaneohe	HI	96744
452.	Rosita	Aranita	P.O. Box 86	Ookala	HI	96774-0086
453.	David	Lewiston	715 S Kihei Road	Kihei	HI	96753-9070
454.	Charles	Connors	75-212 Aloha Kona Drive	Kailua Kona	HI	96740-2006
455.	Carolyne	Lampe	p.o.box 8150	Honolulu	HI	96830-0150
456.	Amy	Alexander	1717 Mott-Smith Dr. 1005	Honolulu	HI	96822-2815
457.	Jonathan	Boyne	2065 Lanihuli Dr.	Honolulu	HI	96822-2112
458.	Niki	Pestel	974 Kahena St	Honolulu	HI	96825-1077
459.	Kay	Miller	4224 Waialae Ave., #400	Honolulu	HI	96816-5330
460.	John P.	Gallagher	91-893 Nohoihoewa Pl	Ewa Beach	HI	96706-4031
461.	Judith	Zissa	2611 Ala Wai Blvd. #806	Honolulu	HI	96815-3906

462.	Robert	Staples	91 Malapua Place	Kula	HI	96790-8262
463.	Charles	Hildebrand	1703 East 9th Street	Des Moines	IA	50316-2053
464.	Joan	Winn	312 Marshall St	Ollie	IA	52576-0024
465.	Curt	Miner	115 3rd Ave NW	Clarion	IA	50525-1116
466.	Janice	Killian	1321 EAST SHERIDAN	AVE		Des Moines
467.	Raquel	anonymous	1032 West Fifth Street	Waterloo	IA	50702-2806
468.	William	Scannell	1230 Dement Street	Larchwood	IA	51241-7624
469.	frank	belcastro	285 north grandview avenue	dubuque	IA	52001-6327
470.	Traci	Rodriguez-Cisneros	2070 King #8	Des Moines	IA	50320-2459
471.	Dr. Robert	Klauber	1100 Univ Manor Dr., #38B	Fairfield	IA	52556-2088
472.	Diane	Gallagher	2313 W.8th St.	Waterloo	IA	50702-3935
473.	Hugh	Griffin	12289 Quaker St	Indianola	IA	50125-8822
474.	Dennett	Hutchcroft	1422 College St.	Iowa City	IA	52245-4409
475.	Steven	McLeod	1453 E 23RD ST	des moines	IA	50317-6409
476.	Diana	Rhine	2311 Fox Trail Dr. N.E.	Cedar Rapids	IA	52402-6742
477.	Cherie	Cartier	509 Terry Terrace	Marshalltown	IA	50158-4457
478.	Charlie	Hogue	1721 Chestnut Lane Ne	Cedar Rapids	IA	52402-3761
479.	Dawn	Ask Mart?n	1604 Lilac Lane	Cedar Falls	IA	50613-5314
480.	Linda	Thompson	407 Dickens St.	Parkersburg	IA	50665-2013
481.	Delores	Emerson	2928 195th St.	Sidney	IA	51652-6009
482.	Henry	Martin	224 E. Elwood Ln.	Boise	ID	83706-7005
483.	Jules	Levin	5801 N Yaquina Head Way	Boise	ID	83714-8060
484.	dale	degeeter	1156 tennyson ln	naperville	IL	60540-0374
485.	Sherr	Lotito	1175 S. Batavia Avenue	Batavia	IL	60510-3083
486.	Stanley	Davis	740 W. Aldine	Chicago	IL	60657-3430
487.	tom	cwerenz	450 S. Lombard Rd.	Addison	IL	60101-4230
488.	Robert	Schwalb	2625 N. Clark Apt. 1806	Chicago	IL	60614
489.	Susan	Schwichow	1509 Oak	Evanston	IL	60201-4263
490.	Robert	Bauer	1180Middlebury Ln	Wheeling	IL	60090-2452
491.	Raymond	Prigodich	157 Eisenhower Drive	Oswego	IL	60543-7409
492.	Bonnie	Richardson	1447 W. Touhy Ave., #405	Chicago	IL	60626-2605
493.	Jeffrey	van Davis	419 W. Downer Place	Aurora	IL	60506-5051
494.	James	Kohler	21124 W. Buckeye Ct.	Plainfield	IL	60544-7463
495.	Sharon	Vaughn	2024 N. Arrowood	Quincy	IL	62305-8987
496.	Sue	Eberhardt	12540 Boxwood Court	Huntley	IL	60142-7488
497.	Charles	Rosenberger	18033 Oak Avenue	Lansing	IL	60438-2142
498.	William	Lee	4 Three Lakes Rd.	Barrington	IL	60010-4032
499.	Dr. Arthur C.	Donart	804 Lucas Avenue	Thomson	IL	61285-7734
500.	Ann	Porter	1711 Cross St	Shiloh	IL	62269-2912
501.	Dick	Beal	1400 Oak St	Western	IL	60558-1021

				Springs		
502.	Sara	McDonald	219 Willow Run	Moro	IL	62067-1707
503.	Stephen	Gliva	3660 N Lake Shore Dr., #614	Chicago	IL	60613-5304
504.	Jeanne	Vanis	1781 Hartley Drive	Algonquin	IL	60102-4373
505.	Natasha	Shpiller	1240 W Farwell #2A	Chicago	IL	60626-3819
506.	Dan	Edgar	4903 Voltaire Dr.	Godfrey	IL	62035-1641
507.	Jeff	Moluf	1306 Eliot Drive	Urbana	IL	61801-6913
508.	Rachel	Spatafora	707 Cottage St	Shorewood	IL	60431-9352
509.	Nayeem	Aslam	18W218 Lowell Lane	Villa Park	IL	60181-3814
510.	Susan	Moorman	442 Michgamme Lane	Lake Forest	IL	60045-2819
511.	Harold	Piggott	211 N. Meridian Rd.	Glen Carbon	IL	62034-1333
512.	Ivan	Lippitz	20 Trafalgar Square	Lincolnshire	IL	60069-3065
513.	Brendan	Hughes	1709 S. Glenwood	Springfield	IL	62704-4005
514.	Judith	Byrne	1098 Bothwell Lane	Bolingbrook	IL	60440-1670
515.	Manoj	Paul	9101 South 84th Avenue	Hickory Hills	IL	60457-1801
516.	Margot L.	Davis	1673 Coach Dr. #203	Naperville	IL	60565-2453
517.	Michael	Stuart	3116 Shady Dr.	Wonder Lake	IL	60097-9318
518.	Barry	Seth	1355 Wilmot Road	Deerfield	IL	60015-2069
519.	Walter	Schmitt II	10005 Gentian Drive	Machesney Park	IL	61115-1542
520.	William G.	Sowa	702 S Rohlwing Rd	Itasca	IL	60143-2569
521.	Marla	Neal-Roberts	508 E. Bellarmine Dr.	Joliet	IL	60436-1834
522.	Daniel	Puetz	990 N. Cove Drive	Palatine	IL	60067-1900
523.	Ted	Liu	612 E Devon Av	Elk Grove Vlg	IL	60007-4639
524.	Mary	Solomon	3515 N. Damen	Chicago	IL	60618-6107
525.	Allan	Levy	3 Lyndhurst Place	Champaign	IL	61820-7712
526.	Paul	Waterhouse	3515 N. Damen	Chicago	IL	60618-6107
527.	Victoria	Ciofani	637 Auburn Ct.	Crystal Lake	IL	60014-8910
528.	Matthew	Lagod	5455 N. Sheridan Rd. #2806	chicago	IL	60640-7441
529.	James	Harris	665 Chapman St.	Edwardsville	IL	62025-1257
530.	Linda	Tucker	1358 East 48th Street	Chicago	IL	60615-2040
531.	Janet	Ma'ly	5403 73rd Court	Summit	IL	60501-1008
532.	Don	Mingesz	714 Morris Ct	Lombard	IL	60148-4043
533.	David	Gustafson	3419 50th Street	Moline	IL	61265-6619
534.	Joanne	Aggens	1915 Highland Ave	Wilmette	IL	60091-2359
535.	Tabitha	Metreger	3N174 Timberline Drive	West Chicago	IL	60185-5937
536.	Mike	Lenkowski	7211 W Rascher Ave	Chicago	IL	60656-1806
537.	Adrian	Kocurek	1033 W Loyola Ave	Chicago	IL	60626-5217
538.	Sue	Szumigalski	9561 Arrowhead Drive, A2	Hickory Hills	IL	60457-2731
539.	Ryan	Danzinger	1536 N. Hickory Ave.	Arlington Heights	IL	60004-4042
540.	Johanna Ellison	Hanks	999 Breezy Bluff Dr	Galesburg	IL	61401-8431
541.	CHARLES	BROUNT	3312 LAKE KNOLL DRIVE	NORTHBROOK	IL	60062-6316
542.	James	McConkey	1836 Kerrybrook Ct.	Sycamore	IL	60178-2755

543.	Michael	Rynes	611 E. Gundersen Dr., Apt 209			Carol Stream
544.	Donna	Hilbrich	2247 Petworth Ct.	Naperville	IL	60565-4283
545.	Paul	Stubblefield	316 E Birchwood St	Morton	IL	61550-2506
546.	Peter	Gray	728 W. Jackson Blvd.	Chicago	IL	60661-5490
547.	Nancy	Burns	501 E Turner Ave	Roselle	IL	60172-2508
548.	Warren	Adams	13898 Benjamin Ct.	Bloomington	IL	61704-6772
549.	Barbara	Singer	8731 W. Summerdale Ave.	Chicago	IL	60656-2330
550.	John	Carter	22118 W Spruce Dr	Antioch	IL	60002-9376
551.	Gina	Strafford	914 School St. Apt. 1	Lisle	IL	60532-1957
552.	Andrea G	di Marco	14321 S Eggleston Ave	Riverdale	IL	60827-2336
553.	John	Craig	306 West Lincoln Avenue	Libertyville	IL	60048-2725
554.	Andrew	Jenkins	1433 w lunt ave	Chicago	IL	60626-2860
555.	rhonda	miller	1516 w 88th st	chicago	IL	60620-4827
556.	Darryl	Mestel	214 N 8th St	Elkville	IL	62932-0575
557.	Navin	Shankar	1030 E. Maple St.	Lombard	IL	60148-3150
558.	Lindsay	Humpal	717 W. Montrose Ave.	Chicago	IL	60613-1515
559.	Randy	Dautel	815 Revere Rd.	Glenview	IL	60025-3944
560.	Laura	Rothberg	1811 Hanover Lane	Flossmoor	IL	60422-1923
561.	Andrea	Rundell	402 W Michigan	Urbana	IL	61801-4948
562.	ERNST	HEIMANN	1748 PARK RIDGE POINTE	PARK RIDGE	IL	60068-1311
563.	Michael	Quirk	10112 s. utica	evergreen park	IL	60805-3527
564.	Reuben	Metreger	3N174 Timberline dr	West Chicago	IL	60185-5937
565.	Marlene	Bedard	2443 Courtyard Circle Unit 6	Aurora	IL	60506-6618
566.	Gail	Hendrickson	Post Office Box 852	Mundelein	IL	60060-0852
567.	Michael	Yannell	2911 N. Racine Ave.	Chicago	IL	60657-4223
568.	Manker R.	Harris	47 Country Place	Springfield	IL	62703-5310
569.	len	fassett	319 brandy dr.	mackinaw	IL	61755-9709
570.	Laraine	Kubiak	5012 W. Greenbrier Drive	McHenry	IL	60050-5166
571.	Thomas	Roby	1212 S. Michigan Ave. #2702	Chicago	IL	60605-2466
572.	Cheri	Anderson	884 Gosselin Circle	Batavia	IL	60510-4515
573.	Sabrina	Choi	5408 Marshall Drive	Wonder Lake	IL	60097-8705
574.	Emma	Fabbri	2627 N Clinton ST	River Grove	IL	60171-0346
575.	Bill	Eschker	7643 Lowell	sKOKIE	IL	60076-3713
576.	Suzanne	K	1018 cottonwood court, unit 2A			Wheeling
577.	Richard	Bossie	4343 N Clarendon Ave Apt 1902			Chicago
578.	Barry	Rabichow	435 N Oak Park Ave. #1	Oak Park	IL	60302-2122
579.	Louis	LaRocco	1107 N Humphrey Ave	Oak Park	IL	60302-1109
580.	Charles	Whitmore	1703 Liberty Street	Alton	IL	62002-4515
581.	Dennis M	Ripley	505 Heinze Dr	Rock Falls	IL	61071-1920
582.	JOyce	Pfennig	1002 W. Springfield Ave	Champaign	IL	61821-3303
583.	Dale	Jones	3121 Blackberry	Mount Vernon	IL	62864-2516

584.	Rose	Ingram	701 McBride Ave.	Dupo	IL	62239-1039
585.	Charles	Moss	12 Yorkshire Dr	Mackinaw	IL	61755-9725
586.	Dana	Powers	520 S. Third St.	West Dundee	IL	60118-2810
587.	Rhodia	Mason-Milici	4719 N Talman	Chicago	IL	60625-7023
588.	Gina	Bilotto	15724 Peggy Lane	Oak Forest	IL	60452-3107
589.	Peter	Gunther	2318 W. Sunnyside #3	Chicago	IL	60625-2114
590.	Sally Corneliso	Egan	1010 Oakland Lane	Aurora	IL	60504-8993
591.	Ravi	Grover	pOB 802103	Chicago	IL	60680-2103
592.	L.	Carter	4343 North Clarendon Avenue, #1803			Chicago
593.	sheila	nicolai	1901 richmond ct	schaumburg	IL	60194-2236
594.	Mike	Hansen	874 Swan Lane	Deerfield	IL	60015-3671
595.	DAVID	LAIRD	1130 WEST 9TH ST.	ALTON	IL	62002-2320
596.	Michael	Lokshin	2907 West Logan Blvd #2	Chicago	IL	60647-1796
597.	Lee	Lorentzen	9800 Bianco Terrace	Des Plaines	IL	60016-1635
598.	Charles	Scouten	29W528 Forestview Drive	Warrenville	IL	60555-2101
599.	Kaneli	Galiotos	5027 W. HOWARD ST.	skokie	IL	60077-2830
600.	Suzanne L.	Lampka	1909 N. Neva	Chicago	IL	60707-3831
601.	Kathleen	Prokuski	5249 W. BERENICE AVENUE			chicago
602.	LuAnn	Kowar	6718 N. Rockwell - 2nd floor	Chicago	IL	60645-4626
603.	James	Dougherty	5115 W Grace St	Chicago	IL	60641-3453
604.	Connie	Wilson	810 E Shady Way Unit 304	Arlington Hts	IL	60005-4365
605.	Donald	Ruedin	22347 S. River Rd.	Joliet	IL	60431-7651
606.	Ajay	Gupta	2787 Shellingham Dr	Lisle	IL	60532-4244
607.	Jude	Garner	8610 Bard Rd	Crystal Lake	IL	60014-6807
608.	Duane	Diamond	4905 pleasant ridge dr	evansville	IN	47711-2643
609.	Keith	Myers	8110 East 45th Street	Indianapolis	IN	46226-3903
610.	Steven	Culp	11100 S 800 W	Daleville	IN	47334
611.	Janice	Hoftiezer	404 Burlington Beach Road	Valparaiso	IN	46383-1993
612.	D. Colleen	Parker	23 EMS Lane C-14	Warsaw	IN	46582
613.	Mary	Gajewski	489 Serena Lane	Bloomington	IN	47401-9226
614.	Gabriel	Gardner	1615 Dodge	Fort Wayne	IN	46805-3667
615.	Jack	Brady	2202 Beauvoir Ct	Kokomo	IN	46902-2914
616.	Mark	Dolezal	16717 Hurshtown Rd	Spencerville	IN	46788-9440
617.	Richard	Schlueter	803 So. 7th. St.	Goshen	IN	46526-4016
618.	Robert	Smith	6615 E 575 N`	Churubusco	IN	46723-9319
619.	Beth	Spiteri	2811 Macarthur Ave	South Bend	IN	46615-3556
620.	Jessica	Cresseveur	52 Wynn Gate Ct	New Albany	IN	47150-6538
621.	Christopher	Mott	3130 North Green River Rd	EVANSVILLE	IN	47715-1356
622.	Laura G.	Homeyer	2138 N Delaware Pkwy	Munster	IN	46321-3207
623.	Steve	Grob	11712 Eagle Creek Pass	Fort Wayne	IN	46814-3253

624.	Bruce	Biehl	11419 Robinair Dr.	Fort Wayne	IN	46818-8915
625.	Anthony	Perry	29 lasalle st	sellersburg	IN	47172-1310
626.	Dorothy	Wyatt	5322 Epworth Rd.	Newburgh	IN	47630-8724
627.	Samantha	Pishkur	1219 120th Street	Whiting	IN	46394-1903
628.	Judith	Stanley	5299 Skyline Lane	Greenwood	IN	46143-8953
629.	Monica	Oclander	7684 Santa Barbara Drive	Indianapolis	IN	46268-5380
630.	Marcella	Ciucki	8723 Oakwood Avenue	Munster	IN	46321-2731
631.	Mark	Bishton	route 1 Box 273A	Bloomfield	IN	47424-9751
632.	Jon	Abbey	2305 Highland Road	Anderson	IN	46012-1921
633.	David Paul Xavier	Burch	901 East Victoria Street	South Bend	IN	46614-1339
634.	David Paul Xavi	Burch	901 East Victoria Street	South Bend	IN	46614-1339
635.	CLARICE	WARRICK	reid hosp	RICHMOND	IN	47374-1908
636.	Barbara	Becker	2611 Malibu Drive	Evansville	IN	47725-9602
637.	Dale	LaCognata	6244 Dover Ct.	Fishers	IN	46038-4707
638.	Christine	White	51873 Carriage Hills	South Bend	IN	46635-1083
639.	Kendra	Stuckey	256 Doty Street	Hammond	IN	46320-3911
640.	Patridia	Hardy	916 E. Elizabeth St	Olathe	KS	66061-6487
641.	Maude	Wahlman	9700 Overbrook Rd.	Leawood	KS	66206-2310
642.	Edward	Fenimore	13100 Mohawk	los angeles	KS	66209-4106
643.	Frances	Tan	2300 W 26th St Apt E30	Lawrence	KS	66047-3137
644.	Judy	Williams	5510 Pitkin	Kansas City	KS	66106-1335
645.	Rita	Riley	524 Mississippi St.	Lawrence	KS	66044-2238
646.	Benn	Gibson	1620 Ames Ave	Winfield	KS	67156-2542
647.	Mark	Roeyer	1301 Inverness Dr.	Lawrence	KS	66049-3817
648.	Denise	Rice	10312 Ensley Lane	Leawood	KS	66206-2513
649.	William	Peterson	21460 W 123rd Terrace	Olathe	KS	66061-9721
650.	David	Scheidt	12462 S. Ortega Dr.	Olathe	KS	66062-5636
651.	Sean	H.	2402 N. Cranbrook St	Wichita	KS	67226-3664
652.	Resa	Boydston	1236 sw Belle Terrace #3	Topeka	KS	66604-2060
653.	Dorothy	Boydston	2124 se 37th	Topeka	KS	66605-2418
654.	Raymundo	Rojas	1510 J Greenway Dr.	Eudora	KS	66025-9536
655.	John	Hinds	816 N. West St. # 7	Wichita	KS	67203-1272
656.	John	Orr	1614 S Saint Paul St	Wichita	KS	67213-5609
657.	Dorothy	Buchholz	7901 W 115th St	Overland Park	KS	66210-2555
658.	Mike	Sexton	2524 Commonwealth 52	Junction City	KS	66441-4286
659.	Jean	Teel	8717 W. 73 St.	Merriam	KS	66204-2702
660.	Donna	Riggle	8116 Pine Castle Drive	Louisville	KY	40219-4633
661.	William	Steger	345 Bullock Pen Dr.	Crittenden	KY	41030-8937
662.	John Paul	Markham	111 North Highland Ave.	Princeton	KY	42445-2036
663.	Joyce C.	Cotton	375 Dennis Drive	Shepherdsville	KY	40165-6211
664.	Zoser	Vargas	7511 Belinda Way	Louisville	KY	40291-2790

665.	Monika	Gossett	7362 Hwy 39	Somerset	KY	42503-5106
666.	Chad	Dunbar	8502 Westover Drive	Prospect	KY	40059-9494
667.	george	hendley	1511 Greenery Dr	Florence	KY	41042-7052
668.	Ellen	Davis	8715 Running Fox Circle	Louisville	KY	40291-2666
669.	ANNE	LEWIS	674 Sheridan Dr	Lexington	KY	40503-1726
670.	Paul	Yates	112 Gano Ave	Georgetown	KY	40324-1912
671.	joe	survant	762 minnie way	bowling green	KY	42101-9210
672.	Roy	Madden	1060 Woodland Dr	Richmond	KY	40475-8489
673.	Gwendolynn	Smiley	1340 LOngfield Ave	Louisville	KY	40215-1926
674.	Margaret	Houck	9201 S. Pirogue Ct.	Louisville	KY	40299-1577
675.	Thomas	Avery	3013 Lynnwood Way	Louisville	KY	40299-3101
676.	Larry	sNYDER	3817 Keene-Troy Pike	Versailles	KY	40383-9401
677.	Gwen	Brown	PO Box 26	Gravel Switch	KY	40328-0026
678.	Garland	Wyatt	26 Samuel Dr	Benton	KY	42025-7373
679.	Joan	Frohlich	131 Lake St	Nicholasville	KY	40356-1083
680.	Deborah	Bolt	117 E. Center St	Hartford	KY	42347-1107
681.	Ruth	Newman	750 Zorn Ave. #46	Louisville	KY	40206-3505
682.	Saundra	Shinall	1546 State Route 93 North	Kuttawa	KY	42055-0321
683.	Louis	Philpott	2013 Woodbourne Ave	Louisville	KY	40205-1909
684.	Monique	Keeling	501 Roselawn Avenue	Monroe	LA	71201-5347
685.	William	Nelson	926 Bear Creek Road	Quitman	LA	71268-4523
686.	Kevin	Hamilton	3309 Chestnut Street	New Orleans	LA	70115-2438
687.	Donald	Champagne,Sr.	974 Bayou Dularge Rd.	Houma	LA	70363-7613
688.	Linda	Williams	64320 Lake Superior Rd.	Amite	LA	70422-5324
689.	Bobby	Brandon	P. O. Box 831	Oberlin	LA	70655-0831
690.	Jack	Worgan	1708 Dunkirk St	Slidell	LA	70461-4521
691.	Cindy	Warner	23 holly avenue	Northfield	MA	01360-9795
692.	Rosemary	Cardello	21 Cushing Ave	Newburyport	MA	01950-1826
693.	Frank C.	Taylor	1317 Alewife Circle	South Yarmouth	MA	02664-6105
694.	Paul	Anderson	65 Mower St	Worcester	MA	01602-4111
695.	Linda	Couture	96 Butternut Hollow Road	West Springfield	MA	01089-2131
696.	Erin	Brenner	4 Country Spring Loop	Haverhill	MA	01832-1272
697.	John	Ponte	25 Hartford Street	Dover	MA	02030-0462
698.	Anita	Purcell	58 Pinedale Avenue	Haverhill	MA	01830-2046
699.	Joshua	Lubarr	25 Harding Avenue	Belmont	MA	02478-4412
700.	Robert	Plourde	1030 High Street	Fall River	MA	02720-3608
701.	Heidi	Hayes	156 Elliott Street	Danvers	MA	01923-3834
702.	T.	Crugnola	Venditto Rd.	Revere	MA	2151
703.	Sharon	Dupree	154 June St;	Worcester	MA	01602-3250
704.	Achmad Moeljadi	Chadran	206 Stow Road	Harvard	MA	01451-1905

705.	Maureen	Sheehan	156 Congress St.	Bellingham	MA	2019
706.	Leslie	DeFilippis	199 Marlborough Street	Boston	MA	02116-1836
707.	l	gols	6 Walden Dr	Natick	MA	01760-3859
708.	Ralph	Thomas	113 Randall St	N Easton	MA	02356-2237
709.	frances	lynch	28 cedar st	Duxbury	MA	02332-3838
710.	Elizabeth M.	Ferranti	Po Box 724	Marstons Mills	MA	02648-0724
711.	Jennifer	Lynde	142 Carlisle Street	Lowell	MA	01852-5207
712.	Charlotte	Boccuzzi	9 Par Three Court	Mashpee	MA	02649-2873
713.	Catherine	Brown	21 Old Barn Road	Plymouth	MA	02360-2987
714.	Thom	Lissey	5 Vernon Street #6	Bradford	MA	01835-7232
715.	Nancy	Free	141 Pierce St Apt 23	Malden	MA	02148-1546
716.	Janet	Hose	1335 Beacon St.	Newton	MA	02468-1739
717.	jessie	schell	7 Murdoch Rd	Natick	MA	01760-3604
718.	Hazel	Arnett	10 Rogers St	Cambridge	MA	02142-1246
719.	Patricia	Doucette	6 Hopkins Road	Hopkinton	MA	01748-2670
720.	Frederick	O'Brien	37 Turmaine St.	Marlboro	MA	01752-1536
721.	Paul D.	Hand,Sr	71 Morningside Rd	Worcester	MA	01602-2545
722.	J. L.	Edwards	21 Berlin Ave.	Milton	MA	02186-5103
723.	Barbara	Cowan	5 Roberts Road #3	Cambridge	MA	02138-3203
724.	priscilla	adams	10 snell st	fiskdale	MA	01518-1104
725.	Roland F.	Shute	230 High Street	Greenfield	MA	01301-2618
726.	Jane	Bozek	9 Conant Street	Salem	MA	01970-2654
727.	Philip	Garnick	241 Perkins Street C-206	Boston	MA	02130-4008
728.	Lorraine	Blank	Box 42	Cheshire	MA	01225-0042
729.	Patrick	Brennan	11 Trowbridge St	Belmont	MA	02478-4001
730.	Carrie	Gilbert	92 Lloyd Ave.	Springfield	MA	01119-1618
731.	Andrea	Tooker	277 South Street	Wrentham	MA	02093-1504
732.	Nicholas	Zessoules	11 Willow Street	Belmont	MA	02478-2746
733.	Karen J.	Brown	97 Samoset Avenue	Hull	MA	02045-2513
734.	Paul	Geishecker	18 Cleveland Place	Boston	MA	02113-2547
735.	Ellen	Walker	7 Foulds Terrace, Apt. 8	North Andover	MA	01845-1834
736.	Don	McKelvey	24 Mendelssohn St	Roslindale	MA	02131-4004
737.	June	Stewart	674 Tyler St.	Pittsfield	MA	01201-4302
738.	Heidi	Smith	63 Highland Street	Easton	MA	02375-1306
739.	Francoise	LaMonica	944 Centre St	Newton	MA	02459-1266
740.	Jerri	Higgins	286 Montague City Rd. #1	Turners Falls	MA	01376-1813
741.	Erika	Abrahamsson	52 Adams St	Arlington	MA	02474-6827
742.	Paul	Ryan	20 Thatcher St	Carver	MA	02330-1184
743.	Eli	Castro	65 Strathhmore Rd #6	Brighton	MA	02135-7740
744.	Terry	Gilchrist	151 T Providence Rd.	Grafton	MA	01519-1523
745.	neil	fahey	503 chicopee st	chicopee	MA	01013-2158
746.	Dianne	Phillips	16 Cape Ave	Wareham	MA	02571-2813
747.	Lu	HAner	9 Sherman Rd.	Millis	MA	02054-1540
748.	Jody	Riley	5 Alice Ave	Pembroke	MA	02359-2423
749.	Eve	Curtis	27 Amherst Road	Waban	MA	02468-2301

750.	Richard	Clinton	85 Loring Ave.	Winchester	MA	01890-1641
751.	Warren	Frederick	19 Rydal St	Worcester	MA	01602-1724
752.	James F.	Driscoll	50 Woodrow St	Hudson	MA	01749-2848
753.	Corey	Mondello	115 Appleton Street	Boston	MA	02116-6128
754.	Marguerite	Gregory	241 Crescent St.	Northampton	MA	01060-2116
755.	wendy	mcettrick	P.O. box 575	Pembroke	MA	02359-0575
756.	Matthew	Carter	60 Liberty Street #2	Danvers	MA	01923-3361
757.	Jonathan	Meyer	70 Maple St. Apt 2	Waltham	MA	02453-4438
758.	Thomas	Silvia	67 Peter Rd.	Plymouth	MA	02360-5022
759.	Eileen	Donahue	9 Mann Street	Medway	MA	02053-1628
760.	RAY	MORAN JR	3007 PALMER STREET	BONDSVILLE	MA	01009-0892
761.	Michael	Onorato	1892 Memorial Dr Apt 210	Chicopee	MA	01020-4351
762.	Donald	Dwyer	51 Lincoln St	Dedham	MA	02026-3310
763.	Sara	Skinner	29 South Bedford St.	Burlington	MA	01803-4512
764.	John	Hess	19 Rosecliff Street	Roslindale	MA	02131-3526
765.	Laurie	Goldbarg	30 Holden Wood Road	Concord	MA	01742-4912
766.	Paula	Menyuk	162 Mason Terrace	Brookline	MA	02446-2772
767.	Theresa	Morrell	75 Sea St.	Weymouth	MA	02191-1418
768.	Juliet E.	Farrell	46 Chopteague Lane	Marstons Mills	MA	02648-1632
769.	nancy	fish	236 south st #2L	Northampton	MA	01060-4112
770.	anna	roblin	99r franklin st, #2	allston	MA	02134-1411
771.	The Rev. Marlene	Gil	50 Silver Street	Taunton	MA	02780-4618
772.	Michelle	Lerner	659 Longley Rd.	Groton	MA	01450-1022
773.	Mary Ann	King	P.O Box 294	Cummaquid	MA	02637-0294
774.	dorothy	dean	78 boylston circle	shrewsbury	MA	01545-1811
775.	Paul	Filiault	1149 Dutton Street	New Bedford	MA	02745-1515
776.	RAY	RILEY	519 E RIVER ST #112	Orange	MA	01364-2108
777.	Paula	Bushkoff	29 Alcott St.	Acton	MA	01720-5546
778.	Martha	Olver	P. O. Box 28	Amherst	MA	01004-0028
779.	Joseph	McNamara	51 Fort Meadow Dr	Hudson	MA	01749-3139
780.	Buce	Truesdale	4 Penn Road	Peabody	MA	01960-3331
781.	George	Manning	128 Old Washington St.	Pembroke	MA	02359-2709
782.	Thomas	Burnickas	20 Deborah Ln	Westfield	MA	01085-4138
783.	William	Schonman	60 Harlow Road	Sandwich	MA	02563-2608
784.	James	McMahon	10001 Windstream Drive - Unit 207			Columbia
785.	Anthony	Kostreski	3232 Bidle Rd	Middletown	MD	21769-8101
786.	Henry	Bosch	1406 Hubner Ave	Baltimore	MD	21228-4327
787.	Mark	Wemple	359 Dun-Robbin Dr.	Severna Park	MD	21146-1401
788.	Jeff	Maurer	3 Briardale Ct.	Derwood	MD	20855-2028
789.	Sally	Schwartz	1402 Jefferson Street	Hyattsville	MD	20782-3450
790.	Juanita	One	611 W. 33rd St.	Baltimore	MD	21211-2702
791.	James	Jordan	4535 FISH HAWK CT	CHESAPEAKE BEACH	MD	20732-3595
792.	Harvey	Eisen	8503 Rosewood Dr.	Bethesda	MD	20814-1433

793.	Gail	Helinski	1002 Bernadette Drive	Forest Hill	MD	21050-2708
794.	Donald	Bradshaw	12209-F Saint Peter Court	Germantown,	MD	20874-2539
795.	Melvin	Friedman	121 Channel Buoy Road	Ocean City	MD	21842-4805
796.	James	Welms	2601 Bradwell Ct.	Parkville	MD	21234-1518
797.	Stanley	Gabor	3953 Cloverhill Rd.	Baltimore	MD	21218-1708
798.	Peter	Bates	220 Margate Road	Timonium	MD	21093-5233
799.	Cathleen	McCann	1504 Jackson st	Baltimore	MD	21230-4732
800.	Carl	Hahn	13743 Lakeside Dr.	Clarksville	MD	21029-1346
801.	Gregory	Poehlman	5924 charnwood rd	Baltimore	MD	21228-1205
802.	Terry	Dalsemer	214 Homewood Terrace	baltimore	MD	21218-2804
803.	Charles C Campb	Jr	5917 ST Marys St	Baltimore	MD	21207-4702
804.	Linda	Hayes	7902 Nottingham Way	Ellicott City	MD	21043-6721
805.	Cheryl	Grant	15106 plum tree way NW	bowie	MD	20721-3028
806.	Doug	McNeill	33T Ridge Road	Greenbelt	MD	20770-0718
807.	Pam	Wanveer	8818 First Avenue	Silver Spring,	MD	20910-2737
808.	John	Gazurian	608 Craycombe Avenue	Baltimore	MD	21211-2238
809.	Susan	Levine	10204 Green Forest Drive	Silver Spring	MD	20903-1536
810.	Frank	Weisel	11055 Cedarwood Drive	North Bethesda	MD	20852-3400
811.	Ann	Andrews	407 Russell Ave., M805	Gaithersburg	MD	20877-2812
812.	JOAN	JOHNSON	370 CHERRY HILL RD	Elkton	MD	21921-2716
813.	Bruce	Strand	12712 Barbara Rd	Silver Spring	MD	20906-4250
814.	C.	Barton	517 KANSALA DRIVE	ANNAPOLIS	MD	21401-8101
815.	Alfred	Fisher	5404 Bucksaw Court	Columbia	MD	21044-5717
816.	Joe	DiMaggio	603 Valley Lane	Towson	MD	21286-7312
817.	David	Dittman	16965 Moss Meadow Way	Mount Airy	MD	21771-3502
818.	Evelyn	Miles	9226 throgmorton rd.	Parkville	MD	21234-1913
819.	brookieann	gregory	30055 charlotte hall	charlotte hall	MD	20622-3048
820.	Wade	Headley	10229 Green Clover Dr	Ellicott City	MD	21042-1615
821.	Bruce	White	9713 Greenel Road	Damascus	MD	20872-2301
822.	rolf	piekarz	1813 snowdrop lane	silver spring	MD	20906-3361
823.	Denise	Moses	po box 122	new windsor	MD	21776-0122
824.	Albert	Banwart	2980 Mourning Dove PL	Unit E		Waldorf
825.	Lester	LaForce	3941 Rickover Rd	Silver Spring	MD	20902-2328
826.	DEnise	Jones	8645 Glen Hannah Court	Windsor Mill	MD	21244-1107
827.	Irene	Tremper	5800 Swarthmore Dr.	College Park	MD	20740-2633
828.	Jerry	Booth	678 National Hwy.	Lavale	MD	21502-7226
829.	Irene	Marsh	4912 40th Place	Hyattsville	MD	20781-2103
830.	Janet	Graham	23542 Rolling Fork	Gaithersburg	MD	20882-2838

			Way			
831.	Elliott	Lehem	3714 Brentford Road	Randallstown	MD	21133-3705
832.	Patricia S.	Snowden	5145 Westbard Ave.	Bethesda	MD	20816-1413
833.	Frank	Watson	314 New York Ave.	Salisbury	MD	21801-3616
834.	David	Samuels	130 Slade Ave	Pikesville	MD	21208-4910
835.	Karen	Mitchell	11335 Little Patuxent Parkway	Columbia	MD	21044-3957
836.	Samuel	Day	20 Bon Oak Court	Reisterstown	MD	21136-1704
837.	Marie	Plante	9209 Topeka Street	Bethesda	MD	20817-3307
838.	Paul	Leuba	14240 Cuba road	Hunt Valley	MD	21030-1214
839.	Karen	Croce	3703 4th street	N. Beach	MD	20714-9731
840.	Toni	Marshall	275 Greenleaf Circle	Arnold	MD	21012-1938
841.	June	Krell	9413 Russell Rd	Silver Spring	MD	20910-1445
842.	John	Mazzullo	4248 Buckskin Lake Drive	Ellicott City	MD	21042-1254
843.	Jeffrey	Levitan	5510 Dowgate Court T-7	Rockville	MD	20851-2021
844.	Mary Xakellis	Chapman	6B Ridge Road	Greenbelt	MD	20770-1954
845.	David	Seidman	10601 Patternbond Terrace	Wheaton	MD	20902-4163
846.	kim	richardson	7885 gordon ct, apt 530	glen burnie	MD	21060-6203
847.	Richard	Gorman	11623 Deborah Drive	Potomac	MD	20854-3709
848.	Scott	Lawrence	6225 York Rd., Apt E313	Parkton	MD	21212-2616
849.	Barbara	Clary	5519 Jefferson Boulevard	Frederick	MD	21703-6942
850.	Phyllis	Fischer	104 Court St.	Farmington	ME	04938-5922
851.	Paul	Watkins	102 Thompson St	South Portland	ME	04106-3042
852.	Renee	Page	43 Northern avenue	Farmingdale	ME	04344-4501
853.	Margaret	Weeks	20 Willow Drive	Sanford	ME	04073-4459
854.	R	Cousins	95A MUNJOY ST	PORTLAND	ME	04101-4442
855.	nancy and george	rallis	81 ocean view rd	cape elizabeth	ME	04107-1343
856.	Franklin J.	Harte	38 High St.	Kennebunk	ME	04043-6932
857.	june	andresen	30 whitebirch ln#19	gorham	ME	04038-1526
858.	Joan	Willoe	21 Beech Hill Rd.	Northport	ME	04849-3200
859.	Mary Ann	Smale	37 Dyers Bay Rd.	Steuben	ME	04680-3110
860.	Kandis	Powell	4 East Presque Isle Road	Caribou	ME	04736-3673
861.	Bruce P.	Burnham	POBox 88	Alfred	ME	04002-0088
862.	Stewart	Libby	106 Hardy St	Presque Isle	ME	04769-3033
863.	Gail	O'Leary	157 Granite Street	Biddeford	ME	04005-4031
864.	Pete	Doanato	1504 E 11 Mile Rd	Royal Oak	MI	48067-2028
865.	Gordon	Thompson	9849 Towner Rd.	Portland	MI	48875-9409
866.	Tom	Ward	24712 Princeton	St. Clair Shores	MI	48080-1027
867.	Robert	Kull	3009 Mentel Rd.	Monroe	MI	48162-9312
868.	John	Scott	3000 Glenbrook Dr	Lansing	MI	48911-2341
869.	James	Corcoran	30877 Lee Frank	Madison Heights	MI	48071-2241
870.	Gary	Hornfeld	6655 Davis Rd.	Saginaw	MI	48604-9747

871.	Anca	Vlasopolos	820 Notre Dame	Grosse Pointe	MI	48230-1242
872.	edith louise	faller	27300 groveland	roseville	MI	48066-4336
873.	Steven	Anthony	30310 Vernon Drive	Beverly Hills	MI	48025-4939
874.	Art	Hanson	1815 Briarwood Dr.	Lansing	MI	48917-1773
875.	Thomas	Tomaszewski	19918 Maplewood	Livonia	MI	48152-2020
876.	Virginia	Gruse	9770 Houghton	Livonia	MI	48150-2430
877.	Howard	Palmer	295 Shadowlawn Drive	Inkster	MI	48141-3536
878.	Sharon	McGladdery	35310 Edythe Drive	Farmington Hills, MI	MI	48331-2025
879.	Julie	Skelton	40900 Bemis Rd.	Belleville	MI	48111-9159
880.	Erik	Ohrnberger	1556 Crimson Drive	Troy	MI	48083-5505
881.	Richard	VAN Dusen	8265 Burpee Rd.	Grand Blanc	MI	48439-7419
882.	John	Dadourian	15832 Kinloch	Redford	MI	48239-3861
883.	Michael	McManus	800 East Lincoln Ave. #5	Royal Oak	MI	48067-3349
884.	Jean	Ojeda	36818 Ladywood St	Livonia	MI	48154-1709
885.	Glenn	Callans	29292 Red Maple Dr	Chesterfield	MI	48051-2750
886.	Sally Shaheen	Joseph	6263 Stonegate Parkway	Flint	MI	48532-2150
887.	Ole	Kristensen	29731 Township Park Rd	Calumet	MI	49913-9115
888.	Gregory	Manore	2610 Yemans St	Hamtramck	MI	48212-4018
889.	Carole	LaVigne	3307 Pine Grove Dr	Midland	MI	48640-2373
890.	Wendell	messer	15341 sherwood lane	fraser	MI	48026-2306
891.	Andrew	Jones	5399 Chaison	Gladstone	MI	49837
892.	Art	Hanson	1815 Briarwood Dr.	Lansing	MI	48917-1773
893.	Stephen	ONeill	1879 Wexford Circle	Ypsilanti	MI	48198-3294
894.	joaquin	betancourt	713 dorroll ne	grand rapids	MI	49505-4206
895.	Jim	Nedeau	2278 Harding Ave.	Muskegon	MI	49441-1322
896.	Chad	Fordham	805 W 27Th Ave Apt B1	Sault Sainte Marie	MI	49783-9445
897.	sally	ziegler	36500 Marquette St #713	westland	MI	48185-3246
898.	Brian	Westphal	7913 Trotters Park Street	Ypsilanti	MI	48197-1870
899.	Richard	Walczyk	32179 Knapp	Warren	MI	48093-1083
900.	Patricia	Heethuis	2513 Cascade Creek Dr.	Jackson	MI	49203-3769
901.	cynthia	messina	8952 cribbins rd.	jeddo	MI	48032-8100
902.	Georgina	Stockton	250 Elm Ave.	Roscommon	MI	48653-9598
903.	James	Rindhage	2376 N. Vassar Rd.	Fairgrove	MI	48733-9759
904.	Linda	Sessine	6900 Post Oak Drive	West Bloomfield	MI	48322-3839
905.	James A	Clark Jr	500 East Fulton Street	Apt. 103		Grand Rapids
906.	william	burnett	3842 14th.st.	ecorse	MI	48229-1328
907.	Betsy	Gingerich	3912 Robin Lane	Kalamazoo	MI	49008-4113
908.	Bruce	Montney	232 N Avery	Waterford	MI	48328-2906
909.	Donna	Ferraro	185 Taos NE	Ada	MI	49301-8532
910.	Margaret	Novitski	1208 E. Preston Rd.	Mt. Pleasant	MI	48858-3927
911.	Chad	Halsey	709 South Johnson	Bay City	MI	48708-7627

Continued- Page 2:

Consumer Petition to the Centers for Medicare and Medicaid Services: Relating to the Suspension of Public Release of SIP-2 Measure (appropriate antibiotic selection for surgical prophylaxis:

I was disturbed to learn that CMS will not release all of the data collected on surgical site infection prevention to the public According to a recent study, surgeons give a preventive antibiotic before surgery in only about half of cases. Hospitals can address this with pre- and post-operative policies and procedures. I want to know which hospitals in my community excel in preventing surgical site infections using the three measures that experts have said are effective.

It sets a bad precedent to stop the release of this information at a time when the public is demanding more information about hospital infections in this country, not less.

I urge you to release information about all three infection prevention measures you have collected to the public.

999.	Arthur	Schilhab	5721 Hawthorne Dr	House Springs	MO	63051-2282
1000.	Charles	Watters	1615 Hawthorne	Pacific	MO	63069-1847
1001.	Harold	JOHNSON	PO Box 93	Savannah	MO	64485-0093
1002.	David	Bell	914 Strode	Independence	MO	64050-3121
1003.	Larry	Burrows	3523 E. Cinnamon Pl	Springfield	MO	65809-2011
1004.	Katherin	Weiss	2101 ladnier rd lot 129	gautier	MS	39553-6918
1005.	Eles	Renfroe	6781 Hwy 481 South	Morton	MS	39117-9128
1006.	Wayne	Johnson	1041 Hillshire Drive	Mc Comb	MS	39648-7570
1007.	Richard	Wojtowicz	119 N. 9th Ave.	Bozeman	MT	59715-3323
1008.	Hank	Slosson	504 Pine St	Anaconda	MT	59711-2845
1009.	Bob	Nichol	1615 S. Black	Bozeman	MT	59715-5785
1010.	George	Slater	1100 Avenue D N.W.	Great Falls	MT	59404-1740
1011.	Cheryl	Kindschy	945 Montanaave-#302	Helena	MT	59601-7932
1012.	Vicki	Hoyt	280 Shelter Valley Drive	Kalispell	MT	59901-7589
1013.	Ruth	Kotaki	820 11th Av No	Glasgow	MT	59230-1509
1014.	Randy	Norley	2900 Sherman Avenue	Butte	MT	59701-4221
1015.	Deborah	Fox	102 Balboa Court	New Bern	NC	28560-8418
1016.	Juan	Vega	2512 Foxworth Dr	Monroe	NC	28110-8900
1017.	Ed	Norman	3005 Huntley St.	Spring LAke	NC	28390-1615
1018.	Barbara	Rabinowitz	122 woodglen dr.	cary	NC	27511-8606
1019.	Jean	Reed	10240 Withers Road	Charlotte	NC	28278-6834
1020.	Sam	Cook	PO Box 487	Montreat	NC	28757-0487
1021.	Thomas J.	Strini	4201 Singletree Rd	Mint Hill	NC	28227-9282
1022.	Richard	Hicks	2930 Eddystone Ln	Winston Salem	NC	27103-5422
1023.	Nancy	Bauman	505 Booth Road	Chapel Hill	NC	27516-9649
1024.	Jennifer	Pohlhaus	1612 Valley Run	Durham	NC	27707-3668

1025.	Mary	Rand	1205 Old Coats Rd	Lillington	NC	27546-7842
1026.	Janice	Phillips	931-B South Main Street, #344			Kernersville
1027.	Joe	Phillips	P. O. Box 282	Colfax	NC	27235-0282
1028.	Steve	Plante	3052 Rambling Hills Drive	Morrisville	NC	27560-9304
1029.	Michael	Procton	420 Edgedale Dr.	High Point	NC	27262-2908
1030.	Martha	Halyburton	142Forest Acres Lane	Taylorsville	NC	28681-3444
1031.	Bruce	Blacknight	1160 High Rock Mtn. Rd.	Marshall	NC	28753-5382
1032.	Peter	Jack	106 Old Cabin Lane	Kernersville	NC	27284-3420
1033.	Robert	Mason	2029 Millikan Road	Chapel Hill	NC	27516-7402
1034.	Wilfred	Robin	549 11th Ave. Cir. Nw	Hickory	NC	28601-3627
1035.	Michael	Wechter	15 Poplar Forest Road	Fairview	NC	28730-7625
1036.	Bob	Wood	219 Bremen Drive	Lexington	NC	27295-1103
1037.	Thomas	Boyd	PO Box 788	Hendersonville	NC	28793-0788
1038.	Herbert J	Keeler	5117 Mockingbird Rd	Greensboro	NC	27406-9421
1039.	marsha	williams	po box 124	rodanthe	NC	27968-0124
1040.	Tony	D'Andrea	225 White Crane Rd	Salisbury	NC	28146-1415
1041.	Robert	Reiff	1045 Bartlette Rd	Marion	NC	28752-5081
1042.	Viola	Moore	2547 Vestal Avenue	Fayetteville	NC	28301-2443
1043.	Francis	Symmes	1207 Clipper Lane	Wilmington	NC	28405-4146
1044.	Joseph	Phillips	5380 Brittainywood Road	Kernersville	NC	27284-9693
1045.	David	Hock	40 Coral Ridge Circle	Franklinton	NC	27525-8045
1046.	patricia	silinski	724 clifden dr	matthews	NC	28104-7003
1047.	Earl	Kawales	132 Mountain Circle	Franklin	NC	28734-1705
1048.	Denise	O' Connor	824 Mockingbird Ct.	Apex	NC	27502-2067
1049.	Mark	Rosenfeld	414 Center Pointe Drive	Cary	NC	27513-5728
1050.	Robert	Schlagal	365 Highland Ave	Boone	NC	28607-4611
1051.	Marcia	Bailey	1270 Cabbage Patch Rd.	Burnsville	NC	28714-7321
1052.	Holly	Shuffler	4993 Lakeview Acres Road	Valdese	NC	28690-9662
1053.	Rolland H.	Bushner	326 Erskine Rd	Tryon	NC	28782-2661
1054.	Edward	Kurtz	20 S Wildwood Lane	Fletcher	NC	28732-9545
1055.	Mary M.	Owen	79 carver mtn valley	Sylva	NC	28779-9402
1056.	Rodney	Fongemie	1709 Chateau Circle	Sanford	NC	27332-8302
1057.	Laura	Fitzpatrick	3612 Briarthorne Dr	Charlotte	NC	28269-1273
1058.	Rachel	Penix	70-4 summit hill dr	franklin	NC	28734-2753
1059.	Steve	West	2710 Briarcliff Place	Charlotte	NC	28207-2648
1060.	John	Alexander	1407 Florida Street	Gastonia	NC	28052-0723
1061.	Sarah	Palmer	923 Edith St.	Durham	NC	27705-4108
1062.	Brent	Lawrence	404 Thornwood Dr.	Jamestown	NC	27282-9434
1063.	David	Schickedantz	105 Ravens Bluff Ct.	Browns Summit	NC	27214-9108
1064.	Todd	O'Buckley	2572 Barwick Dr.	Durham	NC	27704-4006
1065.	Michael	Johnson	8738 Pinnacle Cross Drive	Huntersville	NC	28078-2701
1066.	Robert	McCormick	531 N. Gurney St.	Burlington	NC	27215-4819
1067.	Kay	Blevins	8709 Chesley Ct.	Raleigh	NC	27613-4313

1068.	Louise	Koslofsky	8300 Bromley rd	Hillsborough	NC	27278-8014
1069.	L.	Phipps	4228 Glen Erin Way	Raleigh	NC	27613-4236
1070.	Wells	Eddleman	811 Yancey Street	Durham	NC	27701-3151
1071.	EUGENE	OBRIEN	106 Blue Ridge Court	Durham	NC	27703-9353
1072.	Amy C	Whitfield	1230 Treybrooke Circle	Greenville	NC	27834-9157
1073.	Roland	Neal	4172 Craven Pines Rd.	Sophia	NC	27350-8058
1074.	Janet	Peele	P O Box 366	Aberdeen	NC	28315-0366
1075.	Deborah	Christie	17 Stoneridge Circle	Durham	NC	27705-5510
1076.	Michele	Sinclair	837 Prospect Ave.	Grafton	ND	58237-1655
1077.	Ray	Mihulka III	5120 N86th St	Omaha	NE	68134-2814
1078.	Margery	Coffey	205 Farley Ave.	Rosalie	NE	68055-4013
1079.	Cynthia A.	Zurmuhlen	1502 Cobblestone Lane	Bellevue	NE	68005-6709
1080.	Mary Catherine	Haftings	510 S 35th St #2	Omaha	NE	68105-1294
1081.	Thurman	Williams	10526 Ellison Plaza Apt. 1	Omaha	NE	68134-1135
1082.	claude	Hidy	p.o.box 222	stratton	NE	69043-0222
1083.	Arturo	Gonzalez	4962 South 194th Avenue	Omaha	NE	68135-3571
1084.	Evelyn	Fink	6510 S. 41st St	Lincoln	NE	68516-2906
1085.	Brian	Napier	11 Beacon Street Apt. # 4	Concord	NH	03301-4441
1086.	Mary	Cambal	37 Arundel Road	Peterborough	NH	03458-1600
1087.	James N	Bannister	851 Rt 63	Westmoreland	NH	03467-4224
1088.	David	Scott	PO Box 125	Warner	NH	03278-0125
1089.	albert	perreault	po box 714	manchester	NH	03105-0714
1090.	Gene	Poire	401 Ledgeview Dr.	Gonic	NH	03839-5625
1091.	Kevin	Karcz	32 Poor Farm Road	Nottingham	NH	03290-5404
1092.	Robert	Griffon	116 westwood dr.	manchester	NH	03103-6138
1093.	Richard	Maynard	29 Prospect St 1L	Manchester	NH	03104-3523
1094.	William	Bennett	87 South Road	North Hampton	NH	03862-2009
1095.	Michael	Letendre	92 Cass St. #1	Portsmouth	NH	03801-4941
1096.	carol	knieriem	1500 Union St	Manchester	NH	03104-1845
1097.	Betty	Gay	10 Woodmeadow	Salem	NH	03079-2336
1098.	Sandy	Guldin	948 Lois Drive	Williamstown	NJ	08094-1338
1099.	Ann	Rea	197 Christopher St.	Montclair	NJ	07042-4205
1100.	Sam	glucksberg	29 Bainbridge Street	Princeton	NJ	08540-3901
1101.	Pat	Pire	18 Beach Place	Maplewood	NJ	07040-1241
1102.	Nikki	Taussig	233 Harrison Ave	Highland Park	NJ	08904-1815
1103.	Rheta	Johnson	12 Scherer Ct	Lawrenceville	NJ	08648-2640
1104.	Michela	Colosimo	60 Oakhurst Lane	Mount Laurel	NJ	08054-3158
1105.	randy	russell	399 westminster pl	lodi	NJ	07644-1218
1106.	Robert	Armstrong	287 Elmwood Ct.	Howell	NJ	07731-3020
1107.	Denise	Lytle	73 Poplar St.	Fords	NJ	08863-1836
1108.	Nancy	Ashton	108 Briarcliff Ct	Haddonfield	NJ	08033-2504
1109.	Ellen	Mendelsohn	183 Bergen Avenue	New Milford	NJ	07646-2805
1110.	J Patrick	Carpenter	11 Armstrong Drive	Moorestown	NJ	08077-4529
1111.	Patricia	Snover-Postma	4113 Ravens Crest	Plainsboro	NJ	08536-2422

			Dr.			
1112.	joan	adams	1 oakdale drive	middletown	NJ	07748-2122
1113.	ROBERT	ANDERSON	617 RIVERSIDE AVE.	TOMS RIVER	NJ	08757-1007
1114.	Abdur-Rahim	Rasheed	4404 Norma Pl	Toms River	NJ	08755-1051
1115.	Gordon	Snyder	66 Glattly Drive	Denville	NJ	07834-3837
1116.	Robert	Monda	27 Heckel St	Belleville	NJ	07109-1028
1117.	Carolyn	Johnson	72 Patricia Avenue	Colonia	NJ	07067-1815
1118.	G.	Konecky	350 Plaza Road North	Fair Lawn	NJ	07410-3640
1119.	RIchard	Anderson	207 Goat Hill Rd	Lambertville	NJ	08530-2609
1120.	Nancy	Keegan	15 Beechwood Rd	Florham Park	NJ	07932-2802
1121.	James	LaRegina	322 Richard Mine Road, #C-6	Wharton	NJ	07885-1805
1122.	diana	obal	54 skidmore road	Freehold	NJ	07728-7867
1123.	Katharine	Emory	89 Wood Place	Bloomingdale	NJ	7403
1124.	Andre	Drabyk	86 Livingston Ave	Edison	NJ	08820-2214
1125.	ELLIOT B	HUNT	5 MADISON ST	Newton	NJ	07860-2006
1126.	Cassandra	Lajeskie	830 Georges Rd.	Monmouth Jct	NJ	08852-3058
1127.	William	O'Brien	22 Hedgewood Road	Howell	NJ	07731-2205
1128.	Zoe	Beale	77 s. main st.	lambertville	NJ	08530-1826
1129.	lillian	ferracone	184 mansgrove road	princeton	NJ	08543-7584
1130.	Donald	Jamison	10 Third St	Freehold	NJ	07728-2461
1131.	Robert	Herbert	47 Tall Pines Dr.	Neptune	NJ	07753-3173
1132.	Charles	Klein	29 Sherborne Street	Somerset	NJ	08873-4642
1133.	Joshua	Maizel	120 Davis Lane	Red Bank	NJ	07701-5536
1134.	Raymond	Meehan	12 Hickory Drive	Stanhope	NJ	07874-2808
1135.	Janis	Townsend	27 Andrea Drive	North Caldwell	NJ	07006-4730
1136.	Laurel	Kornfeld	106 North Sixth Avenue	Highland Park	NJ	08904-2938
1137.	Michael	Wisher	63 Parkside Circle	Willingboro	NJ	08046-2610
1138.	Donald	Kuna	27 Buffa Drive	Somerset	NJ	08873-2752
1139.	Ralph	Lopez	32 CUTLER ROAD	MORRIS PLAINS	NJ	07950-1860
1140.	Carol	Sneath	2147 S Olden Ave	Trenton	NJ	08610-1814
1141.	Carolyn	Kohn	18 Van Beuren Rd	Morristown	NJ	07960-7025
1142.	Matthew	Baldassano	624 Bedford Lane	Manchester	NJ	08759-4646
1143.	Phyllis	Warren	17 Merritt Dr	Lawrenceville	NJ	08648-3131
1144.	john	hughes	237 wave rd	manahawkin	NJ	08050-1709
1145.	R.	Kelly	25 Grand Ave.	Hackensack	NJ	07601-4619
1146.	Hugo	Rojas	22 Berlant Ave.	Linden	NJ	07036-3670
1147.	James	Campbell	13 Pinewood Dr	Englishtown	NJ	07726-1810
1148.	Donald	Borg	36 Crestview Dr.	Princeton	NJ	08540-7618
1149.	George	Colbert	38 Granby Lane	Willingboro	NJ	08046-3224
1150.	Shulamit	Lazarus	25 osborne street	Bloomfield	NJ	07003-2714
1151.	Tom	Williams	56 Sunset Drive	Mount Holly	NJ	08060-1915
1152.	Ann	Li	71 South Monroe Street	Ridgewood	NJ	07450-3734
1153.	Joe	Romero	7542 Park Ave	Pennsauken	NJ	08109-3016
1154.	Erica L.	Ahrens	4 Hanover Street	Pemberton	NJ	08068-1106
1155.	Elizabeth	Callery	27 liberty drive	Dayton	NJ	08810-1612
1156.	Alan	Chernin	41 Highview Rd	Caldwell	NJ	07006-5501

1157.	Joan	Carpenter	27 Portsmouth Drive	Toms River	NJ	08757-6635
1158.	Martin	Wolff	1028 Carnation Dr	New Milford	NJ	07646-2508
1159.	Anthony	Ivankovic	17 Jerome Place	Wayne	NJ	07470-3007
1160.	Oswaldo	Carrion	72 Dorothea Ter	Belleville	NJ	07109-1516
1161.	Geo	Costello	49 Jennifer La.	Burlington	NJ	08016-1144
1162.	Joan	Grant	233 Canal Way	Hackettstown	NJ	07840-1274
1163.	Paul	Netusil	9 Lachmund Court	Old Tappan	NJ	07675-7237
1164.	Roy	Wallace	18 Cranbury Neck Rd.	Cranbury	NJ	08512-2810
1165.	Mary Ann	Cappel	9 Waltham Way	Sicklerville	NJ	08081-9321
1166.	Elyn	Carlock	71 Lowell Avenue	West Orange	NJ	07052-3709
1167.	Beverly	Solomon	582 Jobel Dr	Haddonfield	NJ	08033-1034
1168.	David	Brewer	828 Hudson St. #1	Hoboken	NJ	07030-5037
1169.	Kathleen	Tortora	405--31 Franklin Turnpike	Mahwah	NJ	07430-2222
1170.	Marc	Weuste	436 Taylor Ave	hackensack	NJ	07601-6509
1171.	Raul	Pascual	702 Monmouth Rd	Wrightstown	NJ	08562-2416
1172.	James	Sabanskas	24 Florence Ave.	Leonardo	NJ	07737-1015
1173.	Jack	Holodak	2 Mistletoe Drive	Matawan	NJ	07747-3716
1174.	Ron	Chaplin	72 West Edward Street	Iselin	NJ	08830-1149
1175.	fran	schneider	1328 Taft Rd	Teaneck	NJ	07666-2827
1176.	Althea	Peterson	10 Kipp Ave	Elmwood Pk	NJ	07407-1009
1177.	Jennifer	Tjoumakaris	736 Central Ave.	Ocean City	NJ	08226-3723
1178.	Joan	Carpenter	27 portsmouth dr	TOMS RIVER	NJ	08757-6635
1179.	nita	hollander	11 f lincoln place	north brunswick	NJ	08902-4034
1180.	Lita	Cohen	541 Highland Ave	Montclair	NJ	07043-1203
1181.	Philip	Bachman	1 Arbutus Way	Monmouth Junction	NJ	08852-2744
1182.	Joseph	Autore	41 Mary Ave 2nd Fl	West Paterson	NJ	07424-2858
1183.	Jan	Robbins	342 Rileyville Rd.	Ringoes	NJ	08551-1501
1184.	rosalyn	frunzi	44 bartsch ave	west paterson	NJ	07424-2927
1185.	virginia	Kirchoff	465 lincoln ave	Wyckoff	NJ	07481-3022
1186.	Maria	Lisath	463 West South Orange	Avenue		South Orange
1187.	Dean	Smith	36 Dutch Valley Rd	Howell	NJ	07731-2302
1188.	Samuel	Brody	18A West Hamilton place	Jersey City	NJ	07302-1608
1189.	bolinda1@juno.c	Kahn	475 Northam Drive	North Brunswick	NJ	08902-4243
1190.	Michael	San Jose'	543 Park Ave	Cliffside Park	NJ	7010
1191.	Dawn	Walker-Cinco	101 hobart avenue	Bayonne	NJ	07002-4207
1192.	Cheri	Dzubak	69 Elton Avenue	Yardville	NJ	08620-1531
1193.	Joseph	Ponisciak	30 Nottingham Dr.	Willingboro	NJ	08046-1924
1194.	Linda	Gianni	135 Stickles Pond Road	Newton	NJ	07860-2778
1195.	Janet	Unger	21 Forestdale Rd	Kinnelon	NJ	07405-2558
1196.	jon	rosenblatt	1110 Charter St	Piscataway	NJ	08854-3308
1197.	DENNIS	Keener	11 Pine Road	Medford	NJ	08055-8155
1198.	Martin	Wolff	1028 Carnation Dr	New Milford	NJ	07646-2508
1199.	arnold & dr maxine	lehrer	associnpsychotherapy	scotch plains	NJ	07076-4664

1200.	Karen R.	Searle	22 Windsor Way	Berkeley Heights	NJ	07922-1857
1201.	Andrew	Colletto	po box 1342	somerset	NJ	08875-1342
1202.	John	Smith	427 woodbine ave	Westville	NJ	08093-1039
1203.	RJ	Legge	24 Jones Street	Jersey City	NJ	07306-3103
1204.	Carol	Behrens	290 Asbury West Portal Rd	Asbury	NJ	08802-1129
1205.	Robert	Groom	618 Guilford Road	Cherry Hill	NJ	08003-1446
1206.	Basilia	Azcona	2049 Barnsboro road	Blackwood	NJ	08012-2524
1207.	Neil	Haymes	526 Fairway Road	Ridgewood	NJ	07450-3536
1208.	James	Hall	55 First St	Keyport	NJ	07735-1501
1209.	Patricia	Knudsen	153 Division St.	Keyport	NJ	07735-1538
1210.	Norma	Vlahides	537 Highland Avenue	Upper Montclair	NJ	07043-1203
1211.	Barry J.	Wilcox	P.O. Box 392	Trenton	NJ	08603-0392
1212.	David	Stupin	51 Vista Redonda	Santa Fe	NM	87506-9471
1213.	Christina	Maris	7553 Isleta Boulevard SW #1	Albuquerque	NM	87105-8213
1214.	Milton	Moomaw	92 Calle Sinsonte	Santa Fe	NM	87507-0103
1215.	Roslyn	Pulitzer	2742 La Silla Dorada	Santa Fe	NM	87505-6703
1216.	Douglas	Kurtz	4915 Chippewa Trail	Las Cruces	NM	88011-9311
1217.	Judith	Shipsky	12200 Academy Rd NE	Albuquerque	NM	87111-7251
1218.	Carter	Beckett	760 Placita Santa Fe	Santa Fe	NM	87505-4543
1219.	Joan	Earnshaw	Box 502	La Plata	NM	87418
1220.	Larry	Rouse	7032 Oersted Rd NE	Rio Rancho	NM	87144-6512
1221.	Tom	Ruhl	2884 West Island Loop	Rio Rancho	NM	87124-8109
1222.	Terry	MacDonald	2 Windsong Rd	Edgewood	NM	87015-6971
1223.	ernest	huerta	p.o. box 207	hurley	NM	88043-0207
1224.	Gretchen	A. Byrne	12625 Singing Arrow Ave. SE	Albuquerque	NM	87123
1225.	Stusrt & Jeanne	Klein	5304 Dee Drive NE	Albuquerque	NM	87111-1906
1226.	David	Kozlowski	528 Calle Corvo	Santa Fe	NM	87501-2711
1227.	Joel	Hobbs	1706 Lead Se	Albuquerque	NM	87106-4436
1228.	Harry	Smith	6905 Leander Ave NE	Albuquerque	NM	87109-6919
1229.	Stephanie	Morimoto	651 Canyon Road	Santa Fe	NM	87501-2721
1230.	Arthur	Troum	9613 Parsifal Place, NE	Albuquerque	NM	87111-4754
1231.	Lauri	Peacock	718 N. Burk Street	Hobbs	NM	88240-4936
1232.	Robert/Rose Mar	Stearns	329 Sena St.	Santa Fe	NM	87505-8869
1233.	Devaraj	Aran	3016 San Joaquin Ave. SE	Albuquerque	NM	87106-2343
1234.	Pamela	Clark	13170 Central Ave SE Ste B # 162			Albuquerque
1235.	David	Stupin	51 Vista Redonda	Santa Fe	NM	87506-9471
1236.	William	Hudgins	315 Andanada St.	Los Alamos	NM	87544-2405
1237.	Elinor	Zind	P O Box 805	Santa Teresa	NM	88008-9300
1238.	Janne	Bagley-Murray	4749 Trumbull S.E.	Albuquerque	NM	87108-3550
1239.	Bernard	Deutscher	8935 Manalang Road	Las Vegas	NV	89123-0623
1240.	Marlys	Johnston	6205 Eagle Crossing	Las Vegas	NV	89130-7283

			St.			
1241.	Emily	Smith	1926 Villa Way South	Reno	NV	89509-5828
1242.	Norman	Cosman	1703 Flat Ridge Rd.	Henderson	NV	89014-6036
1243.	Roger	Overholt	1723 Bougainvillea Drive	Minden	NV	89423-5107
1244.	William	M Seyfried Jr	4355 S. Durango Dr. #169	Las Vegas	NV	89147-8633
1245.	Brian & Rita	Cohen	4408 Live Oak Drive	Las Vegas	NV	89121-5731
1246.	Douglas	Albro	P.O. Box 5565	Sparks	NV	89432-5565
1247.	Maureen	Fahlberg	1735 Teakwood St.	Boulder City,	NV	89005-2052
1248.	Philip	Brenner	9289 Scenic Mountain Ln	Las Vegas	NV	89117-6401
1249.	Norman	Reuter	PO Box 5253	Incline Village	NV	89450-5253
1250.	Truman	Gleason	P O Box 2930	Pahrump	NV	89041-2930
1251.	George	Davis	3700 Stewart Ave. sp179	Las Vegas	NV	89110-3118
1252.	Patricia	Montgomery	7901 Gothic Ave.	Las Vegas	NV	89117-1345
1253.	Franklin C.	Richard	336 Century Drive	Las Vegas	NV	89110-3253
1254.	Trebor	Gibson	2312 N. Green Valley Pkwy., #2415			Henderson
1255.	Linda	Cox	5824 Madre Mesa Dr.	Las Vegas	NV	89108-3627
1256.	Lisa	Printz	917 Bell St.	Reno	NV	89503-2831
1257.	Bill	Grant	7035 Acorn Ct	Las Vegas	NV	89147-4711
1258.	dawn	carroll	213 n huron ave	Syracuse	NY	13209-1117
1259.	Carlos	Miranda	4570 manhattan college	parkway		bronx
1260.	Patricia	Goldsmith	171 Brighton Blvd	Island Park	NY	11558-2005
1261.	Lois	Sullivan	402 E 65 ST #5A	NY	NY	10021-7110
1262.	dena	lenard	500 Grand St	New York	NY	10002
1263.	Amy	Stoller	63 Downing St.	New York	NY	10014-4331
1264.	Melissa	Lemke	533 Glen Street	Glens Falls	NY	12801-2206
1265.	Dagmar	Boek	1 Raymond Drive;	Woodstock	NY	12498-1730
1266.	steven	goldman	250 e 63 st	new york	NY	10021-7661
1267.	Stephen	Luchs	6801 Bay Parkway	Brooklyn	NY	11204-5503
1268.	Joanne	Zipay	37 Creamery Drive	New Windsor	NY	12553-8011
1269.	Marc	Garber	336 W. 88th St., 2F	New York	NY	10024-2249
1270.	Walt	Rappeport	257 W. 91 Street #1R	New York	NY	10024-1155
1271.	Linnea	Hartmark	3571 Lydius Street	Schenectady	NY	12303-3552
1272.	Walter	Marzinsky	7 Rich Drive	Wappingers Falls	NY	12590-4620
1273.	Rev. Marlena	Mallner	501 West 110th Street	New York	NY	10025-2000
1274.	Rosaria	Tierney	418 Palmer Road	Yonkers	NY	10701-5251
1275.	jay	diaz	817 imperial way	bayport	NY	11705-1529
1276.	Steven	Leiffer	82-93 116th Street	Kew Gardens	NY	11418-3428
1277.	Anthony	Spinello	42 maple drive	Great Neck	NY	11021-1240
1278.	Richard	Mercado	14 Johns Road	Middletown	NY	10941-1104
1279.	Kim	Mills	12 Hamilton	Troy	NY	12183-1305
1280.	Marie	Gutkowski	60-68 69th Avenue	Ridgewood	NY	11385-5154
1281.	Susan	Kulis	175-06 Devonshire Rd	Jamaica Estates	NY	11432-2949
1282.	Chris	Schuhmacher	186 Laurelton Drive	Mastic Beach	NY	11951-5315

1283.	Rosemary Boyd	Parker	36 Leland Road	Rochester	NY	14617-3406
1284.	Gerryl E.	Puelle	540 East 20th Street, #9B	New York	NY	10009-1334
1285.	Mark	Nazimova	558 11 Street Apt. 2B	Brooklyn	NY	11215-4351
1286.	Gregory	Nerode	406 Cayuga Heights Road	Ithaca	NY	14850-1402
1287.	james	boland	1021 baldwin path	dix hills	NY	11746-8138
1288.	cAROL	DOBSON	2130 Broadway	New York	NY	10023-1724
1289.	Robert	Wood	135 Stillwell Ave	Kenmore	NY	14217-2123
1290.	Laura	Silverman	30 Rose Road	West Nyack	NY	10994-2116
1291.	Raymond	Ford	125 West 96th Street	New York	NY	10025-6422
1292.	Sasha	Silverstein	235 Lincoln Place	Brooklyn	NY	11217-3747
1293.	Adam	Kaufman	1 Broad Parkway	White Plains	NY	10601-3733
1294.	Marilyn	DuBois	4484 Ridge Rd.2	Scotia	NY	12302-6120
1295.	Michele	Hungiville	5235 Oakridge Drive	Hamburg	NY	14075-4017
1296.	Robert	Jacobson	342 Dean Street	Brooklyn	NY	11217-1905
1297.	Lynn	Coffey-Edelman	27 Foxwood Drive East	Huntington Station	NY	11746-2128
1298.	Noel Shapard	Dowling	545 West 111th Street	New York	NY	10025-1982
1299.	J.	Capozzelli	315 W. 90 St.	New York	NY	10024-1646
1300.	Herman	Berliss, MD	22 Graycliff Drive	Elmira	NY	14903-7971
1301.	Carolyn	Kalmus	346 W. 56th St. #4-D	New York	NY	10019-4278
1302.	Elaine K.	Harris	29 Gateway Drive	Great Neck	NY	11021
1303.	Bonnie	White	153 rosemont avenue	farmingville	NY	11738-2047
1304.	Anne	Hughes	37 Laurel Drive	Smithtown	NY	11787-3906
1305.	Ellen	Sicignano	125 Brimstone Road	Patterson	NY	12563-2106
1306.	Adele	Bender	99-44 67 Rd	Forest Hills New York	NY	11375-3049
1307.	Kateri	Kosek	420 Route 82	Hopewell Jct.	NY	12533-3610
1308.	David	Lewitzky	24 Norwood Ave. Apt. 4	Buffalo	NY	14222-2104
1309.	Barry	Spielvogel	435 E. 79 St. Apt. 11-O	New York	NY	10021-1078
1310.	LOUIS	BREITBACH	228DELAWAREAVE	MASSAPEQUA	NY	11758-1826
1311.	David	Buck	56A Pond Way	Staten Island	NY	10303-1648
1312.	Irene	Rubner	15 Maple St.	Westfield	NY	14787-1014
1313.	Jonathan	Nash	500 East 83rd Street, #10B	New York	NY	10028-7246
1314.	Wallace & Cathleen	Lambie	5535 Trinity Ave	Lowville	NY	13367-1425
1315.	Werner	Mayer	26 Eklund Blvd.	Nesconset	NY	11767-3115
1316.	Nedenia	Martinez	318 East 89th Street	New York	NY	10128-4518
1317.	Elizabeth	McSweeney	844 Plandome Rd	Manhasset	NY	11030-1302
1318.	Marianne	Bongolan	69 Wiman Avenue	Staten Island	NY	10308-3255
1319.	Sandra F.	Kaplan	782 West End Avenue	New York	NY	10025-5446
1320.	Robert	Miller	19 Suzanne Lane	Chappaqua	NY	10514
1321.	Lynda	Leibowitz	57 Crows Nest Rd. Apt. 3	Tuxedo Park	NY	10987-4265
1322.	Robert	Gordon	78 California Street	Long Beach	NY	11561-1607

1323.	Michael	Keegan	4375 Stonomgton Cr	Syracuse	NY	13215-1579
1324.	Jack David	Marcus	215 West 92nd Street Apt. 15E			New York City
1325.	richard	fedrow	11 kristi drive	jericho	NY	11753-1309
1326.	Martin	Scher	1475 East 31st Street	Brooklyn	NY	11234-3401
1327.	Joseph	Sameh	43-19 41 Street	Sunnyside	NY	11104-3347
1328.	Patrick	St.Amand	764 Trimmer Rd	spencerport	NY	14559-9569
1329.	Valerie	Drake	244 Dorking Road	Rochester	NY	14610-2725
1330.	Sharon L.	McMenamin	72-30 Kessel Street	Forest Hills	NY	11375-5934
1331.	JEFF	COSTELLO	164 MANILA AVE	STATEN ISLAND	NY	10306-5608
1332.	Margot	VanEtten	437 Upper Valley Road	Rochester	NY	14624-2310
1333.	June	Veloce	18 caldwell road	patterson	NY	12563-1246
1334.	Lynda	Naclerio	2913 Fenton Ave	Bronx	NY	10469-5505
1335.	John	Weisenberger	8 Puckey Drive	Cortlandt Manor	NY	10567-6206
1336.		Anonymous			NY	10024
1337.	William	Young	221 Sunnyside Road	Kinderhook	NY	12106-2910
1338.	John	Makowiec	24 Sunset Road	Wellsburg	NY	14894
1339.	Howard	Keyton	7875 Debusse Road	Lyons	NY	14489-9143
1340.	Stephen	DeGobbi	450 Beach 44th St	Far Rockaway	NY	11691-1220
1341.	Michael	Patrey	1 Cornell Place	Great Neck	NY	11020-1103
1342.	David	Rainbeau	17 N HIGHLAND PL	CROTON ON HUDSON	NY	10520-2013
1343.	Stanley	Becker	370 West Broadway, Apt. 3C	Long Beach	NY	11561-3915
1344.	Claude	Morgan	215 Route 31	Glen Spey	NY	12737-5852
1345.	Alan	Teig	47 Greycourt Rd	Chester	NY	10918-4507
1346.	Raymond	Chu	8060 GINGER RD	LIVERPOOL	NY	13090-2017
1347.	Angie	Viscione	18 Duncan Street	Staten Island	NY	10304-3104
1348.	Gladys Marie	Dina	102-40 62 avenue	Forest Hills	NY	11375-1058
1349.	Christine	Georgiou	3145 Sands Place	Bronx	NY	10461-4611
1350.	Diane	Parrish	7826 Keppogg St.	Clinton	NY	13323
1351.	Richard	Oldham	39 Madison St	Mastic	NY	11950-3532
1352.	roberta	bunsick	131 east 29th st #2	new york	NY	10016-8101
1353.	Liana	Halliman	10610 Hanover Rd.	Forestville	NY	14062-9546
1354.	Heidi	Ying	512 REYNOLDS RD	JOHNSON CITY	NY	13790-1219
1355.	Robert	Gunther	507 Moffitt Blvd	Islip	NY	11751-3020
1356.	Lisa	Cohen	179 Old Post Road North	Croton Hdsn	NY	10520-1931
1357.	Thomas	Kilcoyne	72 Devonshire Drive	Guilderland	NY	12084-9449
1358.	Patrick	Connolly	89-20 117th Street	Richmond Hill	NY	11418-3111
1359.	Merri	Vogel	86-09 63 Drive	Rego Park	NY	11374-4825
1360.	Deanna	Davis	608 Grand St	Brooklyn	NY	11211-4802
1361.	Barbara	Metivier	7702 Back Creek Rd.	Hamburg	NY	14075-7204
1362.	Carol	Evans	63 Montebello Commons Drive			Suffern
1363.	Gennaro	Gargano	23 Dewey Ave	Mechanicville	NY	12118-2108
1364.	DONALD	WINNIE 3	P.O. BOX 314	HUDSON	NY	12534-0314
1365.	Barbara	Gunther	286 Bayport Avenue	Bayport	NY	11705-1853

1366.	Marlene	Rennert	225 Frank Avenue	Mamaroneck	NY	10543-2811
1367.	Frank V	Cassano	232 north 5th ST	Lindenhurst	NY	11757-3732
1368.	Robert	Sholtez	6705 Wellington Dr	Derby	NY	14047-9308
1369.	Andrea	Pennisi	p.o. box 20414	NYC	NY	10009-8960
1370.	achilles	petromelis	1 rack lane	east setauket	NY	11733-3416
1371.	marie	Gorsline	1700 York Avenue	NY	NY	10128-7814
1372.	Rachel	Stone	50-25 39th Street	Sunnyside	NY	11104-4507
1373.	julia L.	bonsignore	190 ascan ave	forest hills	NY	11375-5947
1374.	John	Davidson	278 Patent Rd.	Hartwick	NY	13348-2323
1375.	Robert	Murphy	269 Westwood Road	Lancaster	NY	14086-9540
1376.	Susan	Smith	1 Water St.	New Paltz	NY	12561-2302
1377.	John	Hyslop	89-15 89th St.	Woodhaven	NY	11421-2533
1378.	Susan	Montemorano	11 Galileo Court	Suffern	NY	10901-1901
1379.	Laura	Napoleon	252-30 58 Ave	Little Neck	NY	11362-2114
1380.	Lynda R.	DeRigge	504 Palomino Manor	Elmira	NY	14901-9504
1381.	MERRYL	ROSENTHAL	190 WESTMINSTER ROAD	BROOKLYN	NY	11218-3444
1382.	Joy	Roelfs	460 Old Town Rd 15H	Port Jefferson Station	NY	11776-2247
1383.	Joan	Abruzzo	18-15 215 St.	Bayside	NY	11360-2132
1384.	Richard	Karpe	25 East 10th Street	New York	NY	10003-6109
1385.	David	Randall	5 Longacre Court	Port Jefferson	NY	11777-1320
1386.	Henry	Buser	217 Rogers St	Ulster Park	NY	12487-5016
1387.	MARGARET	GIORDANO	241 PELTON AVE	STATEN ISLAND	NY	10310-1537
1388.	Linda	La Rocca	60 TAUNTON ST	STATEN ISLAND	NY	10306-3653
1389.	Vicki	Casarett	107 French Rd	Rochester	NY	14618-3821
1390.	Erin	Edwards	1857 County Rte 10	Ancram	NY	12502-5054
1391.	mike	rudnick	20 Cambric Cr.	pittsford	NY	14534-4512
1392.	Phil	Abrams	5501 31st. Avenue	Woodside	NY	11377-1645
1393.	Jay	Gassman	1919 Middle Country Road	Centereach	NY	11720-3501
1394.	Larraine	Van Slooten	100 Colony Court	East Aurora	NY	14052-1018
1395.	Margaret	DeMarco	72 4th Place	Brooklyn	NY	11231-4053
1396.	Roger	Swanson	301 Windsor Drive	DeWitt	NY	13214-1510
1397.	Carol	Stretmoyer	8260 88th Place	Glendale	NY	11385-7818
1398.	Joseph	Spine	157 Country Road	Utica	NY	13502-7651
1399.	Brian	Sheppard	516 N. 9th Place	New Hyde Park	NY	11040-4215
1400.	marianna	venoski	309 e Maple	newark	NY	14513-1852
1401.	Kira M.	Pierce	38 Echo Lane	Kings Park	NY	11754-3603
1402.	Rachel	Buckley	135 Cedar Hill Avenue	Nyack	NY	10960-3745
1403.	Donald	Argy	26 Andover Road	Hartsadale	NY	10530-2003
1404.	Rachel	Cabrera	MSC 10333	Poughkeepsie	NY	12601
1405.	Audrean	Williams	119 Pennsylvania Avenue	Freeport	NY	11520-2622
1406.	michael	stewart	112-19 guy r. brewer blvd.	jamaica	NY	11433-3819
1407.	Robert	Ellson	20 Dartford Rd	Rochester	NY	14618-4204
1408.	arthur	smaragdas	126 merle ave	oceanside	NY	11572-2235

1409.	Harriet	Crews	144-70 41 Ave. Apt 5P	Flushing	NY	11355-1518
1410.	Helen	Stapleton	198 Hicksville Rd	Bethpage	NY	11714-3421
1411.	Sherri	Ellis	212 Rachel Carson Way	Ithaca	NY	14850-8402
1412.	David L.	Rader	312 Audley Ct.	Copiague	NY	11726-4523
1413.	James	St. John	62 Elm St.	Cooperstown	NY	13326-1233
1414.	Janet	Grossman	414 Main St	Sag Harbor	NY	11963-2956
1415.	Seymour	Kaplan	9 Melaney Dr.	Monsey	NY	10952-1428
1416.	Marsha	Aronson	91 Coldenham Road	Walden	NY	12586-2011
1417.	Bruce	Gibson	81 Lanvale Park	Irondequoit	NY	14617-3707
1418.	George	Hopkins	25 Cricket Hill Dr	Pittsford	NY	14534-2136
1419.	Daniel	Hindes	190 Washington St Apt G	Hempstead	NY	11550-2500
1420.	E.	Randall	Po Box 98	E. Setauket	NY	11733-0098
1421.	Stephen	Lake	50513State Hwy 30	Roxbury	NY	12474-1456
1422.	Amy	Harlib	212 West 22Nd St. #2N	New York,	NY	10011-2707
1423.	Joe	Melhado	50 Lytton Ave.	Hartsdale	NY	10530-1022
1424.	Norine	G Tarasoff	313 Claremont Ave	Mount Vernon	NY	10552-2314
1425.	Michael	Marston	6175 Hawes Road	Altamont	NY	12009-4605
1426.	Jens M.	Krummel	4317 47 ST D4	Sunnyside	NY	11104-1721
1427.	Elizabeth	Ungar	101 West End Ave. 28B	New York	NY	10023-6377
1428.	Sallie	Williams	294 Evergreen Ave	Huntington Station	NY	11746-4538
1429.	Anita	Brandariz	13 Willow Place	Brooklyn	NY	11201-4506
1430.	Jean	Leung	526 10th Street	Brooklyn	NY	11215-4302
1431.	Lupe	Guevara	94-13 117th St	Jamaica	NY	11419-1201
1432.	Binu	Paulose	21A Embassy Square, Apt. 4	Tonawanda	NY	14150-6935
1433.	Carl	Rosenstock	443 Hicks Street, Apt 4G	Brooklyn	NY	11201-5934
1434.	Zerina	Cortes	165 East 179th Street	Bronx	NY	10453-4712
1435.	Thomas	Bartsch	206 Flair Court East	Saint James	NY	11780-3344
1436.	Sal	Libertini	150 Overlook Ave.	Peekskill	NY	10566-3004
1437.	Aviv	Halpert	9108 Colonial Rd.	Brooklyn	NY	11209-6126
1438.	Robert	Madorran	22 Byron Road	Commack	NY	11725-1342
1439.	Barbara	Menkes	173 Sullivan St	NYC	NY	10012-4945
1440.	Mark	Hoffman	1173 E. 32 St.	Brooklyn	NY	11210-4734
1441.	Loretta	Paulson	200 W 86th St Apt 16J	New York	NY	10024-3376
1442.	Jean_Pierre	Maurandy	108, West 75th STreet #2	New York	NY	10023-1931
1443.	Susan Friess	Goldman	2601 Henry Hudson Pwy, #10A			Riverdale
1444.	Andrew	Bellavia	102 Stover Rd	Rochester	NY	14624-4452
1445.	Jacob	Mozes	1559 e. 29th street	brooklyn	NY	11229-1846
1446.	Andrew	Beeler	55 Westbrook Dr.	Nassau	NY	12123-9555
1447.	Jordan	Glaser	18 morris lane	oyster bay	NY	11771-3404
1448.	Steve	Connolly	PO Box 687	Poughquag	NY	12570-0687
1449.	Jerry	Bucci	41 Overlook Drive	Valhalla	NY	10595-2115

1450.	Tom	Sutton	38 Notre Dame Ave	Staten Island	NY	10308-2238
1451.	John	Kempf	15 Van Vorst Drive	Burnt Hills	NY	12027-9712
1452.	Ella	Oblas	651 Vanderbilt St. #2W	Brooklyn	NY	11218-7203
1453.	Alexei	Martinez	50 Underhill Avenue	Brooklyn	NY	11238-3508
1454.	SUSAN	ROBIN	245-43A 76th AVENUE	BELLEROSE	NY	11426-1801
1455.	Amy	Hughes	20 South Mesier Avenue	Wappingers Falls	NY	12590-2719
1456.	Ned	Eisenberg	P.O. Box 230091	NYC	NY	10023-0002
1457.	Richard J.	Vega, LCSW-R, BCD	68-32 60th Street	Ridgewood	NY	11385-5147
1458.	Donna	Greenwell	46 Waterbury St.	Saratoga Springs	NY	12866-1221
1459.	Linda	Billingsley	82 N. Bayview Ave	Freeport	NY	11520-1938
1460.	Jack	Extract	366 Nassau Avenue	Freeport	NY	11520-6317
1461.	Kenneth	Wager	261 Forest Valley Rd.	PIEASANT vALLEY	NY	12569-7607
1462.	Maureen	French	241 East 73rd Street	New York	NY	10021-3652
1463.	Celeste	Winkle	371 brickman road	hurleyville	NY	12747-6001
1464.	Francesco	Morabito	201 Borden Road	Depew	NY	14043-4206
1465.	Jessica	Brill	126 Jamesville Ave, Apt N6	Syracuse	NY	13210-3244
1466.	Raymond	Mangione	606 Ashland Avenue	Buffalo	NY	14222-1309
1467.	Rosemarie	Pretel	2450 Fuller Street	Bronx	NY	10461-2927
1468.	Miriam	Null	87-10 204 street	Holliswood	NY	11423-1513
1469.	James	Igoe	155 E 38th St Apt 16C	New York	NY	10016-2674
1470.	Philip	Carmichael	301 River Road	Grandview	NY	10960-5003
1471.	Darlene	Prescott	302 96th St., 6F	Brooklyn	NY	11209-7828
1472.	caroline	barrett	po box 1505	new york	NY	10268-1505
1473.	Joseph	Nye	po box 2087	montauk	NY	11954-0903
1474.	CATHERINE	DE NICOLA	5 DWYER LANE	WAPPINGERS FALLS	NY	12590-4805
1475.	Barbara H.	Labrecque	306 Mid Ave	Elmira	NY	14904-1908
1476.	Patricia	Moore	43 Highview Drive	Salisbury Mills	NY	12577-5103
1477.	Paul F	Johnson	123 N Main St	Alfred	NY	14802-1021
1478.	Anthony	Breuer	1169 Fleming Road	Delhi	NY	13753-3022
1479.	John	Cooke	192 Haddon Hollow Ct.	Middle Island,	NY	11953-1614
1480.	Paul	Kissel	7 VILLA LANE	MONSEY	NY	10952-1021
1481.	Arthur	Alfreds	565 Broadway Apt 1J	Hastings Hudson	NY	10706-1718
1482.	Eileen	Panico	1869 Louis Kossuth Avenue	Ronkonkoma	NY	11779-6420
1483.	Dr. Scott	Williams	814 Wolf Street	Syracuse	NY	13208-1256
1484.	Donald	Weaver	30 Hawthorne Dr	Spencerport	NY	14559-2120
1485.	Marvin	Glassmann	91 Chichester Rd	Huntington	NY	11743-6340
1486.	DOUGLAS	MAASS	27 POKAHOE DR	SLEEPY HOLLOW	NY	10591-1104
1487.	KATHE	HERTZBERG	32 BEECHWOOD TER	YONKERS	NY	10705-1701

1488.	Ruth	Langone	1963 Central Drive North	East Meadow	NY	11554-5115
1489.	Robert	Smith	10 Irving Johnson Street	East Northport	NY	11731-1915
1490.	Richard	Perras	15 Marville Drive	Albany	NY	12211-1240
1491.	Janet	Field	280 Riverside Dr, Apt. 9J	New York	NY	10025-9026
1492.	MELVIN M	LIPPMAN	40 WEST 90TH STREET	NEW YORK	NY	10024-1560
1493.	Elizabeth	Gray	321 Heritage Lane	Monroe	NY	10950-5175
1494.	Britney	Mann	42 Grant Dr	Fredericktown	OH	43019-9092
1495.	Sara	Lustig	139 Village Gate Blvd.	Delaware	OH	43015-8938
1496.	Lillian	Meek	5036 E 86th Street	Garfield Hts	OH	44125-2000
1497.	Cheryl	Thomas	1332 Oakmont Avenue	Hamilton	OH	45013-3860
1498.	Bianca	Kelley	7345 State Route 67 W	Kenton	OH	43326-9363
1499.	John J.	Berger	7610 Roeper Rd	Parma	OH	44134-6110
1500.	Jabran	Khan	8745 Harpers Point Drive	Cincinnati	OH	45249-2413
1501.	Ruby	Bing	61 Chestnut Court	Mansfield	OH	44906-4009
1502.	steve	simmons	173 james river road	beavercreek	OH	45434-4228
1503.	Christina	Ross	3467 Green Road	Beachwood	OH	44122-7704
1504.	Fredde	Hollman	420 east 124th st	Cleveland	OH	44108-1708
1505.	Patty	Koteles	9002 Avery Rd.	Broadview Hts.	OH	44147-2508
1506.	Anatole and Marina	Kurkov	19052 Inglewood	Rocky River	OH	44116-2847
1507.	Jayleen L.	Hatmaker	162 East State Route 73	Springboro	OH	45066-9108
1508.	Brenda	Thurlow	P. O. Box 1081	Jackson	OH	45640-7081
1509.	Joe	Maffett	6613 Grovebelle Drive	Dayton	OH	45424-8121
1510.	Kimberly	Lowe	612 Sycamore Mill Drive	Gahanna	OH	43230-2262
1511.	Melodee	Kornacker	PO Box 218207	Columbus	OH	43221-8207
1512.	Lynn	Walker	15901 Corsica Ave.	Cleveland	OH	44110-1440
1513.	jackie	hendrickson	431 flintwood drive	gahanna	OH	43230-2020
1514.	Douglas	Tussing	3839 Eagle View Cir	Sylvania	OH	43560-3581
1515.	Edward	Chamberlain	280 Barkley Place East	Columbus	OH	43213-4023
1516.	Mary	Hitchcock	3015 Wichita	Toledo	OH	43613-1934
1517.	Barb	Shank	8220 Paddington Ct.	West Chester	OH	45069-5114
1518.	Mary	Hruby	181 Marvin Ave	Akron	OH	44302-1070
1519.	Richard	Mason	111 E. 14th St.	Dover	OH	44622-1129
1520.	Stephen C	Carpenter	9969 Aldridge Dr.	Columbia Station	OH	44028-9621
1521.	Harold	Floyd	3150 Slate Stone Road	Cable	OH	43009-9754
1522.	Mark	Bonneville	1000 S Roosevelt Ave	Bexley	OH	43209-2545
1523.	Joanne	Kennedy	710 Chestnut St.	CONNEAUT	OH	44030-1449
1524.	Anita	Lock	40 Colony Dr.	Oberlin	OH	44074-1419

1525.	Kelly	Smith	6540 Afton Drive	Dayton	OH	45415-1836
1526.	Carl	Klotz	2581 21st St	Cuyahoga Falls	OH	44223-1724
1527.	Alberto	Molina	29301 Oaborn Rd.	Bay Village	OH	44140-1830
1528.	Rob	Bumm	12974 Harlon Avenue	lakewood	OH	44107-2812
1529.	Susan	Walker-Meere	11990 Butternut Rd.,	Newbury	OH	44065-9624
1530.	JANE	REXROAT	8879 EAGLEVIEW DR.	WEST CHESTER	OH	45069-6706
1531.	Carol	Bradley	2540 Berwick Blvd.	Columbus	OH	43209-2913
1532.	Rick	Kelley	2421 Trotter Court	Beavercreek	OH	45434-5674
1533.	Steven A	Zilber	4186 Stonehaven Rd	South Euclid	OH	44121-3163
1534.	carell	edson	1670 n. cole st	lima	OH	45801-2436
1535.	Dee	Bell	1833 Duncan	Toledo	OH	43613-5207
1536.	John	Gomolka	3714 Mayflower Oval	Brunswick Hills	OH	44212-4143
1537.	Robert	Buselmeier	1615 Barnsdale Ct	Cincinnati	OH	45230-2229
1538.	James and Joan	Fields-Cox	307 Ross Avenue	Hamilton	OH	45013-4729
1539.	Michael	C. McCarty	8565 Smith Calhoun Rd. # 31	Plain City	OH	43064-9112
1540.	Bruce	Lott	1362 Mountain Ash Ct.	Amelia	OH	45102-1091
1541.	Cristina	Macarie	5432 Northcrest Ln	Cincinnati	OH	45247-6419
1542.	John W.	Appleman	27519 Bray Hollow Rd.	Mcarthur	OH	45651-8723
1543.	KAREN	RIGGAR	7338 SALEM TRAIL	RAVENNA	OH	44266-8944
1544.	Robin	Anderson	240 Nathan Avenue	Cuyahoga Falls	OH	44221-2613
1545.	Louise	Gomer bangel	7095 Winding Way	Cincinnati	OH	45236-3336
1546.	Ellin	Ray	5293 Butternut Ct. W.	Columbus	OH	43229-5211
1547.	Gerald	Head	1980 Crest Rd	Cincinnati	OH	45240-2060
1548.	Keith	Ellacott	5017 Shady Ridge Ln	Brooklyn Heights	OH	44131-1046
1549.	Deacon Deb	Rivera	969 Evangeline Rd.	Cleveland	OH	44110-3173
1550.	Greg	Gaffney	668 Brandy Way	Cincinnati	OH	45244-1205
1551.	Leo	Chico	1205 Larriwood Avenue	Kettering	OH	45429-4718
1552.	Johannah	Hupp-Clark	22900 Caves Rd.	Gambier	OH	43022-9786
1553.	Helen	Kopp	12521 Indian Hollow Rd.	Grafton	OH	44044-9190
1554.	David	Poe	7910 Birchwood Ct.	Mason	OH	45040-6906
1555.	Oral	Mehmed	22365 Sandy Lane	Fairview Park	OH	44126-2561
1556.	Jason	Bean	2479 Abbotsford Way	Dublin	OH	43016-8630
1557.	Ronald D.	Gilbert	1651 Peck Leach Rd.	N. Bloomfield	OH	44450-9724
1558.	Carol	Roberto	168 Asbury Rd.	Cincinnati	OH	45255-4602
1559.	Olivia	Zivney	46 Neil Avenue	Gallipolis	OH	45631-1619
1560.	Steven	Miskey	3676 MARY LOU LN N	MANSFIELD	OH	44906-1011
1561.	Alan	Friedman	5146 Graham Dr.	Lyndhurst	OH	44124-1040
1562.	J	Sullivan	4698 CROFTSHIRE DR	Kettering	OH	45440-1705
1563.	Joan	Zeeb-Roman	3050 Brady Lk. Rd.	Ravenna	OH	44266-1612
1564.	Jeffri	Frontz	310 Walhalla Rd	Columbus	OH	43202-1444
1565.	Linda	Becker	3220 Cheltenham Rd.	Toledo	OH	43606-1818

1566.	Mary	Ruffing	2650 Sylvan Road	Cuyahoga Falls	OH	44221-2944
1567.	Dorothy	Koontz	740 Chestnut Lane	Edenville	OH	44849
1568.	Mary	Collins	3675 Clague Road	North Olmsted	OH	44070-1656
1569.	Tina	Leach	15927 Henry-Wood County Line Rd			Grand Rapids
1570.	Karen Sue	Strouse	6010 Summit Street	Sylvania	OH	43560
1571.	Gary	Turner	4928 Tall Oaks Drive	dayton	OH	45432-3226
1572.	Judy	Shannon	4610 Kalida Ave.	Dayton	OH	45424-5787
1573.	Judy	bennett		hudosn	OH	44236-1144
1574.	William R.	Webster	6185 Governors Place	Mentor	OH	44060-8601
1575.	joan	pigg	5695 coach dr. east #f	dayton	OH	45440-2747
1576.	Maribeth	Smith	2155 County St 2890	Chickasha	OK	73018-7968
1577.	DR.LARRY	ZIEGLER	3124 e.26pl	Tulsa	OK	74114
1578.	Bob	Case	2205 Cardinal Road	Ponca City	OK	74604-2802
1579.	Dan	Banks	3715 E 55 St.	Tulsa	OK	74135-3845
1580.	Betty	Davidson	1813 S Maplewood	Tulsa	OK	74112-7218
1581.	Nicole	Nascenzi	315 S. College Ave.	Tulsa	OK	74104-2421
1582.	Jim	Barlow	1824 S. Broadway Blvd	Ada	OK	74820-8324
1583.	Dale	Monks	5608 SOUTH ASH COURT	BROKEN ARROW	OK	74011-5002
1584.	D	Hopson	8510 W 820RD	Fort Gibson	OK	74434-5833
1585.	Darren	Page	6321 Mesa Circle	Stillwater	OK	74074-1090
1586.	Marguerite	Chapman	3120 East 4th Place	Tulsa	OK	74104-2418
1587.	Timothy	Stebler	2834 Mark Cr.	Stillwater	OK	74075-4115
1588.	Kenneth	Maurer	P.O. Box 309	Weatherford	OK	73096-0309
1589.	Duane	Cutting	3529 E 23rd St	Tulsa	OK	74114-1915
1590.	A.	Bain	1820 Oakmeadows Dr.	Norman	OK	73071-1255
1591.	Fred	Sapulpa	9168 e.newton pl.	tulsa	OK	74115-5946
1592.	Emily Beth	Moreno	307 Showalter Drive	Midwest City	OK	73110-5342
1593.	Robin D.	Harrison	11005 N. Eagle Ln.	Oklahoma City	OK	73162-3044
1594.	Timothy	Morgan	121 1/2 W Linn St	Norman	OK	73069-5835
1595.	Frances	O'Brien	335 NE Fircrest Place	McMinnville	OR	97128-9016
1596.	Tom	Heberlein	7556 SW Barnes Rd #B117	PORTLAND	OR	97225-6217
1597.	Frank	Graham	1188 NE Lincoln	Roseburg	OR	97470-2122
1598.	Brian	Seymour	27482 Crow Road	Eugene	OR	97402-9276
1599.	Susan	Carney	170 Jessica Lane	Ashland	OR	97520-1277
1600.	Janie	Moore	2525 S.W. Park Place	Portland	OR	97205
1601.	Louise/Edward	Gilman/Anderson	12615 SW 60th Ct	Portland	OR	97219-7001
1602.	Wayne	Lammers	14960 SW 92nd Ave	Tigard	OR	97224-5726
1603.	Gordon	Gore	2080 NW Thorncroft Dr Apt 1136	Hillsboro	OR	97124-9036
1604.	Tevis	Dooley Jr.	P.O. Box 46	Cannon Beach	OR	97110-0046
1605.	Wendy	Gehring	5706 N. Denver Avenue	Portland	OR	97217-4321
1606.	David	Bridgeman	18411 E Burnside #29	Portland	OR	97233-5350
1607.	Fred	Jasmer	1974 Lomond Ave	Springfield	OR	97477-2581

1608.	Arran	Thomson	4613 NE 19th Ave	Portland	OR	97211-5807
1609.	Tom	Winniford	701 SE Church St	Sublimity	OR	97385-9500
1610.	Demelza	Costa	28626 Ridgeway Rd.	Sweet Home	OR	97386-9523
1611.	Krystal	Kyle	I	Estacada	OR	97023
1612.	Barbara S.	Dersch	21079 Woodhaven Ave.	Bend	OR	97702-2461
1613.	Debra	Siscaretti	15532 SE Bybee Dr.	Portland	OR	97236-7822
1614.	Marcia	Cooperman	1563 Se Bidwell	Portland	OR	97202-6025
1615.	Felicia	Madrigal	5009 SW Humphrey Park Road			Portland
1616.	Ron	Berti	155 SW 88th Ave	Portland	OR	97225-6454
1617.	Anthony	DeMore	254 Landau Ln	Grants Pass	OR	97527-7437
1618.	Lisa	Abramovic	3415 SE Glenwood St	Portland	OR	97202-8251
1619.	Danny	Dyche	4251 SE Averi Ct	Hillsboro	OR	97123-5917
1620.	David	Burkhart	7735 Sunnyside Road Se	Salem	OR	97306-9537
1621.	Mark	Marshall	2901 E 2nd ST, Unit 140	Newberg	OR	97132-9600
1622.	Jay	Smith	2808 Geary st. S.E.	Albany	OR	97322-5510
1623.	Laura	Hanks	7634 SE Alder	Portland	OR	97215-2312
1624.	Douglas	McLean	19444 Marlin Ave	Lake Oswego	OR	97035-8045
1625.	Michelle	Hmelevsky	214 Haven Street	Medford	OR	97501-2428
1626.	Imogene	Abrams	833 Richland Ct	The Dalles	OR	97058-4420
1627.	Deandra	Vallier	1101 Sherman Avenue	Hood River	OR	97031
1628.	Will	Riley	600 SE 28th Ave.	Portland	OR	97214-3012
1629.	Pam	Hopper	PO Box 1315	Lake Oswego	OR	97035-0516
1630.	J. Gregory	Twain	1422 SE 34th Avenue	Portland	OR	97214-4226
1631.	Stuart	Johnson	2459 NW Savier	Portland	OR	97210-2515
1632.	Larry	Erickson	2470 SW 173rd Court	Beaverton	OR	97006-4332
1633.	Mark	Baker	8346 N Dwight Ave	Portland	OR	97203
1634.	Ian	Shelley	16090 Sw Audubon St. #103	Beaverton	OR	97006-2492
1635.	Marguerite	Reilly	6105 NE 46th Ave	Portland	OR	97218-1355
1636.	Sally	Kirsher	15 Tyee Street	Hammond	OR	97121-9702
1637.	Larry	Saltzman	9889 SE 42 Ave	Milwaukie	OR	97222-5788
1638.	Glen and Gail	Stone	6336 SE 45th Ave.	PORTLAND	OR	97206-7031
1639.	Linda	Hopkins	324 SW Plymouth Way	Beaverton	OR	97006-3652
1640.	Gayle	Lee	57700 Nehalem Hwy S.	Vernonia	OR	97064-9651
1641.	P	Silagyi	567 Deerfield Dr.	Nazareth	PA	18064-1230
1642.	Dennis	Cook	101 Bellows Way	Lansdale	PA	19446-6334
1643.	Danelle	Nelson	297 N Maple Ave	Lansdowne	PA	19050-1442
1644.	Kelly	Riley	248 Valley Stream Lane	Wayne	PA	19087-5859
1645.	Robert	Hamburger	709 Lawn Ave.	Sellersville	PA	18960-1547
1646.	Edward	Thomas	301 Susquehanna Avenue	Selinsgrove	PA	17870-1145
1647.	Jeff	Lowry	922 bucknell ave	Johnstown	PA	15905-2214
1648.	Edward	Waxman	2677 Carnegie Road	York	PA	17402-3751
1649.	richard	linsenberg	1901 walnut st	Phila	PA	19103-4640

1650.	Barbara	Aitchison	833 Cottonwood Drive	Malvern	PA	19355-3139
1651.	Steven	Busselen	1935 Wallace St., 2F	Philadelphia	PA	19130-3290
1652.	Missy	Anderson	107 Hedgerow Lane	Five Points	PA	19606-2453
1653.	Alex	Barylo	11114 Greiner Rd	Philadelphia	PA	19116-2602
1654.	FRANK	SWEETSER	3881 Sterling Way	Columbia	PA	17512-9026
1655.	Candace	Jenner	109 Clearview Drive	Downingtown	PA	19335-1101
1656.	Bruce	Hippensteel	18 Crestview Drive	Akron	PA	17501-1108
1657.	Marliese	Bonk	1335 Commercial Street	Pittsburgh	PA	15218-1151
1658.	Frank X.	Kleshinski	209 North Drive	Jeannette	PA	15644-9629
1659.	JOhn	Kolesar	1800 Murdstone Road	Pittsburgh	PA	15241-2104
1660.	richard	mawhir	3029 hazel st.	erie	PA	16508-1665
1661.	Catherine	Lindsey	1019 Wallace St.	Vandergrift	PA	15690-1633
1662.	Kathleen	Lynn	1500 Locust Street, Apt 3608	Philadelphia	PA	19102-4324
1663.	John	Fleckenstein	236 N Concord St	Lancaster	PA	17603-3522
1664.	Alvin	Unbekant	3218 Stump Hall Road	Collegeville	PA	19426-1407
1665.	christian	hartleben	732 spring lane	Philadelphia	PA	19128-1038
1666.	Robert	Morgan	P.O.Box 246	Danielsville	PA	18038-0246
1667.	Lynn	Stauffer	101 Moorestown Drive	Bath	PA	18014-1403
1668.	Thomas	Hinkle	2169 Charleston Rd.	Wellsboro	PA	16901-8470
1669.	Dan	Karney	424 Lynetree Drive	West Chester	PA	19380-1709
1670.	Richard	Bronk	314 w oak st	Shenandoah	PA	17976-2135
1671.	peter	kocotis	513 bells ct b2	bensalem	PA	19020-7756
1672.	Arthur	Soifer	1700 Butler Pike APT 9F	Conshohocken	PA	19428-1252
1673.	Anthony	Haday	28 Denise Drive	Thornton	PA	19373-1007
1674.	Phillip	Silmser	3224 Lenape Dr	Dresher	PA	19025-1804
1675.	S.J.	Rudolph	621 Colebrook Rd	Philadelphia	PA	19115-2808
1676.	Florence	Dollman	232Yankee RD. Lot#120	Quakertown	PA	18951-5337
1677.	Robert L.	Heath	2160 Greentree Road	Pittsburgh	PA	15220-1407
1678.	Loretta	Hildenbrand	1342 S. Howard Street	Allentown	PA	18103-3921
1679.	sylvia	miller	545elainedr	pgh	PA	15236-2418
1680.	Connie	Ashenfelder	6750 Mill Creek Rd Apt 2	Levittown	PA	19057-4015
1681.	shirley	kephart	308 trcziyulny st.	osceola mills	PA	16666-1328
1682.	James	Charnock	608 Maine Ave	Aldan	PA	19018-3221
1683.	Joan	Sage	914 Kimball Street	Philadelphia	PA	19147-3819
1684.	Rob	Das	310 Flourtown Road	Lafayette Hill	PA	19444-1005
1685.	Phyllis	Tyzenhouse	84 St. John Circle	Lititz	PA	17543-2227
1686.	Karen	Battaglia	4104 Willow Ave	Pittsburgh	PA	15234-1324
1687.	Mario	Dominick	325 Spruce St.	Latrobe	PA	15650-2922
1688.	Hal	Lehman	2031 Locust St	Philadelphia	PA	19103-5611
1689.	Ned S.	Coates	154 English Hill Rd.	Cogan Station	PA	17728-9376
1690.	Frederick	Ruch	943 Long Street #203	Bethlehem	PA	18015-2662
1691.	Kevin	Mahony	417 fox circle	easton	PA	18042-5397

1692.	Carl	Casella	201 Canterbury Drive	Wallingford	PA	19086-6617
1693.	Charlene	Rush	100 Anderson St. #541	Pittsburgh, PA	PA	15212-5842
1694.	Kenneth	Glosenger	PO Box 237	Sayre	PA	18840-0237
1695.	Garry	Doll	400 Lycoming St Apt 201	Williamsport	PA	17701-4957
1696.	Bruce	Pierce	3008 Hetherton Drive	Aston	PA	19014-1719
1697.	HOWARD	GITTLER	3297 Hemlock Farms	Lords Valley	PA	18428-9115
1698.	Robert	Thompson	2255 Ramsey Road	Monroeville	PA	15146-4823
1699.	R Renee	Dolney	2315 Orlando Place	Pittsburgh	PA	15235-2768
1700.	Jaime	Loyola	12 Parkview Rd.	Cheltenham	PA	19012-1815
1701.	Warren	Conner	R.D.2	Gillett	PA	16925-9802
1702.	Henry	Rappold	2181 Black Forest Drive	Coplay	PA	18037-2264
1703.	Clare	Szilagyi	30 Pinetree Dr	Audubon	PA	19403-2025
1704.	Paula	aagordon	2142 North 32nd Street	Philadelphia	PA	19121-1105
1705.	James	Fiedler	3065 Rauchtown Rd	Jersey Shore	PA	17740-7248
1706.	Holly	Wilson	216 E. Glenside Ave.	Glenside	PA	19038-4522
1707.	Shelden	Radin	1939 Weyhill Drive	Center Valley	PA	18034-8749
1708.	Jennifer	Morse	1234 Richmond St	Pittsburgh	PA	15218-1017
1709.	Lawrence	Brick	3017 Midvale Avenue	Philadelphia	PA	19129-1027
1710.	Linda and Denny	Murray	49 Prospect St	Mansfield	PA	16933-1026
1711.	Joseph	Cirafesi	9644 Longswamp Road	Mertztown	PA	19539-8801
1712.	Patricia	Nolan	936 bay ridge avenue	pittsburgh	PA	15226-2134
1713.	Cindy	Black	2320 Wagon Wheel Drive	Easton	PA	18040-7816
1714.	Francis	McCarthy	RR 1 BOX 539	Dingmans Ferry	PA	18328-4109
1715.	Robert	Lake	115 Woodcrest Drive	Coraopolis	PA	15108-9162
1716.	David	Cohen	6 Aspin Ct	Pittsburgh	PA	15215-1610
1717.	Serena	Fogelberg	1106 Towncrest Rd	Williamsport	PA	17701-4132
1718.	Joseph	Pryber	1011 New Hope St., Apt 46A	Norristown	PA	19401-4176
1719.	Mark	Leeson	44 Hickory Court	Orwigsburg	PA	17961-9124
1720.	Howard	Krom, Jr.	1309 Biltmore Avenue	Pittsburgh	PA	15216-2313
1721.	Maurice	duBois	131 Wheaton Dr	Littlestown	PA	17340-1357
1722.	Thom and Deb	Fistner	10 W. Chester Pike Apt 105	Ridley Park	PA	19078-1607
1723.	ed	day	609 desmond st	athens	PA	18810-1908
1724.	Linda	Good	114 Huntley Drive	harrisburg, pennsylvania	PA	17112-3215
1725.	Robert M	Goodman	2415 Rolling Hills Drive	Mechanicsburg	PA	17055-9207
1726.	Linda	Buck	4623 Paul Street	Philadelphia	PA	19124-3311
1727.	Milton	Wolfson	2414 Shady Ave	Pittsburgh	PA	15217-2410
1728.	William	Sharp	RD#3 Box 169	Ford City	PA	16226-8826
1729.	Lynn C.	Jaeger	1125 Colonial Ave	Roslyn	PA	19001-3102
1730.	Robert	Matalavage	1107 Eyer Street	Berwick	PA	18603-1727
1731.	Susan	Lindemuth	8861 Route 28	Brockway	PA	15824-2715

1732.	patricia	hochwarter	2779 Freemansburg Ave	Easton	PA	18045-6085
1733.	Regina	Reppert	1101 Marion St. 3rd fl	Reading	PA	19604-2131
1734.	Mark C	Knobil	3559 Bethoven St.	Pittsburgh	PA	15213-1017
1735.	Robin	Butler	4501 Fritchey Street	Harrisburg	PA	17109-2812
1736.	Mary	Gontaryk	239 Ashby Rd.	Upper Darby	PA	19082-4013
1737.	Charles	Seibert	312 tiffany court	gibsonia	PA	15044-6212
1738.	Paul	Shanabarger	PO Box 185	Bessemer	PA	16112-0185
1739.	Evalyn F.	Segal	6655 McCallum St. #211E	Philadelphia	PA	19119-3127
1740.	Edwin A.	Bonilla	Sect. Canales	Juncos	PR	00777-7704
1741.	Ramon	Espino	Urb.El Rosario Calle B E20	Vega Baja	PR	00693-5709
1742.	Jon	Foley	Apt. 708	Providence	RI	02906-4493
1743.	Gwenneth	Rae	P.O. Box 729	Wakefield	RI	02880-0729
1744.	Albert	Suter	1985 Crasnston St	Cranston	RI	02920-3963
1745.	Roberta	Shaw	115 Goldsmith Ave. Apt 411	East Providence	RI	02914-2225
1746.	K.	Schroeder	11 Blossom Drive	Cranston	RI	02920-3414
1747.	Sharon	Lamond	50 Abbott Run Valley Rd.,#1939			Cumberland
1748.	Lori	Bukoski	5 Hillside Avenue	Barrington	RI	02806-2304
1749.	Karen	Grant	181 Ann St	Cumberland	RI	02864-7217
1750.	V Jean	Trefes	461 Atlantic Avenue	Westerly	RI	02891-4333
1751.	J.B.	Coleman	201 Ginger lane	Easley	SC	29642-1319
1752.	Wanda C.	Tripp	26 W. Gantt Circle	Piedmont	SC	29673-9289
1753.	Anthony J.	Lawrence	111 Paris Lane	Summerville	SC	29483-9737
1754.	Kathleen	Crawford	6 Saco Street	Greenville	SC	29611-4717
1755.	Will	Crenshaw	7 College St	Due West	SC	29639-9554
1756.	Steve C.	Dennis	2505 Hardscrabble Road	Columbia	SC	29223-7710
1757.	G.	Sutton	2 Pelot Ct	Okatie	SC	29909-4541
1758.	Doris	Murphy	702 Miles Circle	Myrtle Beach	SC	29577-2631
1759.	Frank	Gorman	1283 George St . NE	Aiken	SC	29801-4152
1760.	Kent	Petersime	324 Sunburst Way	Summerville	SC	29483-5628
1761.	Michael	Hampton	220 Fountain Inn Dr	Fountain Inn	SC	29644-9451
1762.	yvonne	harron	371 Flat Shoals Rd	Salem	SC	29676-3606
1763.	Jane	Bryant	214 Ashmore Bridge Rd	Mauldin	SC	29662-2841
1764.	Katherine	Mabry	406 E Park Dr	Spartanburg	SC	29302-3238
1765.	Paige	Walk	531 Shelton Dr	Columbia	SC	29212-3264
1766.	Jerry	Burdette	337 Ray McMahan Road	Iva	SC	29655-9656
1767.	JOSEPH	GREEN	5 Elmwood St	Charleston	SC	29403-4301
1768.	Charles	Rives	1523 Madison Ave	Florence	SC	29501-4532
1769.	Ruth	Barclay	166 Laurel Ridge Cir	Aiken	SC	29803-7794
1770.	Trumbull	King	106 Cottonwood Creek Ln	Aiken	SC	29803-2749
1771.	Sarah	Burdette	337 Ray McMahan Rd.	Iva	SC	29655-9656
1772.	Clay	Young	10 Legends Way	Simpsonville	SC	29681-4009
1773.	Angel	Muehlenkamp	205 Burnham Road	Summerville	SC	29485-5145

1774.	WILLIAM	KNAPP	502 Tisdale St. PO Box315	JACKSON	SC	29831-0315
1775.	Laura	Gabrels	9 Burlwod Ct	Taylors	SC	29687-5100
1776.	Barbara	Rystsrom	138 Summerall Court	Aiken	SC	29801-7224
1777.	Tom	Petras	420 Dover Ct	Anderson	SC	29625-2558
1778.	Eldon	Wedlock	2323A Stark St.	Columbia	SC	29205-1065
1779.	Susan	Hogan	1954 Walkers Ferry Pl	Johns Island	SC	29455-8152
1780.	john	mcmahan	po box 943	iva	SC	29655-0943
1781.	William	Edlund	1547 Inverness Dr	Charleston	SC	29412-2616
1782.	susan	Brown	P. O. Box 34	Oldham	SD	57051-0034
1783.	gene	bocknek	114 aster dr.	andersonville	TN	37705-3034
1784.	James	Martin	810 Bellevue Rd Unit 243	Nashville	TN	37221-2736
1785.	Vivian	Kannon	3636 Burwick Pl.	Antioch	TN	37013-2549
1786.	Karen	Hardin	241 Allensville Road	Sevierville	TN	37876-1611
1787.	Polly Anna	Harris	1200 Grist Mill Circle	Knoxville	TN	37909-3103
1788.	Jeffrey	Erwin	4208 East Mallory Ave	Memphis	TN	38111-7819
1789.	Kati	Thompson	128 51St Avenue North	Nashville	TN	37209-3302
1790.	Roberta	Thurmond	6626 Hillbrook Lane	Hixson	TN	37343-2925
1791.	Peter	Iano	1305 Forrest Oaks Ct N	Nashville	TN	37221-3963
1792.	JOHN	INSPRUCKER	2533 POTTER DR	COLUMBIA	TN	38401
1793.	Mr. & Mrs. Jerome	Holland	4530 S Germantown Rd	Memphis	TN	38125-3406
1794.	Dianna	Holland	4530 S Germantown Rd	Memphis	TN	38125-3406
1795.	Robert	Sutton	3798 Altruria Rd	Memphis	TN	38135-1543
1796.	Constance	Anderson	2180 Newt Huff lane	Sevierville	TN	37862-7404
1797.	michael	redmond	PO Box 55	Memphis	TN	38101-0055
1798.	charlene	nash	po box 11048	chattanooga	TN	37401-2048
1799.	Mark	Berkheimer	4219 Lamour Road	Knoxville	TN	37909-3303
1800.	Sue	Knight	822 Goose Creek Rd	Seymour	TN	37865-7030
1801.	AMY	MARTIN	2817 WEST END AVE	NASHVILLE	TN	37203-1453
1802.	Lisa	Jones	265 Countryside Drive	Oakland	TN	38060-4056
1803.	Clayton	Carroll	1233 Concord hunt Drive	Brentwood	TN	37027-8760
1804.	Juliana	trotman	1745 Glen Echo Rd.	Nashville	TN	37215-2909
1805.	Barbara	Kramer		Johnson City	TN	37604-8930
1806.	Patrick	Casey	4321 Sunny Trail Cv.	Bartlett	TN	38135-0419
1807.	Leah	McFadden	2008 N. Main St.	Crossville	TN	38555-5406
1808.	jaanjoford@yahoo	Jones-Ford	700-I Longview Rd	Knoxville	TN	37919-3747
1809.	Beatrice	Collins	4009 Deerfield Road	Knoxville	TN	37921-3215
1810.	Virgil	Siler	7331 Valley Ln	Hixson	TN	37343-2207
1811.	Stephen	Rosenthal	101 Tammy Trail	Sanger	TX	76266-5055
1812.	Brenda	Bural	2207 Lincoln Ave	Fort Worth	TX	76106-8039
1813.	robert	king	po box 82013	austin	TX	78708-2013
1814.	Barry/Michele	Harber	156 Young Ranch Rd	Georgetown	TX	78628-4313

1815.	Aurora E.	Hunter	15711 Sandy Hill	Houston	TX	77084-3634
1816.	Arlene	Brodhead	5603 Pecos Court	Granbury	TX	76049-5273
1817.	Sophia	Vassilakidis	407 Avondale	Houston	TX	77006-3027
1818.	Bryan	Smith	12117 Rayo De Luna Lane	Austin	TX	78732-1978
1819.	Sharon	Clutter	2602 Vermillion Drive	Seabrook	TX	77586-2823
1820.	Stewart Ransom	Miller	9310 Esplanade Drive	Dallas	TX	75220-5038
1821.	James	Cleven	23118 Osprey Ridge	San Antonio	TX	78258-2779
1822.	Charles	Henderson	109 King Arthur Dr	Weatherford	TX	76086-5940
1823.	Richard	Kendrick	3541 North Hills	Austin	TX	78731-3270
1824.	Aileen	Thatcher	1601 S Camino Seco	Tucson	TX	885710
1825.	Phil	Curry	1903 Redlands	Austin	TX	78757-2827
1826.	Mark	Lynn	22103 Manor Estates Dr.	Katy	TX	77449-3817
1827.	Evelyn	Adams	4920 Pecan Place Drive	Mckinney	TX	75071-7030
1828.	JH	Webber	1510 W North Loop	Austin	TX	78756-2041
1829.	laurin	smith,sr.	7007 kiva lane	Dallas	TX	75227-1717
1830.	Martha	Hughes	1615 Capstan	Houston	TX	77062-4519
1831.	Tommy	Nichols	808 Calhoun Ave	Waco	TX	76704-2704
1832.	Martha	Clark	903 S. Elm St	Denton,	TX	76201-6811
1833.	Charles	Moss	327 Fort Edward Drive	Arlington	TX	76002-4499
1834.	William	Ford	10722 Candlewood	Houston	TX	77042-1435
1835.	Bill	Thompson	1607 Sparta	Duncanville	TX	75137-3815
1836.	David W.	Thorell	1006 Salvia Court	Leander	TX	78641-3933
1837.	rosemarie	waiand	16013 country club court	jersey village	TX	77040-1127
1838.	Robert	Geohagan	9189 Lucille Lane	Conroe	TX	77384-4633
1839.	James	Swanson	207 Chelsea	Hewitt	TX	76643-4208
1840.	Steven	Ortiz	6902 Zapata Drive	Houston	TX	77083-2217
1841.	Pamela	Dean	935 W Silver Sands #2515	San Antonio	TX	78216-5422
1842.	Cheryl	Bagley	10906 Beauty Lane	Dallas	TX	75229-3832
1843.	Vernon	Whitney	8411 Academy Street	Houston	TX	77025-2901
1844.	Priscilla	Althaus	953 Althaus-Davis Road	Fredericksburg	TX	78624-6815
1845.	James	Horn	3905 Escoba Dr	Grand Prairie	TX	75052-6827
1846.	kay h.	andresen	8722 cinnamon creek drive	San Antonio	TX	78240-4520
1847.	Gloria Jean	Morrison	1709 W. Jackson Blv.	Pecos	TX	79772-4702
1848.	Caroleanne	Greer	P O Box 77	Montgomery	TX	77356-0077
1849.	Roger	Mahon	1904 E. Warren	Victoria 7	TX	77901-4231
1850.	Dolph	Hess	1914 County Rd. 307	McDade	TX	78650-5017
1851.	Travis	Casper	4202 Cat Mountain Dr.	Austin	TX	78731-3705
1852.	g	kelly	POB 642	DRIPPING SPRINGS	TX	78620-0642
1853.	Roy	Wilhite	15501 Lymko Drive	Austin	TX	78728-3695
1854.	David	Souder	1000 Texas Trail	Roanoke	TX	76262-6884

1855.	Joseph	Robinson	6518 Oakland Hills	Houston	TX	77069-1720
1856.	Roger	Rich	9700 Timber Creek Dr.	Bonham	TX	75418-5144
1857.	Tim	Duda	340 Queen Anne Court	San Antonio	TX	78209-6625
1858.	J Scott	Daniels	2111 Holly Hall Apt. 2314	Houston	TX	77054-3956
1859.	Kelly	Epstein	18319 Champion Forest Dr.	Spring	TX	77379-3973
1860.	Rev. Lawrence W	Althouse	4412 Shenandoah	Dallas	TX	75205-2028
1861.	ROBERT	STREBECK	509 ARANSAS	EULESS	TX	76039-7516
1862.	Robert W.	Jones	1413 SEminary Ridge	Garland	TX	75043-1242
1863.	James	Mayfield	4350 First View	San Antonio	TX	78217-3634
1864.	Nelda	Lewis	202 Dolomita St	Borger	TX	79007-8024
1865.	Joseph	Boley	10422 Eagle Fox	San Antonio	TX	78245-1039
1866.	Nancy	Yates	791 Lakeview Drive	Coppell	TX	75019-5415
1867.	Susan	Graybill	11 Glen Eagles Dr.	Sugar Land	TX	77479-2962
1868.	Emma	Squires	734 N. Nursery	Irving	TX	75061
1869.	Rudy	Casillas	13831 Flairwood St.``	San Antonio	TX	78233-4466
1870.	Mary	Shelar	917 Wayne Trail	Azle	TX	76020-5014
1871.	Patricia	Mccain	1405 Jim Mathis	Bryan	TX	77808-8041
1872.	Emily	Hersh	909A E 37th St	Austin	TX	78705-1807
1873.	Charles	Love	400 East Defee	Baytown	TX	77520-5117
1874.	Marianne	Baker	3308 Bridle Path	Austin	TX	78703-2712
1875.	John	Taylor	1601 County Rd 461	Elgin	TX	78621-5378
1876.	Walter	Chelmo	1533 Northcrest Dr	Waco	TX	76710-1041
1877.	Rodney	Wilson	8614 Twisting Vine	Houston	TX	77040-4620
1878.	Robert	Ramming	4182 FM 1002 N.	winnsboro	TX	75494-8218
1879.	Sherman	Robinson	2 Pembrook Court	Bellaire	TX	77401-5043
1880.	Byron	Glunz	22 Chapellwood	San Antonio	TX	78254-5583
1881.	Angelina Mc	Nabb	10898 shadow wood	Whitehouse	TX	75791-9315
1882.	Richard	Beyer	628 Sp Terry Rd	Belton	TX	76513-6985
1883.	Robert	Renner	1317 CR 1858	YANTIS	TX	75497-4552
1884.	Tami	Payne	234 Rentz Place Circle	Weatherford	TX	76086-5575
1885.	James	Wilson	Abilene	Abilene	TX	79603
1886.	Patsy	Gibbs	8018 Petra Dr.	Houston	TX	77083-5024
1887.	Eileen	Maxey	6350 Goliad	Dallas	TX	75214-3601
1888.	David	Lawhon	4211 Lafayette St., Apt. 635	Dallas	TX	75204-4496
1889.	Robert	Dain	6531 Robin Road	Dallas	TX	75209-5320
1890.	joanne	groshardt	302 Trailridge Dr	Richardson	TX	75081-4727
1891.	Allen	Newbrand	105 Lakeside Dr	Shady Shores	TX	76208-5742
1892.	Allen	Rindfuss	109 Laburnum Dr.	San Antonio	TX	78209-2121
1893.	Jess	Jessen	3109 Knox St. #648	Dallas	TX	75205-4029
1894.	B. L.	Melton	2332 Godwin Circle	Orange	TX	77630-2214
1895.	Keith	Thornton	4737 Mount Hood Road	Fort Worth	TX	76137-5144
1896.	Johnnie	Prosperie	851 Cr 4191	Nacogdoches	TX	75961-7969
1897.	Marvin	Thomas	118 Aylesbury Hill	San Antonio	TX	78209-5442

1898.	Chris	Snively	5703 76th St.	Lubbock	TX	79424-2415
1899.	william	larson	9122 oak downs court	san antonio	TX	78230-5226
1900.	Sally	Simpson	326 Crooked Creek	Garland	TX	75043-3100
1901.	Susan	Thornton	3508 Alpine Circle, #126	Austin	TX	78704-7166
1902.	Andres, Jr.	Estrada	1039 Meadow Run Drive	Duncanville	TX	75137-3599
1903.	Frances	Allen	3608 Wedgway	Fort Worth	TX	76133-2135
1904.	william	banet	1518 Barton Spgs. Rd. #7	austin	TX	78704-1047
1905.	Toby	Pigford	P.O. Box 270244	Corpus Christi	TX	78427-0244
1906.	Janet	Reid	11851 Belair Dr. Apt. 10041	San Antonio	TX	78213-4846
1907.	Margie	Schluter	10970 Plainview Rd.	Krum	TX	76249-4289
1908.	Michael	McDaniel	113 Crestwood Dr.	Longview	TX	75601-4209
1909.	Jason	O'Neill	846 Lillius St	Abilene	TX	79603-5924
1910.	Rebecca	Smith	P.O. Box 293176	Kerrville	TX	78029-3176
1911.	betty	alberson	3911 hillside dr	round rock	TX	78681-3695
1912.	John	Lasater	3603 La Costa Rd.	Missouri City	TX	77459-2406
1913.	Mary Alice	Alvarez	11302 Long Branch Dr.	Austin	TX	78736-6507
1914.	Donna	Laubhan	Box369	Booker	TX	79005
1915.	Duane	Martin	19 Split Rock Ct.	The Woodlands	TX	77381-2539
1916.	Elizabeth	Cremar	929 W. AVE. G.	kINGSVILLE	TX	78363-3046
1917.	Melissa	Behar	626 Merrill St.	houston	TX	77009-6206
1918.	Sam	Pearis	146 Doris	Universal City,	TX	78148-3405
1919.	Randy	Furlong	2931 Jarrard Street	West University Place	TX	77005-3035
1920.	Julie	Lehman	200 Foxtail Court	Coppell	TX	75019-5580
1921.	Rick	McDonald	PO Box 4013	Wichita Falls	TX	76308-0013
1922.	Dyan Bohart	Brinson	5915 oram	dallas	TX	75206-7231
1923.	Betty Ed	Young	608 Meadow Top	Converse	TX	78109-1636
1924.	Javier	Aponte	215 Blue Juniper	San Antonio	TX	78253-5252
1925.	Donna	Weaver	16310 Weaver Lane	Conroe	TX	77303-4218
1926.	Paul J.	Finnegan	1500 N. Garrett Ave. # 112	Dallas	TX	75206-7832
1927.	Frank	Aaron	19251 Preston Rd	Dallas	TX	75252-8552
1928.	Sky	Pulford	9821 Katy Freeway	Houston	TX	77024-1206
1929.	LaVette	Ulichnie	4912 Remington Park Drive	Flower Mound	TX	75028-3094
1930.	Perry	Sego	15421 Whistling Straits drive	Austin	TX	78717-3838
1931.	Grant	Barnes	732 Timberhill Dr.	Hurst	TX	76053-4326
1932.	Maria	Williamson	2310 Lake Road	Highlands	TX	77562-2020
1933.	Liz	Wally	5528 Victor	Dallas	TX	75214-5055
1934.	Tamara	Teague	140 Woodcreek	Rockwall	TX	75032-5630
1935.	Anthony	Jones	8775 Park OLympia	Universal City	TX	78148-3259
1936.	Barbara	Dorf	103 Bay Court	Aransas Pass	TX	78336-5232
1937.	Debra	McLeod Sears	203 Lakemere	Houstont	TX	77079-7317
1938.	Scott	Nicol	1604 S Orange	Weslaco	TX	78596-7924
1939.	Gabe	Arnold	6638 Tara	Richmond	TX	77469-5830

1940.	Al	Brown	1809 Edna St.	Arlington	TX	76010-2102
1941.	James	Nauls	6707 mACZALI dRIVE	mISSOURI cITY	TX	77489-5608
1942.	Ravi	Perera	3800 Tanglewilde St Apt 405	Houston	TX	77063-5161
1943.	kme	harris	23901 spring moss	houston	TX	77373-9022
1944.	Robert	Campbell	7000 Cassye Cove	Austin,	TX	78759-3773
1945.	ROBERT	STREBECK	509 ARANSAS	EULESS	TX	76039-7516
1946.	Barbara	Schlonga	40 Holly Ln	Texarkana	TX	75503-2313
1947.	Connie	Colina	4512 Cliffstone Cove	Austin	TX	78735-6610
1948.	Sandra	Robinson	821 Sherwood Ct	Midlothian	TX	76065-5668
1949.	JC	Dufresne	141 Lindy Hills	Cibolo	TX	78108-4273
1950.	Sarah	Angell	9931 Coldwater Circle	Dallas	TX	75228-3633
1951.	Susan	Upton	1707 Turnberry Ln.	Allen	TX	75002-2640
1952.	Mary Catherinel	Levandovsky	3002 Lois Circle	Copperas Cove	TX	76522-3214
1953.	Rowena	Montgomery	3707 Hialeah Drive	Arlington	TX	76017-3407
1954.	Allison	Byrum	9 Country Lane	Wimberley	TX	78676-2510
1955.	Leonard	Kivett	3512 Golden Aspen Drive	Flower Mound	TX	75028-8905
1956.	Ira	Allen	6303 Villa Rd.	Dallas	TX	75252-2411
1957.	Cecilia	Nall	5114 Vandelia st	Dallast	TX	75235-8828
1958.	George	Croft	2385 E Hickory Hill Rd	Argyle	TX	76226-3128
1959.	Clyde	Perkins	PO Box 1713	Dumas	TX	79029-1713
1960.	Hoi	Heldt	213 2nd st	dickinson	TX	77539-2433
1961.	Louise	Beagle	3916 Reagan Drive	Fort Worth	TX	76116-7721
1962.	Patricia	Farra	4337 Clay Street	Houston	TX	77023-1811
1963.	Patty	Langford	1445 N Hill ST	tatum	TX	75691-1731
1964.	Julie	Holliday	3214 Knoll West Dr.	Houston	TX	77082-3648
1965.	Pat	George	1400 N. Hwy. 91	Denison	TX	75020-9061
1966.	RUssell	Cowser	8247 Southwestern Blvd. #1053			Dallas
1967.	Holly	Nunn	103 South Mt. Rushmore	Cedar Park	TX	78613-3023
1968.	sTELLA	Ecklo	7716 liz lane	savannah	TX	76148-2435
1969.	Brenda	Durant	2114 Long Creek	Granbury	TX	76049-1172
1970.	Juan B.	Angulo	3244 Latham Dr.	Dallas	TX	75229-3844
1971.	Victoria	Whitaker	2104 Rundell Place	Austin	TX	78704-3245
1972.	Miguel	Prats	22427 Waynoka	katy	TX	77450-3333
1973.	Beckye	Estill	1205 Rambling Trl	Cedar Park	TX	78613-4219
1974.	Cheryl	Sargen	25911 Torch Lily	San Antonio	TX	78260-2443
1975.	Frances	Schwartzwald	2505 Vega Street	Grand Prairie	TX	75050-1750
1976.	Bill & Kathy	Sumerford	6103 Blue Sage Cir.	Amarillo	TX	79124-1320
1977.	Robert	Curl	1824 Bolsover	Houston	TX	77005-1728
1978.	MIKE	ROBINS	1848 PORTSMOUTH APT. B	Houston	TX	77098-4307
1979.	Robert	Jefferson	210 Wells Fargo	Houston	TX	77090-4027
1980.	Osburn	Mason	6719 Forest Grove	San Antonio	TX	78240-3317
1981.	Timothy	Newman	9220 Evening Primrose Path	Austin	TX	78750-3546
1982.	robert	knight	3229-62nd st.	lubbock	TX	79413-5527

1983.	KC	Curry	7202 W Sun Lane	San Angelo	TX	76901-6560
1984.	Diane	Cuttler	2052 Glencove Drive	Seabrook	TX	77586-3318
1985.	Ann	Mcmullen	9339 Silvercrest Dr	Sandy	UT	84093-2315
1986.	Christy	Levine	1857 No. Serenity Drive	Saint George	UT	84770-4777
1987.	Von	Taylor	PO Box 340	Providence	UT	84332-0340
1988.	Tessa	Roden	po box 520662	Salt Lake City	UT	84152-0662
1989.	Ray	Donley	1270 Norwalk Rd	Slc	UT	84123-1330
1990.	Bonnie	Harrington	106 South 100 East	American Fork	UT	84003-2328
1991.	Vernon	Harrington	106 South 100 East	American Fork	UT	84003-2328
1992.	Dr Keith	Baker	1250 N Cottonwood	Heber City	UT	84032
1993.	George	Latta	1825 South 2300 East	Salt Lake City	UT	84108-3032
1994.	Cigy	Cyriac	11491 Brambleberry Ln	Draper	UT	84020-9480
1995.	Siegfried	Karsten	560 E South Temple Apt 902	Salt Lake City	UT	84102-1146
1996.	Cathy	Mc Crystal	1526 South Heaton Drive	Kanab	UT	84741-6127
1997.	Anita	Musto	9011 N. Silver Lake Drive	Cedar Hills	UT	84062-8788
1998.	David E.	Hill	435 Tomahowk Dr.	Christiansburg	VA	24073-3717
1999.	John	Hevner	1024 N Utah St	Arlington	VA	22201-5734
2000.	Marco	Lari	3101 S. Manchester St Apt. No. 509			Falls Church
2001.	William	Briggs	202 Grosvenor La. #1	Stafford	VA	22556-4581
2002.	judy	ledoux	1221 grumman drive	Rerichmond	VA	23229-5431
2003.	Frank	Williams	9705 Sudley Manor Drive	Manassas	VA	20109-6255
2004.	Valorie	Lee	5058 Donovan Drive	Alexandria	VA	22304-8628
2005.	Anna	Hitchcock	4816 Stilwell Ave.	Alexandria	VA	22309-3345
2006.	Eric	Steenstra	21324 Small Branch Pl.	Ashburn	VA	20148-4007
2007.	James	Taylor	26 Ridge Pointe Lane	Fredericksburg	VA	22405-2745
2008.	Paul	Fiscella	318 Central Pkwy	Newport News	VA	23606-3726
2009.	Jacqueline	Bowman	1616 Colehollow Dr	Midlothian	VA	23113-4015
2010.	maria	kruse	305 higham ct.	leesburg	VA	20176-2348
2011.	Joel L.	Steinberg	9700 Rolling Ridge Drive	Fairfax Station	VA	22039-2901
2012.	paul	dalton	105 so. utah st.	arlington	VA	22204-1359
2013.	Joanne D.	Ferguson	10610 Holleybrooke Dr.	Spotsylvania	VA	22553-1637
2014.	Nancy B.	Weaver	1803 Melvor Lane	Wincheter	VA	22601-6390
2015.	K	DeRobertis	13347 Point Rider LN	Herndon	VA	20171-3813
2016.	Deb	Fritzler	1489 lowesville Road	Amherst	VA	24521-4221
2017.	Wendy	Jaccard	1206 Jadwyn Road	Maurertown	VA	22644-2402
2018.	Sherley	Redding	20 Executive Drive	Newport News	VA	23606-2225
2019.	Richard	Welter	10705 Deneale Pl.	Fairfax	VA	22032-3009
2020.	M.	Lockard	4606 Tapestry Drive	Fairfax	VA	22032-3617
2021.	Barbara	Tafuni	19 Jordan Placel	Churchville	VA	24421-2652
2022.	Richard	Gelb	5228 Ferndale St	Springfield	VA	22151-3011
2023.	Robert	McCreary	PO Box 3	North	VA	23128-0003

2024.	John	McPeek	3113 Buccaneer Ct. #001	Fairfax	VA	22031-5013
2025.	Lawrence	Pelkey	900 N Stafford St Apt 2325	Arlington	VA	22203-1851
2026.	Thomas	Ariel	PO Box 70217	Richmond	VA	23255-0217
2027.	Thomas	Golden	285 Ariel Drive NE	Leesburg	VA	20176-2236
2028.	Tamara	Wright	253 Red Cedar Road	Barboursville	VA	22923-2759
2029.	Arthur	Oman	520 Pondview Circle	Virginia Beach	VA	23452-1115
2030.	Annette	Andrews	3502 Sussex Dr.	Hopewell	VA	23860-4147
2031.	Linda H.	Mick	Founders Hill Dr.	Alexandria	VA	22310
2032.	Stephen	Guy	407 Mount Crawford Ave Apt 26			Bridgewater
2033.	Cecil	Sheppard	Box 16	Emory	VA	24327-0016
2034.	Susan	Taylor	10547 Sydelle Dr	Richmond	VA	23235-2653
2035.	Barbara	Long	4412 Johns Point Road	Gloucester	VA	23061-4519
2036.	Karen	Ress	5210 Parker St.	Richmond	VA	23231-3728
2037.	Matt	Malacarne	4035 Pritchard West	Blacksburg	VA	24060-0024
2038.	James	Cunningham	9674 Eaton Woods Place	Lorton	VA	22079-2335
2039.	Marian	Goldberg	P. O. Box 449	McLean	VA	22101-0449
2040.	Steve	Price	P.O. Box 555	Christiansburg	VA	24068-0555
2041.	Mary	Branscome	16267 Gayle Court	Triangle	VA	22172-1103
2042.	Christopher	Gonzalez	352 Kildare Drive	Front Royal	VA	22630-3852
2043.	Jennifer	Gonzalez	352 Kildare Drive	Front Royal	VA	22630-3852
2044.	Kent	Smith	21366 Wideoak Ct.	Sterling	VA	20164-8629
2045.	James	Hayes	13600 Crystal Dr	Disputanta	VA	23842-8060
2046.	Lauren	Moore	3354 Lake Ridge Rd	Pulaski	VA	24301-9300
2047.	John	Davis	651 Quarry St. Apt 115	Bristol	VA	24201-4383
2048.	Jan	DeYoung	5802 Merton Court	Alexandria	VA	22311-5834
2049.	Paul	Corcoran	212 Lawford Dr SW	Leesburg	VA	20175-5082
2050.	Robert	Bonometti	260 Golds Hill Rd	Winchester	VA	22603
2051.	Norma	Erny	6903 Dawley Ct.	Springfield	VA	22152-3201
2052.	Randall	Casey	3203 Wildmere Place	Herndon	VA	20171-3920
2053.	Robert	Simanski	751 South Sugarland Run Drive			Sterling
2054.	Howard	Bucy	1206 Ware St. SW	Vienna	VA	22180-6540
2055.	virginia	mintz	4424 north 17th street	arlington	VA	22207-2308
2056.	Vicky	Newell	209 E. Del Ray Avenue	Alexandria	VA	22301-1325
2057.	Mary	Copas	3654 Beech Down Dr	Chantilly	VA	20151-3384
2058.	Virginia	Fredrickson	8727 Sheridan Farms Ct.	Springfield	VA	22152-2216
2059.	Lea	Ekman	7411 Park Terrace Drive	Alexandria	VA	22307-2040
2060.	James	Hartneady	3200 Wayne Road	Falls Church	VA	22042-3837
2061.	Robert	New	2 Teenies Tiny Rd	Rutland	VT	05701-9820
2062.	Tim	McGrath	4 Shelburne Rd.	Burlington	VT	05401-4833
2063.	Douglas L	Bordeau Sr	31 Cobb Hill Road	Hartland	VT	05048-9429
2064.	Bernice	Kelman	12 Kelley Road	Underhill	VT	05489-9207
2065.	liz	conforti	79 spring street	Swanton	VT	05488-8006
2066.	bj	hedahl	3019 NE 95th	Seattle	WA	98115-2436

2067.	Sharon	Cox	6416-97th Dr. N.E. #5	Lake Stevens	WA	98258-4014
2068.	Richard	Sweezey	4933 84th Ave SE	Mercer Island	WA	98040-4616
2069.	JAMES	NELSON	11406 Glendale Way S	Seattle	WA	98168-2174
2070.	Thomas	Wettengel	2443 55th ave. sw	seattle	WA	98116-2277
2071.	Erin	McMillin	7509 210th St SW #6	Edmonds	WA	98026-2803
2072.	Don	Johnson	20042 103rd. Pl SE	Kent	WA	98031-1565
2073.	Carol	Watts	6247 26th Ave NE	Seattle	WA	98115-7109
2074.	Susan	Colwell	1117 32nd Ave S	Seattle	WA	98144-3218
2075.	Ron	Tanzi	219 NE 91st Street	Seattle	WA	98115-2712
2076.	Orion	Gudgell	8309 24Th Avenue Nw	Seattle	WA	98117-4440
2077.	Darby	Bennett	6407 Gehrig Drive	Pasco	WA	99301-7858
2078.	Tom	Ohrbeck	PO Box 554	Edmonds	WA	98020-0554
2079.	Terence	Chapin	17234 51st Ave S	SeaTac	WA	98188-3728
2080.	David & Judith	Laws	1718 Valencia Street	Bellingham	WA	98229-5335
2081.	Fran	Christie	9412 1st Dr SE	Everett	WA	98208-2727
2082.	Jerry	Broadbent	Po Box 146	Bucoda	WA	98530-0146
2083.	Fran	Christie	9412 1st Dr SE	Everett	WA	98208-2727
2084.	Cleo	Northrup	2220 SW Rosario PL	Oak Harbor	WA	98277-8423
2085.	Glenn	Eklund	4975 Jones Rd.	Oak Harbor	WA	98277-9649
2086.	Sue & Bill	Morgan	4391 Nelson Siding Road	Cle Elum	WA	98922-9451
2087.	Ferdinand	Werner	5726 143rd St. SW	Edmonds	WA	98026-3725
2088.	Tony	Tamaccio	23413 S.E. 217th Pl.	Maple Valley	WA	98038-8444
2089.	Dick	Rempfer	22648 Blue Ox Trl SE	Yelm	WA	98597-9044
2090.	Timothy	Smith	3214 W Metaline Pl	Kennewick	WA	99336-2448
2091.	philip	rasic	7080 93rd ave se	mercer island	WA	98040-5440
2092.	Janine	VanSanden	10317-32nd Ave. NE	Seattle	WA	98125-7803
2093.	Jan	Starling	4507-B Lexington Place NE	Lacey	WA	98516-6303
2094.	Howard	Steeley	5309 Donnelly Drive SE	Olympia	WA	98501-5015
2095.	Michelle	Hansen	4301 SW Hanford St. #2	Seattle	WA	98116-3359
2096.	John	Van Staveren	6709 S 238th Place #H103	Kent	WA	98032-2644
2097.	Leszek	Cromwell	104 westminster Dr.	kelso	WA	98626-1897
2098.	Charlotte	Howe	1035 NW 166th St.	Shoreline	WA	98177-3714
2099.	Blair	Hopkins	937 W Metaline	Kennewick	WA	99336-3469
2100.	Patrick	Hayes	8419 45th Dr NE	Marysville	WA	98270-2912
2101.	Jackie	Ybarra	15711 180th Place NE	Woodinville	WA	98072-6157
2102.	Robert	Hart	12650 12th Ave S.	Seattle	WA	98168-2243
2103.	Georgann	Falotico	6598 NE Cedar St., Suquamish, WA 98392			Suquamish
2104.	Ronald E.	Figueroa	137 Buckhorn Road	Sequim	WA	98382-8028
2105.	James	Davis	1314 Welch Ave.	Wenatchee	WA	98801-1173
2106.	David	Drott	191 Norush Rd.	Washougal	WA	98671-7057
2107.	John	Vinson	1338 Wingwood Place	Shelton	WA	98584-4026
2108.	Marilyn	Caretti	4604 Somerset Ct	Kent	WA	98032-7156

2109.	Rita	Konzak	8320 234 st s w	edmonds	WA	98026-9321
2110.	Elaine	Syth	12715 E. Guthrie Dr.	Spokane Valley	WA	99216-0343
2111.	Maureen	Michael	4427 Merry Lane, W.	University Place	WA	98466-1343
2112.	Harlan	Solomon	6509 Sierra Dr. SE	Lacey	WA	98503-2932
2113.	Carla	Rei	20700 44th Ave W	Lynnwood	WA	98036-7742
2114.	Charles	Strickland	613 Cedar Park Drive	Port Angeles	WA	98362-8427
2115.	Jeanne	Deller	4235 - 164 Ave SE	Issaquah	WA	98027-7849
2116.	Kristina E.	Bergman	2039 Delphi Rd SW	Olympia	WA	98512-9305
2117.	Patricia	Simon	1142 n. 77th st.	seattle	WA	98103-4808
2118.	Scott	Bishop	1710 Giles NW	Olympia	WA	98502-4734
2119.	Heather	Williams	31514 25th LN S APT# E101	Federal Way	WA	98003-5080
2120.	Eldon	Ball	3022 NE 140th St., #121	Seattle	WA	98125-3588
2121.	Gena	DiLabio	PO Box 1554	Coupeville	WA	98239-1554
2122.	Keith	Margeson Jr.	6228 S Alder St.	Tacoma	WA	98409-4148
2123.	Raven	Crawford	141 windy way	Carlsborg	WA	98324
2124.	Hendrika	Remillard	911 Heather Circle #3	Mount Vernon	WA	98273-9296
2125.	barbara	LaForge	605 Eastside NE	Olympia	WA	98506-4027
2126.	Bob	Blumenthal	2812 NE 62nd St.	Seattle	WA	98115-7221
2127.	Amy	McKay	1806 Main St	Lynden	WA	98264-9763
2128.	Melody	Winkle	2518 NE 92nd St	Seattle	WA	98115-3470
2129.	Dimitrios	Magiasis	12020 101st Ave NE F2	Kirkland	WA	98034-6735
2130.	Gary	Schaitel	815-166th ave se	Bellevue	WA	98008-6027
2131.	Tabo	Miller	1202 47th Avenue East	Tacoma	WA	98424-1232
2132.	Milton	Fife	5500 Olympic Drive	Gig Harbor	WA	98335-1475
2133.	Eivind	Sleveland	5712 37th Ave NE	Seattle	WA	98105-2252
2134.	Jon	Ormond	PO Box 2262	Issaquah	WA	98027-0102
2135.	MARELYN	IMBLER	17427 66TH AVE W	LYNNWOOD	WA	98037-2933
2136.	Carla	Pizzano	3607 Olympiad Dr SE	Port Orchard	WA	98366-8924
2137.	Sara	Ijadi	6420 282nd Ave SE	Issaquah	WA	98027-8862
2138.	Sharon	Vatne	15815 NE 47th Ct	Redmond	WA	98052-5208
2139.	Denise & Travis	Hood	921 Autumn Lane #234	Bellingham	WA	98229-8516
2140.	Alexa	Brown	17524 SE 119th Place	Renton	WA	98059-6604
2141.	Joe	Ginsburg	12210 Densmore Ave. N.	Seattle	WA	98133-7729
2142.	Harrison	Grathwohl	5507 258th Ave. NE	Redmond	WA	98053-2515
2143.	Raymond	Poobus	2115 S. Sheridan	Tacoma	WA	98405-3455
2144.	David	Lomet	17008 NE 139th Street	Redmond	WA	98052-1719
2145.	Wayne	Carpenter	122 N Juniper St Apt 102	Omak	WA	98841-9336
2146.	eric	lesh	6274 old mill rd ne	bainbridge is	WA	98110-3142
2147.	Joan F	Weisenbloom	1950 9th Ave W	Seattle	WA	98119-2820
2148.	Jerry	Richard	1009 W. Blaine St.	Seattle	WA	98119-2935
2149.	John	Bremer	2604 Kentucky St.	bellingham	WA	98229-4058
2150.	Lyn	Henri	18321 E. 9th St.	Spokane Vally	WA	99016-7735

2151.	Ben	Twight	5304 Baker Ave NW	Seattle	WA	98107-2068
2152.	Ernst	Stromsdorfer	6447 Tralee Drive, NW	Olympia	WA	98502-3400
2153.	Kay	Batt	16960 129th Ave SE	Renton	WA	98058-6145
2154.	Gregg	Serene	1626 Gaillard Pl	Richland	WA	99354-2623
2155.	Margarita	Dusek	6035 Crosswinds Dr #8	Cudahy	WI	53110-3421
2156.	Dale	Johnson	319 2nd Ave	New Glarus	WI	53574
2157.	Gerald	Schroeder	E7628 County Road SS	Viroqua	WI	54665-8502
2158.	Regina	Deutsch	500 Bradley Rd, Apt A 210	Fox Point	WI	53217
2159.	Helen	Malinauskas	W2702 Fox Lane	Montello	WI	53949-9027
2160.	Doug	Wright	2815 Hauk St., #105	Madison	WI	53704-5161
2161.	Royal M.	Gordon	122 S. Hartwell Ave	Waukesha	WI	53186-6401
2162.	Lionel	Olson	2414 Lisa Lane	Fitchburg	WI	53711-5533
2163.	James	Wiske	2575 so 82st	West Allis	WI	53219-2420
2164.	david	matthews	N7393 950th st	River Falls	WI	54022-4048
2165.	Kimberly	Salzwedel	w232 n7884 nesting ct	sussex	WI	53089-5702
2166.	Mark	Keleske	524 E Lancaster Ave	Whitefish Bay	WI	53217-5603
2167.	John	Chase	129 13th ave	Union Grove	WI	53182-1286
2168.	Roger	Wood	3400 South 54th Street	MILWAUKEE	WI	53219-4425
2169.	Camilla	Weinandt	616 MAPLE AVE-SIDE DOOR	WAUKESHA	WI	53186-4739
2170.	cymone	simmons	7817 W CALDWELL CT	MILWAUKEE	WI	53218-3526
2171.	Nancy	Gathing	3701 Tulane Ave.	Madison	WI	53714-2952
2172.	Sue	Turner	16775 Gebhardt Rd.	Brookfield	WI	53005-5122
2173.	Wayne	B. Peters	4340 S. 68th St.	Greenfield	WI	53220-3428
2174.	Gretchen	Taylor	206 Mulberry Ln	Lancaster	WI	53813-9603
2175.	Thomas & Sarah	Zimmer	N57W24200 Sycamore Circle			Sussex
2176.	Cindy	Risvold	N7807 Lakeshore Drive	Fond du Lac	WI	54937-1620
2177.	Carl	Pritzlaff	4415 S. 86th Street	Greenfield	WI	53228-2809
2178.	Dave & Tami	Ballard	2607 Camp Phillips Rd	Wausau	WI	54403-9267
2179.	Elysse	C	1610 Dellwood Ct	Grafton	WI	53024-2037
2180.	Daniel	Bosdech	2574 18th Street, #25	Kenosha	WI	53140-4673
2181.	Robert	Hill	E1251 Channel Pk Dr	Waupaca	WI	54981-9737
2182.	Jeanne	Peppard	6906 Schroeder Road, #23	Madison	WI	53711-6108
2183.	Gary	Neu	1810 Fordem Ave #8	Madison	WI	53704-7119
2184.	Ann	Wagner	S4W33255 Government Hill Rd.			Delafield
2185.	Mercedes	Dzindzeleta	609 7th Street	Racine	WI	53403-1129
2186.	Eileen	Prout	14325 Meadowbrook Lane	Brookfield	WI	53005-1630
2187.	Lawrence J	Chisholm	3182 Lower Cove Road	Mathias	WV	26812

2188.	rodman	davis	426 presbyterian church rd	Hedgesville	WV	25427-5516
2189.	Milton	Crum	360 Bluebell Drive	Terra Alta	WV	26764-2619
2190.	Greg	Henshall	217 Brookhaven Drive	Nitro	WV	25143-1103
2191.	Cynthia	Kerfoot	41 Gables Place	Bridgeport	WV	26330-9247
2192.	Kellie	McGettigan	215 Woodland Forest	Winfield	WV	25213-9607
2193.	Jack	Runnels	238 Cody Street	Cheyenne	WY	82009-3400
2194.	Larry	Boyter	9 Pintail Rd	Sheridan	WY	82801-9044
2195.	Joanna	Behrens	P. O. Box 510	Jackson	WY	83001-0510

Submitter : **Mr. Kevin B**

Date: 06/12/2006

Organization : **Private individual**

Category : **Individual**

Issue Areas/Comments

DRG Weights

DRG Weights

This is a test submission.

Submitter : **Mr. Lawrence Vernaglia** **Date: 06/12/2006**

Organization : **Hinckley, Allen & Snyder LLP**

Category : **Attorney/Law Firm**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1488-P-1624-Attach-1.PDF

#1624

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BY ELECTRONIC SUBMISSION

Department of Health and Human Services
Attention: CMS-1488-P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: Comments on Proposed Changes to the Hospital IPPS and FY 2007 Rates

To Whom It May Concern:

We are writing with comments to the Proposed Changes to the Hospital IPPS and FY 2007 Rates (File Code CMS-1488-P) (the "Proposed Rule").[1] Our comments address your discussion in section IV.H.5 of the preamble[2] regarding resident time to be included in the full time equivalent ("FTE") resident count for the purpose of calculating a hospital provider's indirect medical education ("IME") adjustment.

In short, we respectfully assert that the Proposed Rule is *ultra vires* and unconstitutional. Furthermore, we disagree with your conclusion that resident time spent in nonpatient care activities – such as journal clubs or classroom lectures – must be excluded from a hospital's IME FTE count. The agency's contention that the rule excluding nonpatient care activities from the IME FTE count applies retroactively to fiscal years ("FYs") prior to 2001 is unconstitutional and violates the Administrative Procedure Act ("APA").

I. The Proposed Rule is *ultra vires* and thus unconstitutional.

The Social Security Act ("SSA") sets forth a formula to calculate a hospital's IME adjustment.[3] The statute states unambiguously that the IME adjustment is determined by dividing the number of resident FTEs by the number of hospital beds (the "teaching intensity"), and multiplying that ratio by two statutorily-assigned factors. It does not state that resident time spent in nonpatient care activities (or any other activities, for that matter) must be excluded from the calculation of a hospital's FTEs.

The statute's legislative history establishes that Congress did not intend the IME adjustment to be based on actual resident training costs. Congress enacted the IME statute because it believed (i) that inpatient PPS rates were not sufficient to reimburse teaching hospitals for the increased costs associated with training residents and (ii) that the direct medical education ("DME") adjustment did not account for all of the hospital's

[1] 71 Fed. Reg. 23995 (April 25, 2006).
[2] *Id.* at 24114.
[3] *See* 42 U.S.C. § 1395ww(d)(5)(B).

resident training costs. Congress believed that in addition to direct costs – such as salaries and benefits – teaching hospitals incur a host of other immeasurable training costs that the DME adjustment does not capture. The IME adjustment, which is based on a hospital's teaching intensity, was the best proxy for the increased training costs. It was not meant to measure the actual costs of resident training.

Accordingly, the statute and legislative history establish that Congress did not intend that CMS parse apart or exclude certain time from the hospital's FTE count. If Congress had meant for the IME adjustment to be based on a detailed cost reporting scheme, it would have made its intent clear. Thus, the agency is not authorized by the statute to exclude resident time spent in nonpatient care activities. Accordingly, the Proposed Rule is *ultra vires* and unconstitutional.

II. Resident time spent in nonpatient care activities should be included in a hospital's IME FTE count for FYs prior to 2001.

Even assuming that the Proposed Rule were not *ultra vires*, it would nonetheless be improper to exclude nonpatient care time from the IME FTE count for FYs prior to 2001 (as the Proposed Rule does) because CMS did not enact regulations that excluded nonpatient care activities from a hospital's IME FTE count until 2001.[4]

Prior to 2001, the IME statute, regulations, and manual provisions established that resident time spent in both patient and nonpatient care activities should be included in the IME FTE count. The agency's rule excluding nonpatient care time was initially set forth in the 2001 rule and reiterated in the Proposed Rule. In the Proposed Rule, as in the 2001 rule, the agency stated that the rule was the agency's "longstanding" policy and applied retroactively to FYs prior to 2001. The agency's retroactive application of the rule in the Proposed Rule (as in 2001) is unlawful because it amends the agency's policy prior to 2001 without notice and comment rulemaking as required by the APA.[5]

III. The Proposed Rule conflicts with the Ohio District Court's holding in *Riverside Methodist Hospital.*

The United States District Court for the Southern District of Ohio specifically addressed the retroactive application of the 2001 rule in *Riverside Methodist Hospital v. Thompson,* Case No. C2-02-94 (S.D. Ohio 2003). In *Riverside,* the hospital provider appealed the intermediary's exclusion from its IME FTE count resident time spent in journal club, practice management seminars, OB/GYN seminars, and psychiatric seminars. The Court

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[4] *See* 66 Fed. Reg. 39828, 39896 (Aug. 1, 2001).

[5] *See Shalala v. Guernsey Memorial Hospital,* 514 U.S. 87, 100 (1995) (holding that the APA's rulemaking procedures apply when an agency adopts a "new position inconsistent with any of the [agency's] existing regulations.").

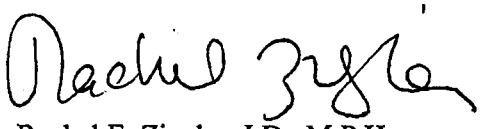
held (i) that the 2001 rule excluding nonpatient care time from the FTE count must not apply retroactively and (ii) that resident time spent on nonpatient care activities should be included in the IME FTE count.

The agency's assertion in the Proposed Rule that nonpatient care activities must be excluded from the IME FTE count flies in the face of *Riverside*. The agency's enactment of the Proposed Rule would constitute an unconstitutional attempt to use the regulatory process to overturn the decision of an Article III court.

We hope that you will consider our comments when preparing the final rule. Please contact us if you have further questions.

Yours truly,

Lawrence W. Vernaglia, J.D., M.P.H



Rachel E. Ziegler, J.D., M.P.H.

LWV/rez

cc: Deb Grady
Stephen Prest
Chris Francazio

::ODMA\PCDOCS\BOSTON\585528\1

CHRISTUS
Health.

June 12, 2006

Honorable Mark B. McClellan, MD, PhD
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 443-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

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

Dear Dr. McClellan,

CHRISTUS Health appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed changes to the Hospital Inpatient Prospective Payment System. Ranked among the top ten Catholic health systems in the United States, CHRISTUS Health includes more than 40 hospitals and facilities in six American states and Mexico. It is our mission to provide quality healthcare to those communities which we serve.

In your proposed rule, you requested comments on the proposed changes to the Diagnosis Related Group (DRG) system. Specifically, we would like to comment on the proposed adoption of severity-adjusted DRGs and the cost-based weighting of DRGs.

At CHRISTUS Health, we support the adoption of severity-adjusted DRGs, such as CMS proposed based upon 3M's APR-DRG methodology. A severity-adjusted system would provide a fair and equitable reimbursement system that appropriately accounts for more severe cases. Likewise, the proposed system will provide valuable assistance to acute care hospitals, such as those in the CHRISTUS Health, that are committed to providing valuable care to patients regardless of their condition or financial status.

While CHRISTUS Health has some concerns over the proposed cost-weighting methodology, we understand the impetus for the changes and are confident that a suitable solution can be reached. On this issue, we would like to offer the following thoughts and concerns:

- CHRISTUS Health is a large system covering over 60 communities, in some areas our acute care hospitals serve a large number of cardiac patients. In these areas, the dramatic reimbursement cuts created by a cost-weighting system will have a large financial impact on acute care hospitals. Any major changes to the reimbursement system must be done in a manner that will minimize the financial impact on community acute care hospitals.

- We share the concerns expressed by the American Hospital Association and others that question the accuracy of the cost-weighting methodology as stated in the proposed rule. In

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order to minimize the impact on acute care hospitals, CMS must ensure that its methodology is accurately measuring relative costs prior to moving forward with major reimbursement changes that will negatively affect acute care providers.

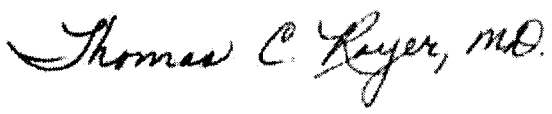
- In order to minimize the impact of adopting a cost-based weighting system, it must be implemented in conjunction with the adoption of severity-adjusted DRG refinements. Both proposals must operate together in order to achieve the objectives CMS seeks. Implementing one proposal before the other will create a skewed system, creating needless hardships on acute care providers until both proposals are fully implemented.

- Once the new DRG system is finalized, it is imperative that hospitals be granted ample time to adjust to the system. These proposals will dramatically alter the finances of acute care hospitals, particularly those that serve a large number of cardiac patients. While the changes may be reasonable in the end, in order to avoid needless complications, hospitals will need ample time to ensure that they have the technology and other tools available to seamlessly adjust to the reimbursement changes. It is not feasible for hospitals to begin planning for these changes based upon a proposed rule, particularly when the exact timing and implementation procedure is still in question. Complicating matters is the looming possibility that the cost weighting methodology may be altered due to the aforementioned concerns regarding the accuracy of the weighting methodology as proposed in the rule.

In conclusion, CHRISTUS Health appreciates the efforts CMS has undertaken to refine Medicare DRGs to more accurately reflect costs and account for the severity of cases. However, we caution that these changes, particularly the cost weighting refinements, may have a more dramatic effect on acute care hospitals than CMS intended. To minimize these potential effects, we ask CMS to take care in ensuring that the methodology used to determine the relative costs weights is an accurate reflection of relative costs. In addition, we suggest that both the severity-adjusted DRG proposal and the cost-weighting proposal be implemented as a package on the same timetable. This timetable must provide acute care providers with ample time and opportunity, after the final system changes are decided upon, to ensure their ability to seamlessly adjust to the new reimbursement system. This adjustment will include refining the hospital's billing system to add the newly created DRGs and alter the components of certain DRGs as outlined in the proposed rule, as well as training staff on changing coding procedures.

As always, CHRISTUS Health stands ready to work with CMS in properly addressing any issue they may have with the acute care healthcare delivery system. Please do not hesitate to call on us if we may be of assistance.

Sincerely,



Thomas C. Royer, M.D.,CEO

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Tel 210.321.8017 • Fax 210.321.8095

Submitter : **Dr. Thomas Royer**

Date: 06/12/2006

Organization : **CHRISTUS Health**

Category : **Health Care Provider/Association**

Issue Areas/Comments

DRG Reclassifications

DRG Reclassifications

see attachment

DRG Weights

DRG Weights

see attachment

Impact Analysis

Impact Analysis

see attachment

CMS-1488-P-1625-Attach-1.DOC

#1625

CHRISTUS
Health

June 12, 2006

Honorable Mark B. McClellan, MD, PhD
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 443-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

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

Dear Dr. McClellan,

CHRISTUS Health appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed changes to the Hospital Inpatient Prospective Payment System. Ranked among the top ten Catholic health systems in the United States, CHRISTUS Health includes more than 40 hospitals and facilities in six American states and Mexico. It is our mission to provide quality healthcare to those communities which we serve.

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order to minimize the impact on acute care hospitals, CMS must ensure that its methodology is accurately measuring relative costs prior to moving forward with major reimbursement changes that will negatively affect acute care providers.

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- Once the new DRG system is finalized, it is imperative that hospitals be granted ample time to adjust to the system. These proposals will dramatically alter the finances of acute care hospitals, particularly those that serve a large number of cardiac patients. While the changes may be reasonable in the end, in order to avoid needless complications, hospitals will need ample time to ensure that they have the technology and other tools available to seamlessly adjust to the reimbursement changes. It is not feasible for hospitals to begin planning for these changes based upon a proposed rule, particularly when the exact timing and implementation procedure is still in question. Complicating matters is the looming possibility that the cost weighting methodology may be altered due to the aforementioned concerns regarding the accuracy of the weighting methodology as proposed in the rule.

In conclusion, CHRISTUS Health appreciates the efforts CMS has undertaken to refine Medicare DRGs to more accurately reflect costs and account for the severity of cases. However, we caution that these changes, particularly the cost weighting refinements, may have a more dramatic effect on acute care hospitals than CMS intended. To minimize these potential effects, we ask CMS to take care in ensuring that the methodology used to determine the relative costs weights is an accurate reflection of relative costs. In addition, we suggest that both the severity-adjusted DRG proposal and the cost-weighting proposal be implemented as a package on the same timetable. This timetable must provide acute care providers with ample time and opportunity, after the final system changes are decided upon, to ensure their ability to seamlessly adjust to the new reimbursement system. This adjustment will include refining the hospital's billing system to add the newly created DRGs and alter the components of certain DRGs as outlined in the proposed rule, as well as training staff on changing coding procedures.

As always, CHRISTUS Health stands ready to work with CMS in properly addressing any issue they may have with the acute care healthcare delivery system. Please do not hesitate to call on us if we may be of assistance.

Sincerely,

Thomas C. Royer, M.D.,CEO

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100 NE Loop 410 • Suite 800 • San Antonio, TX 78216
Tel 210.321.8017 • Fax 210.321.8095

Submitter : **Mr. Doug Holbrook** **Date: 06/12/2006**

Organization : **Saint Joseph's Hospital of Atlanta**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

#1026

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. Glenn Pearson** **Date: 06/12/2006**

Organization : **Georgia Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

DRG Reclassifications

DRG Reclassifications

See Attachment for comments on DRG Reclassifications.

Hospital Quality Data

Hospital Quality Data

See Attachment.

Transparency of Health Care Information

Transparency of Health Care Information

See Attachment.

CMS-1488-P-1627-Attach-1.DOC

#1627

June 12, 2006

Mark McClellan, M.D., PhD.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1488-P and P2
Room 445-G, Hubert. H. Humpfrey 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 Georgia Hospital Association's (GHA) 170 member hospitals, we 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) proposed rules. We endorse and support the comments provided by the American Hospital Association (AHA), including a one-year delay, transparency of health care information, and the proprietary nature of the proposed grouper. GHA is submitting a separate comment letter that specifically addresses the provisions of the Health Care Quality section of the proposed rule.

DRGs: Severity of Illness

GHA supports a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. Prior to making such a significant change in the reimbursement methodology for inpatient services, more analysis is needed to assess the potential financial impact on hospitals. In addition, greater access to the specifics of CMS' methodology and the new CS-DRG GROUPER is needed. The proprietary nature of the proposed CS-DRG GROUPER is of concern. The current DRG GROUPER logic has been in the public domain since the inception of the PPS. Without the new GROUPER logic, it is virtually impossible for GHA or anyone else to thoroughly analyze the system and comment. Without access to the new GROUPER, we have no understanding of how and why patients fall into certain CS-DRGs and cannot evaluate whether it represents policy improvement. We urge CMS to make any new classification system widely available to the public.

HOSPITAL QUALITY DATA

In accordance with the requirements in the DRA of 2005 , CMS has proposed expansion of the 10 quality measure starter set to a total of 21 quality measures and linked the reporting of these measures to the hospital annual payment update (APU) for fiscal year (FY) 2007. The focus areas of the 11 additional measures are acute myocardial infarction, heart failure, pneumonia, and surgical infection prevention (SIP).

The rule also proposes that the data collection for the expanded set of quality measures begin with discharges occurring in the first calendar quarter of 2006 – January – March discharges. This data must be submitted to the QIO Clinical Warehouse no later than August 15, 2006 for hospitals paid under the CMS prospective payment system (PPS) to receive their full market basket update. Failure to submit the data on these additional measures in the time frame proposed will result in those hospitals receiving the full market basket update minus 2 percentage points.

A. **Hospital Quality Data**

- Timing: The final ruling for this proposal will not be announced until August 1, 2006. At this time, hospitals will have only 15 days to comply and submit data for the first 3 months of calendar year (CY) 2006. Although data is not required to be in the data warehouse until August 15, 2006, hospitals must have their data submitted to their performance measurement vendors sometime between June 15 and June 30 depending on the performance measurement vendor, well before the final announcement. Performance measurement vendors have had to move back their cutoff dates to allow hospitals sufficient time to abstract medical records. In essence, a large number of hospitals have only been given about six weeks to meet the new abstraction requirements in this proposed rule.
- Vendor Issues: In preparing to meet the deadlines proposed in this rule, hospitals have to enter into agreements with their performance measurement vendors in order institute a process that allows them to abstract medical records for the additional measures; Hospitals that may have been collecting the data have not authorized their performance measurement vendors to transmit that data to the QIO Clinical Warehouse. In addition, some vendors will need to implement and test new programming quickly to for hospitals to comply.
- Hospital Costs: Hospitals will incur the additional expenses associated with the work required by their respective performance measurement vendors. In addition, overtime costs are required for staff needed to perform this work under an expedited time frame. Hospitals have not been given sufficient time to ensure appropriate training of their medical records staff to ensure a high degree of accuracy in the data abstraction, particularly with respect to the SIP measures. The SIP measures are particularly problematic since few hospitals are presently collecting and reporting these measures to the QIO Clinical Warehouse. Hospitals are concerned about validation scores on these new measures and how it will impact their market basket update.

Recommendations - GHA strongly urges that CMS require the submission of the additional measures, specifically the SIP measures, to begin with 3rd quarter 2006 discharges and that the annual payment update be tied to successful transmission of the measures. Also recommended is that the SIP measures **not** be included in the formal validation process for the annual payment update until after one full year of reporting of the additional measures. GHA does support a review of the records by the Clinical Data Abstraction Center (CDAC) for these measures, especially the SIP measures, to permit hospitals to obtain feedback about the data abstraction for learning purposes during the course of the year.

GHA further recommends that CMS develop a process that affords organizations sufficient time prospectively to begin collection and reporting of any additional measures that will be considered in an annual payment update or part of a value-based purchasing program for hospitals in the future.

Future Measures

The DRA requires the expansion to other quality measures. The types of measures that may be added include: the HCAHPS® patient perception of care survey findings; structure measures as detailed in the recent Institute of Medicine report *Performance Measurement: Accelerating Improvement;* and other measures that reflect consensus among affected parties as required.

Recommendations - CMS has clearly indicated that HCAHPS® results will be considered as part of a future measure expansion. Therefore, hospital payment update may be tied to having HCAHPS® results in the QIO Clinical Warehouse before next fiscal year. Hospitals are required to participate in a dry run before their data is shared publicly but some hospitals have not yet participated. GHA recommends that CMS identify when hospitals will need to have HCAHPS® data reported to the QIO Clinical Warehouse to meet possible time lines for the next fiscal year's APU and to offer another dry run period that will assist hospitals to meet those time frames. Further, GHA recommends that CMS work with the Hospital Quality Alliance (HQA) partners to identify other measures that reflect the quality of hospital care.

B. **Implementing Hospital Value-Based Purchasing in FY 2009**

To improve the quality and efficiency of care delivered to Medicare beneficiaries in America's hospitals, CMS encourages participation in the HQA as a strategy to encourage hospital accountability by making comparative information about hospital performance publicly available.

CMS also notes in the proposed rule that "all providers to which a specific Medicare payment system applies receive the same amount for a service, regardless of its quality or efficiency. As a result, Medicare's payment systems can direct more

resources to hospitals that deliver care that is not of the highest quality or include unnecessary services (duplicative tests and services or services to treat avoidable complications)." Consequently, CMS has indicated that it is examining the concept of "value-based purchasing," which may use a range of incentives to achieve identified quality and efficiency goals as a means of promoting better quality of care and more effective resource use in the Medicare payment systems. And, the DRA of 2005 has directed CMS to develop a plan to implement value-based purchasing beginning with FY 2009.

Comments

- In the CMS proposed rule, the MedPAC report, and the President's FY 2007 Budget, new monies will not be invested in the Medicare program to be used as a quality incentive payment pool. Rather, a small proportion of Medicare hospital payments (1-2 percent of payments) will be set aside to fund a quality incentive payment pool in order to maintain budget-neutrality. CMS has indicated that as its ability to measure quality improves, the amount of money set aside to reward quality performance should increase significantly. Further, MedPAC has recommended that any quality incentive program reward hospitals for improvement and attaining/exceeding certain benchmarks.
- GHA supports the concept of rewarding hospitals both for improvements and attaining/exceeding certain benchmarks, and understands the effort that needs to be invested by hospitals to make and sustain quality improvements in processes of care. However, setting aside 1-2 percent of Medicare payments might not be sufficient to make meaningful awards to hospitals for making improvements and attaining the benchmarks.

Recommendations

- There should be ongoing discussions with partners in the HQA (including the National Quality Forum) with regard to which measures should be added or deleted from any pay-for-performance measurement system.
- GHA supports the development of a composite score for a particular disease category or measure set and believes that composite scoring may help in improving consumer understanding of the processes/dimensions of care as well as assist hospitals in communicating with its clinical teams. Of the two methods described in the proposed rule, GHA prefers the use of the "opportunity model" used in the Premier Hospital Quality Incentive Demonstration project. GHA believes the "opportunity model" provides the flexibility needed to accommodate more individual process and/or outcome measures and the ability to determine whether and how to assign more weight to various measures. GHA would be interested in responding to other composite scoring methodologies under consideration by CMS.
- It is essential that CMS work with HQA partners in developing quality incentive proposals that could be shared in the near future with hospitals for comment given the short-time frame that has been mandated by Congress to begin a Medicare value-based hospital purchasing program.

- An iterative review process should be utilized to build consensus with regards to the value-based hospital purchasing program that CMS selects to implement. GHA recommends that CMS consider implementing a process similar to that used jointly by CMS and the Agency for Healthcare Research and Quality (AHRQ) in shaping the HCAHPS® perception of care survey/ survey methodology. This is a process that involved multiple opportunities for public comment.

B.5. Considerations Related to Certain Conditions, Including Hospital Acquired Infections

Under the Medicare diagnosis-related group (DRG)-based inpatient PPS, payments to hospitals can increase when a post-admission complication, such as infection, occurs. Because of the current design of the DRG system, hospitals with low complication rates could be viewed as being financially penalized because they receive less reimbursement for providing quality care. Under the proposal, hospitals would not receive additional payment for treatment of conditions that potentially could have been prevented if the hospital had implemented evidence-based guidelines.

Recommendations

- Central-line associated bloodstream infections, surgical site infections, and/or ventilator-associated pneumonia would be good candidates for consideration by CMS because there are existing evidence-based guidelines and it would build off CMS' current Surgical Care Improvement Project (SCIP).
- GHA strongly urges CMS to do extensive work to subject the reimbursement schema only to those potentially preventable complications, such as hospital-acquired infections (HAI). Complications do not necessarily represent medical errors, since they are not always preventable even with optimal care. Secondary diagnosis codes indicative of infection serve as poor proxies in identifying true HAIs. Even IF the use of secondary diagnosis codes was an accurate way to detect HAIs, not all HAIs are preventable in every patient. Some patients may be more susceptible to infection due to their disease or condition and not as a result of poor care.
- Another candidate for consideration may be the development of deep vein thromboses or pressure ulcers as they may be more clear-cut and more easily identifiable using secondary diagnosis codes and still build off of the SCIP program.
- GHA recommends that CMS consider a smaller-scale demonstration project to test any methodology with hospitals before a national implementation.

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. HHS intends to identify several regions in the United States with high health care costs where there is significant interest in reducing those costs and improving health care quality.

Significant progress has been made in making quality information more transparent. The AHA, the Federation of American Hospitals and the Association of American Medical Colleges partnered with CMS and others to form the Hospital Quality Alliance (HQA). The work of the HQA has led to the voluntary reporting and sharing with the public of 21 quality measures on the *Hospital Compare* Web site, and more measures of hospital quality and patient satisfaction are planned for the future. This effort has been tremendously successful, with nearly all inpatient PPS hospitals voluntarily reporting quality information. **Efforts to further expand public availability of hospital quality information must continue to be pursued through the HQA.**

While progress has been made regarding quality transparency, similar information on hospital pricing is less accessible. 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).

People deserve meaningful information about the price of their hospital care. Hospitals are committed to sharing information that will help people make important decisions about their health care. Sharing pricing information, however, is more challenging because hospital care is unique. Hospital prices can vary based on patient needs and the services they use; prices reflect the added costs of hospitals' public service role – like fire houses and police stations – serving the essential health care needs of a community 24 hours a day, seven days a week; and most hospitals cannot yet provide prices that reflect important information from other key players like the price of physician care while in the hospital or how much of the bill a patient's insurance company may cover. But more can, and should, be done to share hospital pricing information with consumers.

Providing *meaningful* information to consumers about the price of their hospital care is the most significant challenge hospitals, and CMS, face in increasing transparency of

hospital pricing information. Objectives for improving pricing transparency should include:

- Presenting information in a way that is easy for consumers to understand and use;
- Making information easy for consumers to access;
- Using common definitions and language to describe pricing information for consumers;
- Explaining to consumers how and why the price of their care can vary; and
- Encouraging consumers to include price information as just one of several considerations in making health care decisions.

The AHA recently released a position statement on hospital pricing transparency outlining steps to be taken to improve the pricing information available to health care consumers. The following four steps represent the AHA's roadmap for pricing transparency.

1) A federal requirement for states, working with state hospital associations, to expand existing efforts to make hospital charge information available to consumers.

- Thirty-two states already have statutes requiring hospitals to report pricing information that is made available to the public either by posting to a hospital, hospital association or government Web site, issued in a government or hospital association report, or made available to consumers upon request; five additional states voluntarily do so.
- State efforts on price transparency vary, from making individual hospitals' master list of charges available to the public (e.g., California), to making pricing information on frequent hospital services available to the public (e.g., Missouri, Florida, Nevada, North Carolina), to making information on all inpatient services available to the public (e.g., Colorado, Kentucky, Oregon, Pennsylvania, Wisconsin).

2) A federal requirement for states, working with insurers, to make available in advance of medical visits, information about an enrollee's expected out-of-pocket costs.

- This information is especially important to the majority of consumers who already have some type of health insurance coverage. Their likely interest is in knowing the amount for which they personally are financially responsible. This information is provided today to consumers by their insurance company – it is called an "explanation of benefits, or EOB – but is only given after care is

provided. To help inform consumers in advance of their out-of-pocket obligations, insurers could provide an "advance EOB." This information could be shared with an insured individual by phone or electronically through an insurer's Web site. Aetna is currently piloting a project like this for physician services in Cincinnati.

3) A federal-led research effort to better understand what type of pricing information consumers want and would use in their health care decision-making.

We have learned much based on research about what kind of information consumers want about the quality of their health care. But we know less about what consumers may want to know about pricing information. Consumers need different types of price information, depending on whether and how they are insured. The following illustrates different consumer needs:

- **Traditional Insurance.** Because traditional insurance typically covers nearly all of the cost of hospital care, people with this type of coverage are likely to want information about what their personal out-of-pocket cost would be if they receive care at one hospital versus another.

- **Health Maintenance Organization (HMO) Insurance.** People who have HMO coverage will have even more specific price information needs. They have agreed, in advance, to adhere to certain limits on their choice of physician or hospital in exchange for broad-based coverage of their health care needs. A person with HMO coverage typically faces no additional cost for care beyond their premium and applicable deductibles and copayments, but must agree to use physicians and hospitals that are participating in that HMO plan. These individuals likely have little, if any need for specific price information.

- **High-Deductible or Health Savings Account (HSA) Insurance.** People with HSAs have more interest than a typically insured person in price information. These types of plans are designed to make consumers more price-sensitive and to encourage consumers to be prudent "shoppers" for the care they need. A typical plan of this type has a deductible of $2,500. But consumers with HSA coverage are likely to be more interested in price information for physician and ambulatory care than for inpatient hospital care for several reasons:

    - Many patients admitted to the hospital were first seen on an emergency basis in the hospital emergency department. These are not price-shopping patients, but patients who found themselves in need of emergent care and either came or were brought to the nearest hospital emergency department.
    - For patients admitted to the hospital for a scheduled or elective procedure, inpatient hospital price information may be less important because most, if not all, hospital admissions result in a cost that exceeds the typical HSA deductible of $2,500, and therefore, are covered by most HSA plans.
    - People with HSA coverage may be most interested in comparing prices and shopping for care to be delivered that leads up to meeting their

deductible (typically $2,500). People with this type of coverage may be most interested in prices for physician office visits and other ambulatory care for which they are likely to be responsible for paying the full cost.

- **Uninsured Individuals of Limited Means.** People without insurance who have limited means for paying for the health care services they have received need to know how much of their hospital or physician bill they may be responsible for. In the case of hospital care, the information they need must be provided directly by the hospital, after the hospital can ascertain whether a patient may qualify for state insurance programs of which they were unaware, free care provided by the hospital, or other financial assistance.

4) A hospital-led effort to create consumer-friendly pricing "language" – common terms, definitions and explanations to help consumers better understand the information provided.

More can be done to explain pricing information to consumers clearly and consistently. Hospitals will lead an effort to create common terms, definitions and explanations of complex pricing information. This will include sharing innovative and understandable ways for displaying pricing information for use by consumers.

The four points of this roadmap include an appropriate role for HHS, which should provide incentives to the states to improve transparency at the state and local level. HHS, through the Agency for Healthcare Research and Quality (AHRQ), is in the best position to complete research on what consumers want and would use in purchasing health care services.

The GHA appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me at (770) 249-4500 or gpearson@gha.org

Sincerely,

Glenn Pearson
Executive Vice-President

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

Organization :

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

see attached letter

CMS-1488-P-1628-Attach-1.DOC

#1628

19065 Hickory Creek Drive, Suite 300
Mokena, IL 60448
708 478-6300 **Tel**
708 478-5960 **Fax**

June 9, 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 six hospitals of Provena Health, I appreciate the opportunity to submit these comments to the Centers for Medicare & Medicaid Services (CMS) regarding 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.

The proposed rule, if adopted as proposed, would make the most significant changes to the hospital inpatient prospective payment system (IPPS) since its implementation. For this reason, we believe very strongly that caution and care must be taken as we move forward with any proposals.

CMS' proposal includes significant changes in the methodologies used to calculate the relative weights of the diagnostic related groups (DRGs) that determine Medicare's payments for hospital inpatient services. The proposed rule creates a version of cost-based weights, rather than charge-based, using a newly developed hospital-specific relative values cost center methodology (HSRVcc). CMS proposes this change be implemented for FY2007.

In addition, CMS proposes to change the method for identifying the variation in patients' severity of illness (CS-DRG), resulting in an increase in the number of DRGs. CMS indicates that this change would be implemented in FY 2008, but possibly earlier.

Finally, another major proposal is 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.

While we could support many of the proposed rule's provisions, I wish to express serious concerns about the proposed changes to the DRG weights and classifications. While I am supportive of meaningful improvements to Medicare's inpatient PPS, more time is needed to clearly understand the significant proposed policy changes, which redistribute from $1.4 to $1.7 billion within the Medicare inpatient system. A preliminary analysis shows that the proposed changes are highly unstable, with small changes in method leading to large changes in hospital payment. Moreover, the validity and value of CMS' proposals versus potential other alternatives to improve the DRG weights and classification system is uncertain. In short, moving forward with a proposed rule of this magnitude requires thoughtful change.

Specifically, Provena Health recommends and supports the following:

- One-year Delay: we urge you to delay for one-year the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology.

- Valid Cost-based Weights: While we generally support moving to a DRG-weighting methodology based on hospital costs rather than charges, CMS' proposed HSRVcc method has flaws that need to be addressed.

- A New Classification System Only if the Need Can Be Demonstrated: The need for such a new system is still unclear. Much more work in understanding the variation with 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 out the volatility created by these two generally off-setting changes.

- Three-year Transition: Given the magnitude of payment redistribution across DRGs and hospitals, any changes should be implemented with a three-year transition, during which hospitals are protected from major payment disruptions.

We are concerned about the potential unintended consequences and implications of such unproven or widely tested payment changes on Provena Health's hospitals. Given the obvious potential impact on our hospitals' reimbursements, we respectively urge CMS to postpone implementing either of 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.

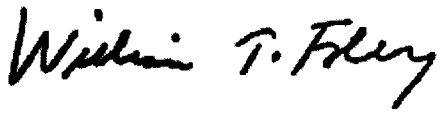
This postponement is all the more essential in light of the newly proposed, but court-mandated, occupational mix adjustment to the area wage index. While we understand

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 smooth out the impact of this change on adversely affected hospitals. Such attention could take the form of a multi-year transition or the use of corridors, as CMS has used in the past.

As regards other areas of proposed rulemaking in the notice (e.g. value-based purchasing, health care IT, health care transparency, etc), we would direct you to the comment letters submitted by both the Catholic Health Association and American Hospital Association, whose recommendations and comments we would support on behalf of Provena Health.

I thank you in advance for your attention to this matter. Hospitals are committed to working with your agency to bring about changes to the Medicare inpatient PPS that are fair and benefit Medicare, hospitals and their patients alike. We look forward to continue working together with you toward this goal.

Sincerely,



William Foley
President and CEO

Submitter : **Dr. Vijay Mirmira** **Date: 06/12/2006**

Organization : **North Oakland Medical Center**

Category : **Individual**

Issue Areas/Comments

GME Payments

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.

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,

Vijay Mirmira
Family Medicine Resident
North Oakland Medical Ctrs

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

Organization : **University Hospital Health System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1630-Attach-1.PDF

#1630

University Hospitals Health System

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, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule.

Dear Dr. McClellan:

As Director of Reimbursement for the University Hospitals Health System in Cleveland, Ohio, I welcome 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.

The rule proposes creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology. It also proposes refining the DRGs to account for patient severity, with implementation as early as FY 2007 but more likely in FY 2008. Additionally, the rule proposes updating the payment rates, outlier threshold, hospital wage index, medical education, quality reporting requirements, and payments for rural hospitals, among other policies.

While supporting the need for refinement of the system, we have serious concerns with the proposed changes to the DRG weights and classifications, especially when using a new methodology as a basis for the proposed changes. Our concerns with the proposed rule are as follows:

1. Per the proposed regulation, **CMS established 10 cost center categories based on broad hospital accounting definitions**: routine day costs; intensive care day costs; and eight ancillary cost centers. The 2003 Medicare cost reports were used as the basis for grouping all of the patient related cost centers into the 10 cost center categories.

   This methodology appears to be flawed in that line subscripting on the cost report is not uniform across all hospitals, and inappropriate groupings could be made due to the inconsistent subscripting. If CMS is going to move to cost-based weights, regardless of the methodology, hospitals will need time to align their mapping cost centers into departments or cost categories for purposes of cost reporting with that of claims reporting.

Should CMS decide to pursue this methodology, we recommend expanding the required lines on the Medicare Cost Report to accurately reflect the groupings and postponing the implementation until corrections are made to account for line subscripting.

2. Through various discussions, **it was not clear whether the cost reports used were audited or as-filed**. If only as-filed cost reports were used, there would be potential errors since corrections and offsets by the fiscal intermediaries were not incorporated into the data. If only audited cost reports were used, there would also be potential errors since not all of the hospitals have had their 2003 cost reports audited. We recommend a thorough review of the cost reports used as a basis for the methodology.

   We support at least a one-year delay in the proposed DRG changes due to our serious concerns about inconsistencies in the new hospital-specific relative values methodology.

3. It has been reported that CMS inadvertently included organ acquisition costs in the data used to set weights for DRGs. Our system performs transplants and these costs should be excluded. This error has a material effect on the resulting weight calculation for transplants.

4. If **changes to complications and commorbidities** (CC's) would correct a "bias" in the DRG system, we support these changes. Given that the current (CC's) have been in place for 20+ years, it would make sense to update and change them to reflect the current state of healthcare. A review would need to be conducted to comprehend the impact these refinements have on the payments to providers. However, changes to complications and commorbidities do not necessarily warrant replacement of the existing DRG system until the effect of the change in (CC's) has been analyzed.

5. **The proposed severity-based DRG system (APR-DRG)** will attempt to distinguish more-sick from less-sick patients through eliminating the "cherry picking" of healthy patients by the specialty type hospitals. While noble in attempt, it is penalizing hospitals that have heavier surgical mix of patients – which comprise the majority of the patients of teaching and urban hospitals. Hospitals with a high medical mix of patients – which comprise the majority of the patients of smaller suburban and rural hospitals appear to benefit by the proposed changes.

   The DRG system currently in place was created to distinguish the resource use required among patients. It has been modified over time to reflect changes in clinical practice and technology. Since the proposed (APR-DRG) system will be based on the severity of illness and not necessarily on the required resources used to treat the patient, the "true" impact of moving to such a system is uncertain.

While we are not opposed to updating the current DRG system, we would recommend delaying the implementation of a severity based system until the effects of changes to the complications and commorbidities could be ascertained and the need for further changes along the severity line be determined. Through correction to the complication and commorbidities, a drastic shift may occur in the payments received by providers. Without the knowledge of how the changes would impact the providers, it would be improper to implement the severity based system in addition to a correction to the complications and commorbidities.

6. **We are also concerned about the proposed re-weighting of the long-term care hospital (LTCH) DRGs for FY 2007.** We are estimating approximately 8.5% in cuts, (1.4%) from the proposed re-weighting in addition to the (7.1%) payment cut resulting from the recent LTCH PPS final rule for 2007. These draconian cuts are detrimental to the provision of care for the patient and may ultimately restrict access for patients needing long-term acute care services. It is extremely difficult for any long-term care hospital to withstand an 8.5 percent cut in one year and we would recommend elimination of these cuts in favor of re-weighting in a budget neutral manner.

   It is irrational to treat the LTCH PPS differently than other Medicare payment systems by failing to re-weight the LTCH PPS in a budget-neutral manner.

7. The proposed rule states that to **qualify for their full market basket update, hospitals would have to pledge to submit data on all 21 measures currently part of the Hospital Quality Alliance's (HQA) public reporting for patients discharged on or after January 1.** Hospitals failing to submit data for the first calendar quarter of 2006 by August 15 would receive an inpatient update equal to the market basket minus two percentage points. Hospitals that fail data validation tests for data submitted for the first three calendar quarters of 2006 would also lose the two percentage points from the market basket update.

   We support the effort to make more information on hospital quality available to the public, and we join with CMS in wanting to make it happen quickly and accurately. However, as written, the proposed rule 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.

   After having to drop everything to prepare early submission of the Occupational Mix data, 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.

   We recommend that the data collection should be done on a prospective basis and CMS should consider publishing the proposal at least one full year prior to the

start of the fiscal year. This will enable hospitals to put the needed data collection processes in place to be able to provide the requested data.

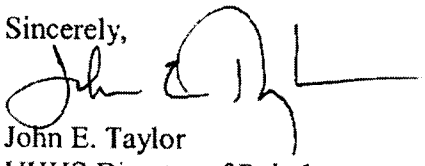
8. **We are concerned with the proposed exclusion of didactic training for Graduate Medical Education.** The proposed rule states that resident training that occurs at non-hospital sites must be related to patient care if a hospital wishes to count that time for direct medical education (DGME) and indirect medical education (IME) payment purposes. Resident time spent in didactic activities that often occur in associated medical schools – such as educational conferences, journal clubs and seminars – would specifically be excluded. CMS noted that its statement in a previous letter on this topic "implying that didactic time spent in non-hospital settings could be counted for direct GME and IME ... was inaccurate." CMS also noted that time spent in these activities could be counted for DGME purposes if they occur in a hospital; however, the counting prohibition applies for IME payments regardless of where the educational activity occurs.

   We strongly urge CMS to rescind the purported "clarification" in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare DGME and IME payments. The stated rationale for the exclusion of this time is that it is not "related to patient care." This position is in stark contrast to CMS' 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."

   We are in agreement with the CMS position in 1999. 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 this change 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.

We appreciate the opportunity to comment on the proposed regulation changes.

Sincerely,



John E. Taylor
UHHS Director of Reimbursement
University Hospitals Health System
11100 Euclid Avenue
Mailstop LND 5022
Cleveland, OH 44106-5022

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

Organization : **NACHRI**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachemnt

CMS-1488-P-1631-Attach-1.DOC

#1631

June 12, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1488-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1488-P, Medicare Program, Proposed Changes to Hospital IPPS: New ICD-9-CM Code Assignments

Dear Dr. McClellan,

This letter is to provide comments regarding the assignment of two new diagnosis codes to the version 24 Medicare DRGs.

In reviewing Table 6A, New Diagnosis Codes (page 24289) we've noticed what may be an error in the assignment of two new diagnosis codes. The new diagnosis code 629.81 habitual aborter without current pregnancy and 629.89 other specified disorders of female genital organs have been assigned to MDC 13 medical DRG 368 Infections, Female Reproductive System. We think these two new diagnosis codes were instead intended to be assigned to DRG 369 Menstrual & Other Female Reproductive System Disorders.

Thank you for your attention to this item.

Sincerely,

John Muldoon
Vice President, Classification Research
NACHRI

Submitter : **Dr. Dwight Reynolds**

Date: 06/12/2006

Organization : **Heart Rhythm Society**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1632-Attach-1.PDF

#1032

June 12, 2006

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

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

Dear Dr. McClellan:

The Heart Rhythm Society (HRS) appreciates the opportunity to comment on the CMS Proposed Rule on the Medicare Hospital Inpatient Prospective Payment System for FY 2007, published in the April 12, 2006 Federal Register (CMS-1488-P). We believe that a hospital prospective payment system needs to successfully provide quality health care to Medicare beneficiaries, while at the same time controlling costs, encouraging efficiency, and simplifying payments for hospital services. An important requirement of any payment system, however, must be to pay appropriately for medical procedures and services, so as not to limit access to care or diminish the quality of care. Payments and the determination of such payments must be reasonable and fair and based on accurate and complete data. The Heart Rhythm Society is seriously concerned that the proposed changes in Medicare's hospital inpatient prospective payment system for Fiscal Year 2007 will be detrimental to Medicare beneficiaries, if implemented in FY '07. The Heart Rhythm Society recommends the following:

- **CMS delay the implementation of this proposed rule at least one year, or until a more thorough and detailed impact analysis be completed, and that all stakeholders have an opportunity to participate and review the data used in the analysis.**
- **CMS implement the severity adjusted patient classification system at the same time as any new DRG methodology is implemented.**
- **The health care community be given a longer period of time (greater than 60 days) to analyze these proposed changes and impacts.**
- **Any such new approach be phased in over a period of a few years to avoid large swings in payment in either direction.**

HRS is the international leader in science, education and advocacy for cardiac arrhythmia professionals and patients, and the primary information resource on heart rhythm disorders. Founded in 1979, HRS is the preeminent professional group representing more than 4,200 specialists in cardiac pacing and electrophysiology, known as electrophysiologists or heart rhythm specialists. HRS' members perform electrophysiology (EP) studies and curative catheter ablations to diagnose, treat and prevent cardiac arrhythmias. Electrophysiologists also implant pacemakers and implantable cardioverter defibrillators (ICDs) in patients who have indications for these life-saving devices. After device implantation, heart rhythm specialists then monitor these patients and their implanted devices. The proposed changes impact the procedures and services Heart Rhythm

1400 K Street NW, Suite 500 | Washington, DC 20005 | USA | Phone: 202-464-3400 | Fax: 202-464-3401 | info@HRSonline.org | www.HRSonline.org

Heart Rhythm Society℠

Society members deliver in communities across the nation. These changes are detailed below. Impacts of this magnitude will likely lead to diminished care for Medicare beneficiaries.

Heart Rhythm DRGs

DRG	Procedure	% Loss	Loss/ Proc.	Total loss
118	Card. pacemaker device replacement	-12.7%	-$1,069.19	-$8 Million
515	Card. defibrillator implant w/o CC	-22.6%	-$6,425.24	-$374 Million
535	Card. defib. implant w/ CC w/ AMI/ HF/ Shock	-23.8%	-$9,784.77	-$86 Million
536	Card. defib. implant w/ CC w/o AMI/ HF/ Shock	-22.2%	-$7,911.27	-$65 Million
551	Perm. card. pacemaker implant w/ maj. CV DX or AICD lead or GNRTR	-12.5%	-$1,991.75	-$107 Million
552	Other perm. card pacemaker implant w/o maj. CV DX	-13.3%	-$1,436.35	-$118 Million
518	Percutaneous cardio proc. w/o coronary artery stent (ablations)	-28.8%	-$2,458.64	-$58 million
	TOTAL			**-$758 Million**

Rationale for Heart Rhythm Society Recommendations:

Data Concerns:
The proposal appears to have methodological flaws and to be based on inaccurate data. For example, the hospital-specific relative value approach exaggerates the redistributive effects of the proposal and biases payments against larger facilities that provide more sophisticated and expensive care to Medicare beneficiaries. The magnitude of the cuts that would be imposed on urban teaching hospitals due to the use of this approach, even those located in primarily rural states, could have significant adverse consequences for patient care.

Significant concerns have also been raised about how data was "trimmed", the accuracy of cost data collected by hospitals through cost reports, as well as mathematical errors in the calculation of the proposed payment rates. It is our understanding that over 200 hospitals were "thrown out" of the data set, including large numbers of academic health centers. This will distort any analysis that CMS conducts. Additionally, CMS failed to adjust for hospital volume of care. The result of this flawed approach is that a small hospital of 50 beds has as much weight in the calculation, as a large tertiary care center/academic health center. These two methodological errors are inherently unfair and need to be corrected in any Final Rule.

The methodology's assumption that there are similar cost-to-charge ratios for devices that vary significantly in cost is not supported by research or data. CMS should consider separate cost categories for complex medical devices. CMS has failed to address issues related to "charge compression." The rule fails to fix the charge compression problem that has penalized technology-intensive procedures for years. Hospitals routinely use different 'mark-ups' for low cost devices (blood pressure cuff) vs. more technologically complex, higher cost devices (ICDs). CMS needs

to acknowledge and address the issue of charge compression to more appropriately reimburse for these items and procedures. Additionally, instead of increasing specificity to identify actual device costs, the rule inappropriately lumps costs together into just 10 national cost centers to derive cost-to-charge ratios.

The Heart Rhythm Society supports the goal of improving payment accuracy for hospital inpatient services, but we believe that CMS should resolve these methodological problems before it implements such sweeping changes. Even if CMS did correct the methodological errors in the proposed rule, there would not be sufficient time for another public comment period to review the CMS changes before publication of the final rule at the beginning of August and implementation in October.

Severity Adjusted DRGs:
The Heart Rhythm Society is concerned about how the proposed changes for Fiscal Year 2007 will be integrated with planned changes for 2008. Payments for some procedures may be dramatically changed in one direction and then the other. The Medicare Payment Advisory Commission (MedPAC) recommends that all changes be implemented simultaneously and we concur. Data was not made available to stakeholders to evaluate implementing severity adjusted DRGs along with the hospital specific relative values and the 10 cost center groupings. The blending of these two major changes is necessary and appropriate; however, it has not been possible to model both of these changes simultaneously.

Phase-In Recommended:
Hospitals need to be given sufficient time to adapt to changes of this magnitude. A significant lead-time before changes are implemented would help hospitals budget accurately. The Heart Rhythm Society is recommending a phase-in of these changes over several. MedPAC has recommended a transition to the new rate setting system and we concur with that recommendation. The hospital reimbursement system has not seen changes this significant for decades and it will take time for hospitals to adapt.

Quality Improvement and Data Collection Efforts Thwarted
CMS and Congress have emphasized the development of quality measures and activities. For example, the recent CMS mandate for hospitals to enroll in the National Cardiovascular Database Registry - ICD Registry, a joint partnership of the American College of Cardiology and Heart Rhythm Society, represents personnel the hospital has to dedicate for this important initiative. Without accurate and appropriate reimbursement for these critical services, hospitals will not be able to dedicate resources to important quality improvement initiatives such as this. Over 1,250 participant hospitals have enrolled in the ICD Registry, with over 18,000 ICD implant records submitted. This represents significant hospital resources and personnel, without any additional payment provided to meet this mandate. If these new DRGs are implemented by CMS, hospitals will find it extremely difficult to devote the necessary personnel to this critical task.

We thank CMS' leaders for their consideration of this matter and hope that these dramatic and unwarranted changes to the hospital payment system are not implemented in FY '07 as proposed. Heart Rhythm Society members will continue to strive towards providing quality heart rhythm services to Medicare beneficiaries. Thank you very much for the opportunity to provide public

Heart Rhythm Society℠

comment on these critical issues. If you have any questions about the position of the Heart Rhythm Society or would like to discuss these issues in more detail, please contact Amy Melnick, Vice President, Heart Rhythm Society at amelnick@hrsonline.org or 202.464.3434.

Sincerely,

Dwight Reynolds, MD, FHRS
President
Heart Rhythm Society

1400 K Street NW, Suite 500 | Washington, DC 20005 | USA | Phone: 202-464-3400 | Fax: 202-464-3401 | info@HRSonline.org | www.HRSonline.org

Submitter : **Mr. Mark Taylor** **Date: 06/12/2006**

Organization : **Spectrum Health Hospitals**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1633-Attach-1.DOC

#1633

Spectrum Health

100 Michigan Street NE
Grand Rapids, Michigan 49503
www.spectrum-health.org

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:

Spectrum Health Hospitals appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the fiscal year (FY) 2007 inpatient prospective payment system (PPS) proposed rules.

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc). It also proposes refining the DRGs to account for patient severity, with implementation likely in FY 2008. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education, among other policies.

While Spectrum Health Hospitals supports many of the proposed rule's provisions, we have serious concerns about the proposed changes to the DRG weights and classifications.

Spectrum Health Hospitals supports meaningful improvements to Medicare's inpatient PPS. We believe it is important to refine the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. 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. Moving forward requires thoughtful change.

Specifically, Spectrum Health Hospitals supports the following:

One-year Delay: The AHA supports a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. We in the hospital field are committed to working with CMS over the next year to address these concerns.

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.

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.

We appreciate the opportunity to submit these comments.

Sincerely,

Mark A. Taylor
Director – Revenue Management Services
Spectrum Health Hospitals

Submitter : **Ms. Crystal Estabrook** **Date: 06/12/2006**

Organization : **Iowa Health - Des Moines**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment regarding the following issues:
1.) DRG Weights and Severity of Illness
2.) Changes to CMI from a New DRG System
3.) Operating Payments - Cost Outliers
4.) Occupational Mix Adjustment
5.) DGME and IME Payments

CMS-1488-P-1634-Attach-1.DOC

#1634

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

Attention: CMS-1488

Dear Administrator McClellan:

Iowa Health – Des Moines welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' proposed rule entitled "Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." Below are the comments that Iowa Health – Des Moines would like to address:

DRG Weights and Severity of Illness

IOWA HEALTH - DES MOINES supports meaningful improvements to the Medicare Diagnostic Related Group (DRG) patient classification system, but stresses **that any change of this nature and magnitude must be ensured to create a better, more accurate and equitable payment system**. In that regard, IOWA HEALTH - DES MOINES supports a **one-year delay** to the proposed changes to the DRG system. During this time, a thorough evaluation must be conducted to ascertain **whether or not there is a need** for a new patient classification system. More work is needed to assess the proposed or other classification systems to understand whether it results in an improved hospital payment system. IOWA HEALTH - DES MOINES supports moving to a cost-based weight structure, but the CMS method is flawed as detailed below. If the need for and best approach for changing the patient classification system can be demonstrated, IOWA HEALTH - DES MOINES **supports simultaneous implementation** of the DRG weight changes and new classification system.

IOWA HEALTH - DES MOINES recommends CMS **provide at least one year from the date of the publication of the final rule to the implementation of the changes** to the DRG reimbursement system. Such a precedent has been set with the HIPAA regulations by allowing a two-year implementation period upon the publication of the final regulations. The state of Maryland has recently adopted the APR-DRG system and moved to a cost-based DRG structure. CMS should more carefully evaluate Maryland's model and use it as a basis upon which to establish its own implementation period. Hospitals in that state strongly recommend providing at least one year to prepare financially and operationally for such changes, and that the changes be made concurrently. **IOWA HEALTH - DES MOINES is committed to working with CMS** to develop and evaluate alternatives for new weights and patient classifications.

The proposals to adopt the Hospital-Specific Relative Value (HSRVcc) and the Consolidated Severity-Adjusted DRG (CS-DRG) system both present particular concern to Iowa hospitals. As written, neither proposal will ensure it will create a more accurate or equitable payment system.

Concerns regarding the proposal to adopt the HSRVcc and the CS-DRGs include:

- The 10 selected cost centers contain inherent flaws because there are no standard reporting requirements for determining which resources go into which cost center on the Medicare cost report. Because of this, some supplies will be grouped into other cost centers, such as the Operating Room (OR). Or, some services, such as cardiac, may be classified into other cost centers than Cardiology. For example, if a hospital inserts a pacemaker during surgery, that cost may go into the OR for hospital A, and into the Supplies & Equipment cost center for hospital B.
- The cost centers taken from the HCRIS file and the cost centers taken from the MedPAR file do not provide a one-to-one correlation. Auditors for Medicare fiscal intermediaries (FIs) are unable to navigate from hospital-to-hospital, the mapping from the MedPAR cost centers to the cost report. Because of this, the auditors provide the MedPAR reports to each hospital for them to map individually.

- CMS did not provide details on how it mapped the cost centers taken hospital claim data to the cost center from the cost report.

- CMS has not provided information on how it collapsed the other cost centers into the 10 defined cost centers.

- Several data errors have been identified since the publication of the proposed rule. Specifically:
  - Organ Acquisition costs were inadvertently included in the data used to set weights for DRGs.
  - The treatment of certain categories of hospitals between their calculation of the FY 2007 HSRVcc weights and the proposed CS-DRG weights was inconsistent, making it difficult to directly compare the results.
  - It is unclear whether the weights published for CS-DRGs included using the transfer-adjusted charges prior to calculating weights.
  - CMS hospital-weighted rather than charge-weighted the calculation of the mean cost-to-charge ratios (CCR) used to scale the charge-based weights. This approach over-weights the routine cost share and under-weights the ancillary cost shares.
  - By using a 1.96 standard deviation to trim the cost center CCRs for inclusion in the calculation of the scaling factors, 260 hospitals' data was excluded.

- Data analysis shows the impact of the changes to be highly unstable with small changes in methodology leading to large fluctuations in hospital payment.

- CMS has not made publicly available CS-DRG GROUPER software, nor has it made available the specifications for the industry to conduct analyses. Iowa hospitals are particularly concerned about the proprietary nature of this software and what this will mean in terms of purchasing this software.

- CMS has not provided a validation analysis that the proposed changes result in more accurate and equitable payments.

- CMS has failed to mention how its other reimbursement systems that rely upon the DRGs would, or would not be, affected by the changes to the DRGs, specifically, the Inpatient Psychiatric Facility and Long-Term Acute Care Facility PPSs.

- Hospitals would incur significant costs in purchasing the encoder software for a CMS-unique patient classification system, while maintaining the encoder software for the existing DRG

system, **and** the APR-DRG system that other payers within the industry are moving toward.

- CMS' claims processing system only recognizes six diagnosis codes and nine procedure codes on hospital claims.

- The proposal fails to address how the outlier policy will be affected.

- The proposal fails to address how the transfer DRGs will be affected.

In response to the numerous concerns detailed above, IOWA HEALTH - DES MOINES recommends the following:

- CMS must be able to illustrate to the hospital industry the proposals to change the DRG system will in fact result in a more accurate and equitable reimbursement system.

- **If CMS uses the methodology it has proposed to develop the cost-based structure to the DRGs, the agency should develop cost reporting instructions that standardize the reporting of resources to various cost centers** so that the data used to construct the weights for the DRGs is sound and consistent. If standard cost reporting instructions are to be issued, the agency will need much more time before it implements changes to the structure of the DRG weights.

- If this cost-base structure methodology is utilized, CMS must provide the following: (1) mapping from cost centers on the MEDPAR to the Medicare cost report and (2) detail on how it collapsed the other cost centers to come to the 10 defined cost centers.

- The data concerns identified above must be accounted for and corrected.

- **Iowa hospitals do not support the adoption of a Medicare-specific payment classification tool** due to the burden it creates on hospitals and for consistency purposes across the other payers that model their reimbursement from the Medicare program. The APR-DRG could be used if CMS sets the values to the unused DRGs to a neutral number.

- If CMS proceeds with its unique patient classification system, it must make publicly available GROUPER software, as has been the case with the current DRG GROUPER. This information must be made available as soon as CMS has made its final decision in time to allow hospitals to prepare both financially and operationally.

- **The regulatory impact analysis must reflect the cost for hospitals to maintain three encoding software packages if**: one for the existing DRGs, the consolidated severity-adjusted DRGs, and the All Payer Refined DRGs. If CMS chooses to use the APR-DRG system, then the analysis must include the cost for maintaining two encoding software packages.

- **Any changes to the structure of the DRG system be made across all reimbursement systems using the DRGs at the same time as the Inpatient PPS,** and appropriate lead time must be provided to allow those provider-types the necessary time to prepare operationally and financially.

- **Before moving to a severity-adjusted payment system, the new GROUPER must use all**

diagnosis and procedure codes on the claim. The HIPAA 837i allows up to 25 diagnosis and 25 procedure codes on the claim, but many FIs ignore or omit these additional codes since they are not needed with the current GROUPER.

- CMS must address how its proposals will affect the outlier payments.

- CMS must address how its proposals will affect the post-acute care transfer policy. With a severity-adjusted DRG system, the number of DRGs subject to the transfer policy should decline dramatically.

- Hospitals need much more lead time to prepare financially for the scale of these changes. **IOWA HEALTH - DES MOINES recommends CMS provide at least one year from the date of the publication of the final rule to the implementation of the changes to the DRG reimbursement system.** Such a precedent has been set with the HIPAA regulations by allowing a two-year implementation period.

Changes to CMI from a New DRG System

CMS suggests in the proposed rule that it would reduce payments to hospitals by instituting a budget neutrality adjustment to offset the fact that case mix may increase because of improved coding rather than actual changes in acuity. However, CMS did not propose an adjustment or even a methodology for determining an adjustment. **IOWA HEALTH - DES MOINES opposes any negative adjustment to payments based on assumptions, rather than factual evidence.**

Operating Payments—Cost Outliers

5.1 percent of total inpatient DRG payments is set aside for outlier payments each year. For the past three years, CMS has underestimated the total amount of outlier payments with only 3.5 percent estimated spent in 2004, 3.8 7percent in 2005, and 4.71 percent in 2006. IOWA HEALTH - DES MOINES urges CMS to publicly account for the amount of unspent outlier payments over the past three years, and to establish a regular policy whereby those unspent funds are returned to the base rate for inpatient PPS spending. For FY 2007, CMS is again proposing to increase the fixed-loss threshold by which cases must exceed to qualify for outlier payments. Before changes are made to the outlier threshold making it increasingly difficult to receive outlier payments, CMS should establish procedures to ensure the total 5.1 percent is spent equitably each year.

Occupational Mix Adjustment

In response to a 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.

IOWA HEALTH - DES MOINES 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.

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 $4 million annually**.

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. IOWA HEALTH - DES MOINES supports data collection of expanded employment categories to recognize different staffing patterns in rural areas.

IOWA HEALTH - DES MOINES also has concerns that CMS intends to apply the occupational mix adjustment for FY 2007 based upon three months of un-audited data. IOWA HEALTH - DES MOINES 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. IOWA HEALTH - DES MOINES 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, IOWA HEALTH - DES MOINES 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.

IOWA HEALTH - DES MOINES 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.**

DGME and IME Payments

We strongly urge CMS to rescind the purported "clarification" in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare DGME and 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 the patient care activities should be interpreted broadly to include "scholarly activities, such as educational seminar, 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,

Crystal Estabrook
Reimbursement Manager
Iowa Health – Des Moines

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

Organization : **Piedmont Healthcare**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Update Factors

Update Factors

All issues addressed on attachment

CMS-1488-P-1635-Attach-1.DOC

CMS-1488-P-1635-Attach-2.DOC

#1635

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

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

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• **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

Submitter : **Mr. Thomas Klessens** **Date: 06/12/2006**

Organization : **Saints Memorial Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1636-Attach-1.DOC

#1636

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, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule.

Dear Dr. McClellan:

On behalf of Saints Memorial Medical Center, 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) proposed rules.

HSRV Weights

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc).

I strongly support the change from the current charge based DRG weighting system to the proposed HSRVcc system in FY07. Using gross charges to determine the DRG weights has altered the weighting process by including hospitals that are typically more expensive than others (that is teaching and specialty) who tend to treat certain cases more commonly than others. The proposed DRG weights under the HSRVcc methodology more closely represent the cost of providing services than the current charge-based system. Hospitals that provide more routine medical admissions as opposed to high-end, high-margin (especially cardiac) surgeries and services have been being disadvantaged for years under the current charge-based system. Even as proposed it is more reflective of the costs of providing services which should be the foundation for payment under the Medicare system.

If I can provide you with any additional information regarding our comments, please do not hesitate to contact me at 978-458-1411.

Sincerely,
Thomas F. Klessens
Chief Financial Officer

Submitter : **Mr. Kenneth Raske** **Date: 06/12/2006**

Organization : **Greater New York Hospital Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

See attachment.

CMS-1488-P-1637-Attach-1.PDF

CMS-1488-P-1637-Attach-2.PDF

#1637

Greater New York Hospital Association
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

June
Twelve
2006

VIA ELECTRONIC MAIL

Mark McClellan, M.D.
Administrator
Centers for Medicare & Medicaid Services
P.O. Box 8011
Baltimore, MD 21244-8011

RE: CMS-1488-P: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates ("GME Payments")

Dear Dr. McClellan:

Greater New York Hospital Association (GNYHA), which represents approximately 100 teaching hospitals in the metropolitan New York region, including hospitals in New York, New Jersey, Connecticut, and Rhode Island, welcomes the opportunity to provide these comments on the graduate medical education (GME) provisions within the Medicare *Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates*, which was published in the *Federal Register*, vol. 71, no. 79, on April 25, 2006, as a proposed rule with comment period. Comments from GNYHA on other provisions within the inpatient prospective payment system (IPPS) proposed rule, including proposed changes to diagnosis related–group classifications and related weights, are being forwarded to CMS under separate cover.

GNYHA member teaching hospitals, like all teaching hospitals across the country, provide fertile ground for the complex set of interrelated activities that take place to ensure that physician residents are appropriately trained to become autonomous physician practitioners. Before commenting on the policies that CMS has described with regard to graduate medical education (GME), it is important to first comment on the seriousness of the issues that are touched upon in this discussion as they affect every one of us who has ever or will ever seek care from a medical professional. In this context, GNYHA fully concurs with the comments on these issues offered by the Association of American Medical Colleges (AAMC). GNYHA also fully endorses the legal opinion prepared by Thomas W. Coons, Esq., Attorney at Law with Ober/Kaler, and former Supervisory Litigation Attorney with the U.S. Health Care Financing Administration (now CMS), included with the AAMC comment letter.

The Evolution of Graduate Medical Education
The serious responsibility that has been entrusted to teaching hospitals has changed in recent years, as complex life-sustaining therapies have been developed for what were once terminal illnesses and patients who were previously consigned to an intensive care unit or a medical-surgical bed in the hospital can now be treated away from the hospital at an outpatient setting. This change has challenged the academic medicine community to develop new models and strategies for training tomorrow's physicians.

In addition, the widespread availability of health information in the media and via the Internet also present significant challenges to physicians, and those who educate them, as these information portals necessitate a more rapid education regarding the various therapies that patients and their families may be accessing in the interest of understanding their diagnoses. In some cases, advances in treatment occur so rapidly and are publicized so widely that patients become aware of new treatments before most physicians and clinical staff have the opportunity to fully digest and understand the utility (and, perhaps, limitations) of these promising advances. It is no longer acceptable for physicians (including physician residents) to learn about new treatments as patients present within the hospital. Facility with and understanding of the various means by which the public gathers medical knowledge is now a major part of the educational process.

For these reasons, the physician educational model is being encouraged to transition from one rooted in "treating the sick" to one rooted in encouraging a healthy lifestyle and becoming a partner in promoting and sustaining health. This encouragement is coming from the medical education accrediting bodies, the specialty boards, consumer advocates, and various policymakers. This evolution, while important and necessary, has presented pedagogical challenges to the academic medicine community. The fundamental challenge for the academic medicine community is to continue to integrate the roles of patient care, research, and education into a coherent whole that will serve the needs of physician residents and the patients they serve. This is a daunting and complex task and we should all be grateful that the academic medicine community has risen to this important and challenging responsibility.

While this is occurring, it is important that this evolution not be hindered or compromised by GME payment policies that inadvertently undermine these important and necessary changes in physician educational strategies. As the largest financial supporter of physician residency, the Medicare program plays a unique role in this dynamic and evolving endeavor. The Medicare program has always been an excellent supporter of GME and GNYHA encourages CMS to ensure that in exercising regulatory discretion and implementing payment policies, the Agency does not hinder the evolution in physician education from which we all benefit every day.

Resident Time Spent in Nonpatient Care Activities as Part of Approved Residency Program (§§413.9 and 413.78(a))
CMS states that it has come to the agency's attention that there may be some "confusion" in the provider community regarding activities that can be counted for Medicare direct GME and indirect medical education (IME) payment purposes. CMS then goes on to clarify what it claims is its existing policy with regard to educational (didactic or "scholarly") activities.

GNYHA was startled to read this policy statement, and we respectfully submit that there is no basis for the clarification that CMS wishes to make. GNYHA recommends that this policy clarification be withdrawn as it is contrary to Congressional intent, inconsistent with previous statements made by CMS, and would create unmanageable documentation strains in an area that is already overwhelmed with an enormous amount of administrative burden.

Patient Care and Educational Activities Are Indistinguishable in GME
GNYHA believes that the distinction that CMS seeks to make between patient care activities and non–patient care activities within the required educational experience of physician residents is without merit. With the exception of discrete, extended time that is set aside for "bench research," all activities in which a physician resident engages as part of his or her educational program is related to patient care. GNYHA and its members reject the notion that a distinction can be made between activities related to patient care and unrelated to patient care in the manner that CMS wishes to do.

The GME learning model is delivery of care to patients under the supervision of a fully trained physician. All that a physician resident does as part of an approved residency training program is built upon the delivery of patient care and the physician resident's educational development into an autonomous practitioner. GNYHA believes that the distinction that CMS wishes to make within the residency educational experience may be more appropriate when comparing undergraduate medical education and GME. Within medical school, the educational model is structured so that students can learn a variety of core subject areas (e.g., microanatomy, pathophysiology) while not being expected to deliver patient care in any plain meaning of the term. Within residency programs, physicians continue to learn these subject areas but do so within the context of the delivery of patient care. That is the essential difference between the undergraduate and graduate medical education experiences.

The Statute Grants CMS Ample Discretion to Support These Activities
GNYHA firmly believes that in electing to support physician residency as a separate identifiable cost eligible for reimbursement within the Medicare program, Congress was well aware of the nature of this educational activity. We believe that Congress did not expect or condone the parsing of activities in which physician residents engage in the manner that CMS now wishes to do. Reviewing important research in a journal club or the treatment plan for a patient at a morbidity and mortality (M&M) conference, as well as other educational activities, are integral aspects of physician residency and serve to promote better clinical outcomes for patients. Certain aspects of the physician resident educational experience have been expanding or changing in recent years, but the activities that CMS seeks to now separate into a non-reimbursable "scholarly" bucket have been a core component of physician education for decades. It is unrealistic to believe that Congress meant to exclude these educational activities from eligibility for the resident count when creating the framework for the program's support for physician residency and teaching hospitals.[1]

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[1] Indeed, CMS notes in its discussion of the importance of documentation elsewhere in the IPPS proposed rule (page 24114) that one full-time person divided equally between Hospitals A and B means that "each hospital would only count 0.5 of an FTE for that resident." All physician residents engage in some didactic and scholarly activities. CMS's illustration regarding resident time again does

GNYHA appreciates that CMS is responsible for ensuring that Medicare payment policies are designed to be consistent with statutory intent, and we respect the Agency's role as guardians of the Medicare trust fund. Nothing we are recommending, however, is inconsistent with the statutory language to which CMS is bound. GNYHA is bewildered by CMS's interpretation, formed without any basis in statute, that only "patient care activities" are eligible for Medicare indirect medical education (IME) reimbursement in the inpatient setting. There is no language in the statute supporting such an interpretation. Rather, CMS has elected to identify a phrase used in the statute regarding *the nonhospital setting*, draw a connection from there to the payment mechanism for IME, and extend this limitation to the hospital inpatient setting. Nor does the fact that the means of paying IME is via an adjustment to the DRG payment justify the leap in interpretation that CMS has made, because the mechanics of payment do not and never will create a justification for a policy. GNYHA recommends that CMS rescind its statement limiting IME payments in this way and acknowledge that it has no statutory basis for having made such a statement in the first place.

CMS's interpretation of the phrase, "related to patient care," in this year's IPPS proposed rule builds on statements made in the last several years regarding the intent of the statutory language regarding resident training in the nonhospital setting. GNYHA and other organizations representing academic medicine have taken issue with some of these statements regarding training in nonhospital settings and we continue to work with CMS to understand the Agency's expectations. In particular, GNYHA continues to disagree that it is impermissible for a teaching hospital to claim resident time spent in the nonhospital setting if the supervising physician is volunteering time in that setting. GNYHA also disagrees that the meaning of the phrase, "all or substantially all," as used in the statute should be understood as meaning, "all." Now, to add to this discussion, CMS is telling the academic medicine community that Congress elected to include the phrase, "related to patient care," in order to exclude certain resident training activities in the nonhospital setting, but that the hospital is expected to incur the costs of those same activities in order to count *any* time spent by residents in the nonhospital setting. While this reading of the statute is not contradictory, it does seem inconsistent.

GNYHA also disagrees with CMS in its implicit assertion that Congress essentially intended to advantage freestanding teaching hospitals and disadvantage academic medical centers (those teaching hospitals that are co-extensive with medical schools) in writing the direct GME statute in this way. Because freestanding teaching hospitals are not co-extensive with medical schools, they must provide virtually all, if not all, of the educational opportunities for their physician residents within the four walls of the hospital complex. Academic medical centers, on the other hand, are able to utilize space within their affiliated medical schools for these activities. Under CMS's policy statement, this incidental, and inconsequential, aspect of building design would now be used against the nation's premier medical facilities in determining Medicare direct GME payment.

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not indicate that such a count would only be in the case of direct GME payment purposes and only when no educational activities have taken place in a nonhospital setting.

GNYHA recognizes that Congress did create separate rules to which teaching hospitals must adhere in order to claim the time that residents spend in nonhospital settings. Those rules, however, were intended as an *incentive* for teaching hospitals to provide nonhospital training opportunities. They were not intended to disadvantage those teaching hospitals that chose to take advantage of the special rules. Yet in straining to overinterpret the phrase, "related to patient care," in the direct GME statute, CMS is punishing teaching hospitals that do just what Congress sought to encourage.

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This is an important illustration that CMS has always viewed educational activities as allowable costs under the direct GME statute, for both the hospital setting and the nonhospital setting. In the 1990 Q&A document, the Agency had ample opportunity to specify that educational activities were not allowable costs. As mentioned in this year's IPPS proposed rule discussion, CMS also stated as recently as 1999 that these activities were allowable. For CMS to now state that the provider community "may be confused" is to reverse its own long-standing policy without any legislative basis for such a reversal. GNYHA urges CMS not to throw the calculation of every teaching hospital's PRA into dispute by now claiming that certain activities that were included in the calculation were included in error.

Distinguishing Physician Residency Time Is Administratively Impossible
As has been said, GNYHA believes that the disallowance that CMS wishes to make is without basis in the statute. Putting aside the issue of the merits of CMS's policy, however, the Agency's apparent expectation regarding tracking of resident time presents a quagmire of administrative difficulties. The reason for the difficulty is that physician residents do not perform defined shift work focused on just one activity. Only in the case of a defined, discrete, longer-term rotation that is limited to bench research where the resident is not available for patient care delivery or consultation would it be fair and reasonable to regard the time as non-reimbursable. In the context of their day-to-day program activities, however, residents are always dealing with patient care issues in some form or another and often do it within a formal learning (didactic) context.

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Medicare GME reimbursement rules as they're currently understood by teaching hospitals facilitate the fiscal intermediary's review and audit of defined blocks of time. This standard of review permits the acknowledgment of the defined differences that are clear when viewing resident time spent in settings (e.g., a research lab) that define the block. If, however, CMS goes further and mandates that so-called scholarly activities are subject to disallowance on a short-term or hour-by-hour basis, the Agency will create a framework whereby each scholarly activity must be subject to a secondary judgment regarding whether it was the principal activity that was occurring during that period of time and a tertiary judgment regarding whether the activity was voluntary or required within the context of that general assignment. These additional judgments would create immediate conflicts and administrative burdens that would be impossible for hospitals and the fiscal intermediary to address.

Consider the example of a physician resident, Dr. Jones, who is scheduled to go off duty no later than 10 pm but who finishes her patient admissions at 8 pm and stops in the medical library (which is located in the co-extensive medical school) to research new therapies that might be beneficial in treating a current patient or a future patient. Is the resident still performing her patient care duties (as the schedule would indicate) or is she now performing scholarly activity subject to disallowance? What if the research is not strictly required (to the extent that this can be defined) but the resident is doing the research voluntarily because she wants to learn to become a better physician to her patients? What if the resident's beeper goes off while doing this research and she speaks to a nurse regarding the care and treatment of the patient that she saw two hours before using the information she has just read? Has a voluntary non–patient care activity suddenly become a required patient care activity in a split second? And, most important, from an administrative and documentation standpoint, is it reasonable to expect residency programs and teaching hospitals to be able to track resident activities to this degree?

If stopping in the medical library is considered a required activity because Dr. Jones is technically still on duty according to the program schedule, then Dr. Jones has precipitated a two-hour Medicare disallowance by deciding to engage in this "scholarly activity." If the residency program and teaching hospital want to avoid this potential disallowance by viewing the research as a voluntary activity, then Dr. Jones is not on duty and she should presumably have turned her beeper off prior to the end of her scheduled time. Doing this, though, might precipitate a patient care crisis because the physician listed on beeper call on the schedule would not be responding when called.

Resident Schedules Do Not Provide An Administrative Solution
When performing audits of teaching hospitals, the fiscal intermediary reviews rotation schedules to determine what service a resident has been assigned to and ensures that the resident's time is being counted properly by a particular hospital. Although this system presents certain documentation challenges to residency programs, teaching hospitals, and the fiscal intermediary, GNYHA and its members recognize that presentation of clear resident schedules are needed in order for the fiscal intermediaries to do their job.

Resident schedules, however, are not designed uniformly, because different rotations call for different formats. For example, a resident schedule for a one-person hematology fellowship program may be an internal memo to relevant staff in the hospital that states, "For the period May 1 to May 31, please contact Dr. Smith for hematology consultations Monday through Saturday between the hours of 8 am and 8 pm. At other times, please contact the patient's attending physician." Other rotation schedules are more detailed, with weekly blocks, daily blocks, and in certain cases, shorter-term blocks specified, depending on the rotation.

If the CMS policy in its current form were to be adopted, virtually all residency programs would need to perform a complete overhaul of their schedules to accommodate the fiscal intermediary's need to know what physicians residents were doing on an hour-by-hour basis. If CMS were to direct the fiscal intermediary to simply rely on the rotation schedule to assess whether a nonreimbursable educational activity had occurred, teaching hospitals would be obliged through their internal compliance programs to ensure that more and more detail was provided and that the hospital was not exposed to charges of inappropriate counting of resident time. Beyond the issue of deciding what the principal activity was at any given time and whether that hour was voluntary or required, the change in requirements would present the industry with a documentation burden unlike any it had ever seen before.

For all of these reasons, *GNYHA recommends that CMS rescind its policy clarification and state unequivocally that time spent in educational activities are allowable for direct GME payments in the nonhospital setting and IME payments in both the hospital and nonhospital settings.*

FTE Resident Count and Documentation
GNYHA appreciates CMS restating the requirements for documentation in order for teaching hospitals to claim the time spent by physician residents for Medicare direct GME and IME payments. Medicare GME policy discussions and clarifications are an essential element for the teaching hospital community and the fiscal intermediaries to understand the intent of CMS

with regard to payment for GME, but the requirements and expectations of the Agency with regard to proper documentation and issues surrounding GME audits are just as important. Clear statements and expectations regarding the latter issues are what assist teaching hospitals in retaining the funding to which they are entitled, and demonstrate that teaching hospitals have assisted CMS and its contractors in ensuring that public tax dollars are being expended as Congress intended. In the context of Medicare GME reimbursement, GNYHA offers the following comments on these critically important issues.

The Intern and Resident Information System
GNYHA believes it is critically important for CMS to devote additional resources and attention to ensuring that the Intern and Resident Information System (IRIS) program and all technical support systems for it are state-of-the-art. Although it may appear that issues associated with this specific piece of CMS technology are beyond the scope of the comments made within the IPPS proposed rule, GNYHA believes that they are fundamental to this discussion as the technology is the linchpin connecting policy, documentation, and audit.

Teaching hospitals and the fiscal intermediaries use the IRIS program as the key reporting tool for resident information and teaching hospitals are expected to provide detailed back-up documentation to support all information that is presented in the IRIS. CMS policy determinations provide the framework to record information that the fiscal intermediaries need in order to allow teaching hospitals to build a portfolio that supports a specific cost item (e.g., residency program is approved, resident is training in that approved program, resident is engaging in an eligible rotation at an eligible site). All of these issues require detailed documentation that gets translated onto the IRIS software, which forms the starting point for audit determinations that require documentation support. If one component of this process is neglected or breaks down, it brings disarray to the entire policy, reimbursement, and audit system.

As the agency for administering Medicare, CMS should be releasing workable tools needed to support proper GME payment. Teaching hospitals should be able to use those tools in an efficient manner so that errors and administrative burdens can be minimized. The fiscal intermediaries should be able to use separate audit tools to provide a check on these payments. In this regard, because the IRIS program plays such a critical role in the teaching hospital payment system, it is imperative that CMS take responsibility for updating the IRIS software in a way that makes it as user–friendly for teaching hospitals as possible. Unfortunately, this has not been done in any meaningful way in a number of years. Instead, teaching hospitals have had to rely on a separate proprietary piece of software to make the IRIS program work. Although the proprietary software is an excellent technological tool, GNYHA believes it is inappropriate for CMS to rely on a private company to provide a workable solution to the deficiencies that have been noted within its own software program. Similarly, teaching hospitals throughout the country should not have to purchase this separate product in order to work with CMS's difficult IRIS software. It is CMS's responsibility to ensure that teaching hospitals have the required tools needed to properly claim and receive the Medicare GME reimbursement to which they are entitled.

On numerous occasions, GNYHA and its members have had to engage representatives of the private company with which CMS has contracted to develop the IRIS "workaround" to discuss fundamental Medicare GME policy issues in order to ensure that the tool is performing in a manner that is consistent with CMS's stated policy. GNYHA believes it has become important to do this since the fiscal intermediary also relies on this proprietary tool to work with the IRIS software. But neither GNYHA nor its teaching hospital members should ever be put in the position of explaining a policy and advocating for a particular interpretation with a private company that has been engaged to create a technological solution to a CMS policy. Rather, CMS should be ensuring on a regular basis that all critically important mechanisms needed for proper payment are consistent with policy, are up-to-date, and work with maximum efficiency.

In this spirit, GNYHA recommends that CMS create an IRIS Taskforce with CMS policy staff, CMS audit staff, and industry and intermediary representation that will address these issues. CMS should dedicate resources to the Taskforce and support its recommendations so that the significant administrative burdens faced by teaching hospitals can be minimized.

Follow-up for More Information

GNYHA appreciates the opportunity to provide CMS with comments on these critically important issues facing the academic medicine community. Our staff would be pleased to provide you with any additional information you need as you review these comments.

Should you or your staff require information, I encourage you to contact Tim Johnson, Vice President for Finance and Graduate Medical Education at GNYHA, at 212-246-7100 or tjohnson@gnyha.org.

Sincerely,

Kenneth E. Raske
President

cc: Liz Richter
Tzvi Hefter

Greater New York Hospital Association
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

June
Twelve
2006

VIA ELECTRONIC MAIL

Mark McClellan, M.D.
Administrator
Centers for Medicare & Medicaid Services
P.O. Box 8011
Baltimore, MD 21244-8011

RE: CMS-1488-P: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates ("GME Payments")

Dear Dr. McClellan:

Greater New York Hospital Association (GNYHA), which represents approximately 100 teaching hospitals in the metropolitan New York region, including hospitals in New York, New Jersey, Connecticut, and Rhode Island, welcomes the opportunity to provide these comments on the graduate medical education (GME) provisions within the Medicare *Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates*, which was published in the *Federal Register*, vol. 71, no. 79, on April 25, 2006, as a proposed rule with comment period. Comments from GNYHA on other provisions within the inpatient prospective payment system (IPPS) proposed rule, including proposed changes to diagnosis related–group classifications and related weights, are being forwarded to CMS under separate cover.

GNYHA member teaching hospitals, like all teaching hospitals across the country, provide fertile ground for the complex set of interrelated activities that take place to ensure that physician residents are appropriately trained to become autonomous physician practitioners. Before commenting on the policies that CMS has described with regard to graduate medical education (GME), it is important to first comment on the seriousness of the issues that are touched upon in this discussion as they affect every one of us who has ever or will ever seek care from a medical professional. In this context, GNYHA fully concurs with the comments on these issues offered by the Association of American Medical Colleges (AAMC). GNYHA also fully endorses the legal opinion prepared by Thomas W. Coons, Esq., Attorney at Law with Ober/Kaler, and former Supervisory Litigation Attorney with the U.S. Health Care Financing Administration (now CMS), included with the AAMC comment letter.

The Evolution of Graduate Medical Education

The serious responsibility that has been entrusted to teaching hospitals has changed in recent years, as complex life-sustaining therapies have been developed for what were once terminal illnesses and patients who were previously consigned to an intensive care unit or a medical-surgical bed in the hospital can now be treated away from the hospital at an outpatient setting. This change has challenged the academic medicine community to develop new models and strategies for training tomorrow's physicians.

In addition, the widespread availability of health information in the media and via the Internet also present significant challenges to physicians, and those who educate them, as these information portals necessitate a more rapid education regarding the various therapies that patients and their families may be accessing in the interest of understanding their diagnoses. In some cases, advances in treatment occur so rapidly and are publicized so widely that patients become aware of new treatments before most physicians and clinical staff have the opportunity to fully digest and understand the utility (and, perhaps, limitations) of these promising advances. It is no longer acceptable for physicians (including physician residents) to learn about new treatments as patients present within the hospital. Facility with and understanding of the various means by which the public gathers medical knowledge is now a major part of the educational process.

For these reasons, the physician educational model is being encouraged to transition from one rooted in "treating the sick" to one rooted in encouraging a healthy lifestyle and becoming a partner in promoting and sustaining health. This encouragement is coming from the medical education accrediting bodies, the specialty boards, consumer advocates, and various policymakers. This evolution, while important and necessary, has presented pedagogical challenges to the academic medicine community. The fundamental challenge for the academic medicine community is to continue to integrate the roles of patient care, research, and education into a coherent whole that will serve the needs of physician residents and the patients they serve. This is a daunting and complex task and we should all be grateful that the academic medicine community has risen to this important and challenging responsibility.

While this is occurring, it is important that this evolution not be hindered or compromised by GME payment policies that inadvertently undermine these important and necessary changes in physician educational strategies. As the largest financial supporter of physician residency, the Medicare program plays a unique role in this dynamic and evolving endeavor. The Medicare program has always been an excellent supporter of GME and GNYHA encourages CMS to ensure that in exercising regulatory discretion and implementing payment policies, the Agency does not hinder the evolution in physician education from which we all benefit every day.

Resident Time Spent in Nonpatient Care Activities as Part of Approved Residency Program (§§413.9 and 413.78(a))

CMS states that it has come to the agency's attention that there may be some "confusion" in the provider community regarding activities that can be counted for Medicare direct GME and indirect medical education (IME) payment purposes. CMS then goes on to clarify what it claims is its existing policy with regard to educational (didactic or "scholarly") activities.

GNYHA was startled to read this policy statement, and we respectfully submit that there is no basis for the clarification that CMS wishes to make. GNYHA recommends that this policy clarification be withdrawn as it is contrary to Congressional intent, inconsistent with previous statements made by CMS, and would create unmanageable documentation strains in an area that is already overwhelmed with an enormous amount of administrative burden.

Patient Care and Educational Activities Are Indistinguishable in GME
GNYHA believes that the distinction that CMS seeks to make between patient care activities and non–patient care activities within the required educational experience of physician residents is without merit. With the exception of discrete, extended time that is set aside for "bench research," all activities in which a physician resident engages as part of his or her educational program is related to patient care. GNYHA and its members reject the notion that a distinction can be made between activities related to patient care and unrelated to patient care in the manner that CMS wishes to do.

The GME learning model is delivery of care to patients under the supervision of a fully trained physician. All that a physician resident does as part of an approved residency training program is built upon the delivery of patient care and the physician resident's educational development into an autonomous practitioner. GNYHA believes that the distinction that CMS wishes to make within the residency educational experience may be more appropriate when comparing undergraduate medical education and GME. Within medical school, the educational model is structured so that students can learn a variety of core subject areas (e.g., microanatomy, pathophysiology) while not being expected to deliver patient care in any plain meaning of the term. Within residency programs, physicians continue to learn these subject areas but do so within the context of the delivery of patient care. That is the essential difference between the undergraduate and graduate medical education experiences.

The Statute Grants CMS Ample Discretion to Support These Activities
GNYHA firmly believes that in electing to support physician residency as a separate identifiable cost eligible for reimbursement within the Medicare program, Congress was well aware of the nature of this educational activity. We believe that Congress did not expect or condone the parsing of activities in which physician residents engage in the manner that CMS now wishes to do. Reviewing important research in a journal club or the treatment plan for a patient at a morbidity and mortality (M&M) conference, as well as other educational activities, are integral aspects of physician residency and serve to promote better clinical outcomes for patients. Certain aspects of the physician resident educational experience have been expanding or changing in recent years, but the activities that CMS seeks to now separate into a non-reimbursable "scholarly" bucket have been a core component of physician education for decades. It is unrealistic to believe that Congress meant to exclude these educational activities from eligibility for the resident count when creating the framework for the program's support for physician residency and teaching hospitals.[1]

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[1] Indeed, CMS notes in its discussion of the importance of documentation elsewhere in the IPPS proposed rule (page 24114) that one full-time person divided equally between Hospitals A and B means that "each hospital would only count 0.5 of an FTE for that resident." All physician residents engage in some didactic and scholarly activities. CMS's illustration regarding resident time again does

GNYHA appreciates that CMS is responsible for ensuring that Medicare payment policies are designed to be consistent with statutory intent, and we respect the Agency's role as guardians of the Medicare trust fund. Nothing we are recommending, however, is inconsistent with the statutory language to which CMS is bound. GNYHA is bewildered by CMS's interpretation, formed without any basis in statute, that only "patient care activities" are eligible for Medicare indirect medical education (IME) reimbursement in the inpatient setting. There is no language in the statute supporting such an interpretation. Rather, CMS has elected to identify a phrase used in the statute regarding *the nonhospital setting*, draw a connection from there to the payment mechanism for IME, and extend this limitation to the hospital inpatient setting. Nor does the fact that the means of paying IME is via an adjustment to the DRG payment justify the leap in interpretation that CMS has made, because the mechanics of payment do not and never will create a justification for a policy. GNYHA recommends that CMS rescind its statement limiting IME payments in this way and acknowledge that it has no statutory basis for having made such a statement in the first place.

CMS's interpretation of the phrase, "related to patient care," in this year's IPPS proposed rule builds on statements made in the last several years regarding the intent of the statutory language regarding resident training in the nonhospital setting. GNYHA and other organizations representing academic medicine have taken issue with some of these statements regarding training in nonhospital settings and we continue to work with CMS to understand the Agency's expectations. In particular, GNYHA continues to disagree that it is impermissible for a teaching hospital to claim resident time spent in the nonhospital setting if the supervising physician is volunteering time in that setting. GNYHA also disagrees that the meaning of the phrase, "all or substantially all," as used in the statute should be understood as meaning, "all." Now, to add to this discussion, CMS is telling the academic medicine community that Congress elected to include the phrase, "related to patient care," in order to exclude certain resident training activities in the nonhospital setting, but that the hospital is expected to incur the costs of those same activities in order to count *any* time spent by residents in the nonhospital setting. While this reading of the statute is not contradictory, it does seem inconsistent.

GNYHA also disagrees with CMS in its implicit assertion that Congress essentially intended to advantage freestanding teaching hospitals and disadvantage academic medical centers (those teaching hospitals that are co-extensive with medical schools) in writing the direct GME statute in this way. Because freestanding teaching hospitals are not co-extensive with medical schools, they must provide virtually all, if not all, of the educational opportunities for their physician residents within the four walls of the hospital complex. Academic medical centers, on the other hand, are able to utilize space within their affiliated medical schools for these activities. Under CMS's policy statement, this incidental, and inconsequential, aspect of building design would now be used against the nation's premier medical facilities in determining Medicare direct GME payment.

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GNYHA recognizes that Congress did create separate rules to which teaching hospitals must adhere in order to claim the time that residents spend in nonhospital settings. Those rules, however, were intended as an *incentive* for teaching hospitals to provide nonhospital training opportunities. They were not intended to disadvantage those teaching hospitals that chose to take advantage of the special rules. Yet in straining to overinterpret the phrase, "related to patient care," in the direct GME statute, CMS is punishing teaching hospitals that do just what Congress sought to encourage.

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reimbursable activities. But because so many of the "scholarly activities" on which CMS focuses are of short duration (several hours or less), the CMS policy as stated immediately begs the question of how to make a precise determination regarding *the* principal activity among a set of activities that are fluid in nature and also begs the question of assessing a voluntary activity in the context of an otherwise required rotation.

The fiscal intermediaries are not called upon to make such fine-tuned judgments as this in short-term, hour-by-hour periods, nor should they be. The principal rules for resident counting that are designed to ensure proper payment are simply that 1) teaching hospitals cannot count an individual physician resident as more than 1.0 FTE, 2) resident time cannot be duplicative, and 3) a resident's time must be spent in activities that are an approved component of the residency program in a setting in which Medicare GME reimbursement can be claimed. GNYHA recognizes that there are separate rules and requirements for counting residents in inpatient psychiatric, inpatient rehabilitative, and nonhospital settings, or when assigned to a bench research project, but these requirements merely specify the need to know *where* the resident has been assigned for a block of time. These separations do not require that teaching hospitals track *what* the resident is doing from moment to moment, which is what would be required in the context of the policy that CMS is now proposing.

Medicare GME reimbursement rules as they're currently understood by teaching hospitals facilitate the fiscal intermediary's review and audit of defined blocks of time. This standard of review permits the acknowledgment of the defined differences that are clear when viewing resident time spent in settings (e.g., a research lab) that define the block. If, however, CMS goes further and mandates that so-called scholarly activities are subject to disallowance on a short-term or hour-by-hour basis, the Agency will create a framework whereby each scholarly activity must be subject to a secondary judgment regarding whether it was the principal activity that was occurring during that period of time and a tertiary judgment regarding whether the activity was voluntary or required within the context of that general assignment. These additional judgments would create immediate conflicts and administrative burdens that would be impossible for hospitals and the fiscal intermediary to address.

Consider the example of a physician resident, Dr. Jones, who is scheduled to go off duty no later than 10 pm but who finishes her patient admissions at 8 pm and stops in the medical library (which is located in the co-extensive medical school) to research new therapies that might be beneficial in treating a current patient or a future patient. Is the resident still performing her patient care duties (as the schedule would indicate) or is she now performing scholarly activity subject to disallowance? What if the research is not strictly required (to the extent that this can be defined) but the resident is doing the research voluntarily because she wants to learn to become a better physician to her patients? What if the resident's beeper goes off while doing this research and she speaks to a nurse regarding the care and treatment of the patient that she saw two hours before using the information she has just read? Has a voluntary non–patient care activity suddenly become a required patient care activity in a split second? And, most important, from an administrative and documentation standpoint, is it reasonable to expect residency programs and teaching hospitals to be able to track resident activities to this degree?

If stopping in the medical library is considered a required activity because Dr. Jones is technically still on duty according to the program schedule, then Dr. Jones has precipitated a two-hour Medicare disallowance by deciding to engage in this "scholarly activity." If the residency program and teaching hospital want to avoid this potential disallowance by viewing the research as a voluntary activity, then Dr. Jones is not on duty and she should presumably have turned her beeper off prior to the end of her scheduled time. Doing this, though, might precipitate a patient care crisis because the physician listed on beeper call on the schedule would not be responding when called.

Resident Schedules Do Not Provide An Administrative Solution
When performing audits of teaching hospitals, the fiscal intermediary reviews rotation schedules to determine what service a resident has been assigned to and ensures that the resident's time is being counted properly by a particular hospital. Although this system presents certain documentation challenges to residency programs, teaching hospitals, and the fiscal intermediary, GNYHA and its members recognize that presentation of clear resident schedules are needed in order for the fiscal intermediaries to do their job.

Resident schedules, however, are not designed uniformly, because different rotations call for different formats. For example, a resident schedule for a one-person hematology fellowship program may be an internal memo to relevant staff in the hospital that states, "For the period May 1 to May 31, please contact Dr. Smith for hematology consultations Monday through Saturday between the hours of 8 am and 8 pm. At other times, please contact the patient's attending physician." Other rotation schedules are more detailed, with weekly blocks, daily blocks, and in certain cases, shorter-term blocks specified, depending on the rotation.

If the CMS policy in its current form were to be adopted, virtually all residency programs would need to perform a complete overhaul of their schedules to accommodate the fiscal intermediary's need to know what physicians residents were doing on an hour-by-hour basis. If CMS were to direct the fiscal intermediary to simply rely on the rotation schedule to assess whether a nonreimbursable educational activity had occurred, teaching hospitals would be obliged through their internal compliance programs to ensure that more and more detail was provided and that the hospital was not exposed to charges of inappropriate counting of resident time. Beyond the issue of deciding what the principal activity was at any given time and whether that hour was voluntary or required, the change in requirements would present the industry with a documentation burden unlike any it had ever seen before.

For all of these reasons, *GNYHA recommends that CMS rescind its policy clarification and state unequivocally that time spent in educational activities are allowable for direct GME payments in the nonhospital setting and IME payments in both the hospital and nonhospital settings.*

FTE Resident Count and Documentation
GNYHA appreciates CMS restating the requirements for documentation in order for teaching hospitals to claim the time spent by physician residents for Medicare direct GME and IME payments. Medicare GME policy discussions and clarifications are an essential element for the teaching hospital community and the fiscal intermediaries to understand the intent of CMS

with regard to payment for GME, but the requirements and expectations of the Agency with regard to proper documentation and issues surrounding GME audits are just as important. Clear statements and expectations regarding the latter issues are what assist teaching hospitals in retaining the funding to which they are entitled, and demonstrate that teaching hospitals have assisted CMS and its contractors in ensuring that public tax dollars are being expended as Congress intended. In the context of Medicare GME reimbursement, GNYHA offers the following comments on these critically important issues.

The Intern and Resident Information System

GNYHA believes it is critically important for CMS to devote additional resources and attention to ensuring that the Intern and Resident Information System (IRIS) program and all technical support systems for it are state-of-the-art. Although it may appear that issues associated with this specific piece of CMS technology are beyond the scope of the comments made within the IPPS proposed rule, GNYHA believes that they are fundamental to this discussion as the technology is the linchpin connecting policy, documentation, and audit.

Teaching hospitals and the fiscal intermediaries use the IRIS program as the key reporting tool for resident information and teaching hospitals are expected to provide detailed back-up documentation to support all information that is presented in the IRIS. CMS policy determinations provide the framework to record information that the fiscal intermediaries need in order to allow teaching hospitals to build a portfolio that supports a specific cost item (e.g., residency program is approved, resident is training in that approved program, resident is engaging in an eligible rotation at an eligible site). All of these issues require detailed documentation that gets translated onto the IRIS software, which forms the starting point for audit determinations that require documentation support. If one component of this process is neglected or breaks down, it brings disarray to the entire policy, reimbursement, and audit system.

As the agency for administering Medicare, CMS should be releasing workable tools needed to support proper GME payment. Teaching hospitals should be able to use those tools in an efficient manner so that errors and administrative burdens can be minimized. The fiscal intermediaries should be able to use separate audit tools to provide a check on these payments. In this regard, because the IRIS program plays such a critical role in the teaching hospital payment system, it is imperative that CMS take responsibility for updating the IRIS software in a way that makes it as user–friendly for teaching hospitals as possible. Unfortunately, this has not been done in any meaningful way in a number of years. Instead, teaching hospitals have had to rely on a separate proprietary piece of software to make the IRIS program work. Although the proprietary software is an excellent technological tool, GNYHA believes it is inappropriate for CMS to rely on a private company to provide a workable solution to the deficiencies that have been noted within its own software program. Similarly, teaching hospitals throughout the country should not have to purchase this separate product in order to work with CMS's difficult IRIS software. It is CMS's responsibility to ensure that teaching hospitals have the required tools needed to properly claim and receive the Medicare GME reimbursement to which they are entitled.

On numerous occasions, GNYHA and its members have had to engage representatives of the private company with which CMS has contracted to develop the IRIS "workaround" to discuss fundamental Medicare GME policy issues in order to ensure that the tool is performing in a manner that is consistent with CMS's stated policy. GNYHA believes it has become important to do this since the fiscal intermediary also relies on this proprietary tool to work with the IRIS software. But neither GNYHA nor its teaching hospital members should ever be put in the position of explaining a policy and advocating for a particular interpretation with a private company that has been engaged to create a technological solution to a CMS policy. Rather, CMS should be ensuring on a regular basis that all critically important mechanisms needed for proper payment are consistent with policy, are up-to-date, and work with maximum efficiency.

In this spirit, GNYHA recommends that CMS create an IRIS Taskforce with CMS policy staff, CMS audit staff, and industry and intermediary representation that will address these issues. CMS should dedicate resources to the Taskforce and support its recommendations so that the significant administrative burdens faced by teaching hospitals can be minimized.

Follow-up for More Information

GNYHA appreciates the opportunity to provide CMS with comments on these critically important issues facing the academic medicine community. Our staff would be pleased to provide you with any additional information you need as you review these comments.

Should you or your staff require information, I encourage you to contact Tim Johnson, Vice President for Finance and Graduate Medical Education at GNYHA, at 212-246-7100 or tjohnson@gnyha.org.

Sincerely,

Kenneth E. Raske
President

cc: Liz Richter
Tzvi Hefter

Submitter : **Dr. Diana mahar**

Date: 06/12/2006

Organization : **Contra Costa Regional Medical Center**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a pediatrician who teaches family physicians in training, 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 pediatrician involved in teaching family physicians, 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,

Diana Mahar

Submitter : Dr. Michael Maves **Date:** 06/12/2006

Organization : American Medical Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1639-Attach-1.DOC

CMS-1488-P-1639-Attach-2.DOC

#1039

We support CMS' 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs, and serve to improve care of individual patients. Disallowing time spent on these activities is at odds with your personal goal of improving the quality of care delivered in this country.

In addition, we are concerned that the exclusion of didactic activities is particularly stringent in non-hospital training programs which cannot be counted in the calculation of either the DGME and IME calculations. This approach would penalize hospital-based residency programs for providing their students with non-hospital training experiences, exacerbating other recent CMS policy changes that disadvantage training programs conducted outside the hospital. As you know, medical care increasingly is delivered outside the hospital and many of the quality measures CMS is proposing focus on this setting. To discourage hospitals from offering training in these settings is short-sighted to say the least.

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. We further recommend that you review and revise CMS policies that discourage training programs in non-hospital settings where supervising physicians volunteer their services or provide this service at a nominal cost.

Sincerely,

Michael D. Maves, MD, MBA

Submitter : **Ms. PATRICIA ANDERSEN** **Date: 06/12/2006**

Organization : **OKLAHOMA HOSPITAL ASSOCIATION**

Category : **Health Care Professional or Association**

Issue Areas/Comments

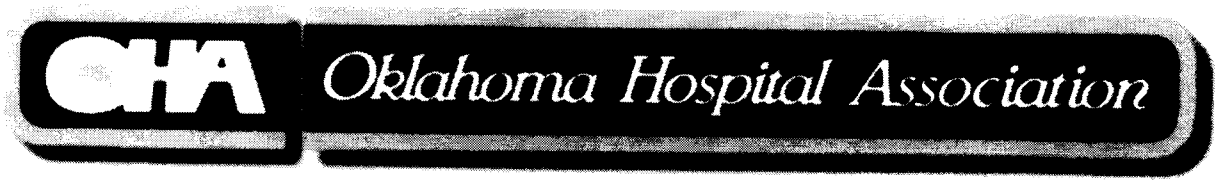
GENERAL

GENERAL

SEE ATTACHED COMMENT LETTER

CMS-1488-P-1640-Attach-1.DOC

#1610



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 Oklahoma Hospital Association's (OHA) 140 member hospitals and health care systems, we 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.

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc). It also proposes refining the DRGs to account for patient severity, with implementation likely in FY 2008. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education, among other policies.

While the OHA supports many of the proposed rule's provisions, we have serious concerns about the proposed changes to the DRG weights and classifications.

The hospital field supports meaningful improvements to Medicare's inpatient PPS. We believe the OHA and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. 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. Moving forward requires thoughtful change.

Specifically, the OHA supports the following:

- **One-year Delay:** The OHA supports a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. The American Hospital Association, OHA and the hospital field are committed to working with CMS over the next year to address these concerns.

- **Valid Cost-based Weights:** We support moving to a DRG-weighting methodology based on hospital costs rather than charges, but CMS' proposed HSRVcc method has many flaws that we believe prevent it from accomplishing the goals CMS has established.

- **A New Classification System Only if the Need Can Be Demonstrated:** The OHA does not support a new classification system at this time, 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.

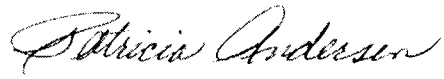
- **Three-year Transition:** Any changes should be implemented with a three-year transition, given the magnitude of payment redistribution across DRGs and hospitals. Too much money moves with each step proposed by CMS demonstrating the need for both the simultaneous implementation (if both are done) and the need for a transition period.

- **Collaborative Approach to Moving Forward**: The OHA in conjunction with the American Hospital Association commits to working with CMS to develop and evaluate alternatives for new weights and classifications.

We have enclosed detailed comments that further explain our concerns and recommendations on the proposed DRG weight and classification system changes, as well as our position on many other issues in the proposed rule.

The OHA appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me at (405) 427-9537 or pandersen@okoha.com.

Sincerely,
OKLAHOMA HOSPITAL ASSOCIATION



Patricia D. Andersen, CPA
CFO & VP-Finance & Information Services

Oklahoma Hospital Association
Detailed Comments on the
FY 2007 Inpatient Prospective Payment System Proposed Rule

Table of Contents

PROPOSED CHANGES

DRG Changes ..... p. 4
New DRG Weights: HSRVcc ..... p. 4
New Patient Classification: Severity of Illness ..... p. 9
DRG Reclassifications ..... p. 12
Long-term Care Hospital DRGs ..... p. 14
Hospital Quality Data ..... p. 15
Outlier Payments ..... p. 17
Core-based Statistical Areas ..... p. 18
Occupational Mix Adjustment ..... p. 18
Hospital Redesignations and Reclassifications ..... p. 20
Geographic Reclassifications ..... p. 21
Wage Index Budget Neutrality ..... p. 23
Low-volume Hospital Payment Adjustment ..... p. 23
SCH/MDH Changes in Qualification Status ..... p. 24
SCH/MDH Volume Decrease Adjustment ..... p. 24
Rural Referral Centers ..... p. 25
Critical Access Hospitals ..... p. 25
Graduate Medical Education Payments ..... p. 26
Emergency Medical Treatment and Active Labor Act ..... p. 27
New Technology ..... p. 29

OTHER FUTURE CONCEPTS

Transparency of Health Care Information ..... p. 30
Hospital Value-based Purchasing ..... p. 34
Health Information Technology ..... p. 36
Hospital-acquired Infections ..... p. 38

PROPOSED CHANGES

DRG CHANGES

In response to payment recommendations from the Medicare Payment Advisory Commission (MedPAC) to address the proliferation of physician-owned, limited service hospitals, the Centers for Medicare & Medicaid Services (CMS) proposed the biggest changes to the calculation of diagnosis-related group (DRG) relative weights since the creation of the prospective payment system (PPS). These changes would significantly redistribute payments among the DRGs and among hospitals. Specifically, CMS proposes 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. CMS also proposes an alternative patient classification system called consolidated severity adjusted DRGs (CS-DRGs), with implementation likely in FY 2008.

The hospital field supports meaningful improvements to Medicare's inpatient PPS. We believe the OHA, the AHA and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs which will provide an equal incentive to treat all types of patients and conditions. We also believe the system should be simple, *predictable, and stable over time*. One of the fundamental values of a *prospective* payment system is the ability of providers to reasonably estimate payments in advance to inform their budgeting, marketing, staffing and other key management decisions. Another core feature of the PPS is clinically cohesive and meaningful DRGs that are 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 OHA believes that these are essential characteristics of a well-functioning PPS and it is within these policy goals that we evaluate CMS' proposal.

Oklahoma has many physician-owned, limited services hospitals. We do not believe that payment changes alone will remove the inappropriate incentives created by physician self-referral to limited-service hospitals. Physicians will still have the ability and incentive to steer financially attractive patients to facilities they own, avoid serving low-income patients, practice similar forms of selection for outpatient services and drive up utilization for services. We strongly urge CMS to rigorously examine the investment structures of physician-owned, limited-service hospitals and consider comments provided by the American Hospital Association (AHA) on the interim report on the strategic plan. It is imperative that CMS continue the suspension of issuing new provider numbers to physician-owned, limited-service hospitals until the strategic plan developed has been fully implemented and Congress has had an opportunity to consider CMS' final report.

NEW DRG WEIGHTS: HSRVCC

CMS proposes an alternative to MedPAC's approach to HSRVs and cost-based weights that could be characterized as a short cut. CMS asserts that this combined methodology, known as the HSRV cost center methodology (HSRVcc), achieves similar results in a more

administratively feasible manner. We do not agree that is the case. Specifically, the CMS proposal involves two major steps.

1. Develop, on a charge-basis, hospital-specific relative weights for each DRG. CMS established 10 cost center categories based on broad hospital accounting definitions: routine day costs; intensive care day costs; and eight ancillary cost centers. CMS calculated DRG relative weights for each of the 10 cost centers by DRG for each hospital and then used those hospital-specific weights for calculating national DRG weights. CMS' current process aggregates charges for all hospitals at the DRG level to calculate weights. CMS believes the new approach removes the variation introduced by hospital characteristics such as teaching, disproportionate share, location and size, among others.

2. "Scale" the charge-based DRG weights to "costs" using the national cost center cost-to-charge ratios (CCRs) developed from the cost report data (as opposed to using hospital-specific CCRs at the claim level). CMS believes this approach will remove the effect of different CCRs across departments within hospitals. CMS chose this methodology because the use of national average rather than hospital-specific departmental CCRs is administratively easier.

The OHA supports the move to cost-based weights but believes CMS' proposed method is flawed. More work is needed to determine the best way to create cost-based weights. Hospitals are willing to work with CMS in a process to develop consensus around the right way to make this change. Below we discuss our detailed concerns and questions regarding the proposed HSRVcc methodology.

The OHA has worked with the American Hospital Association (AHA) and other hospital associations in reviewing and analyzing CMS' Proposed Rule.

HSRVcc METHOD CONCERNS

The OHA believes that more time is needed to develop a sound methodological approach to create cost-based weights and to understand their potential impact.

1. **Errors:** While analyzing CMS' proposed rule, the AHA uncovered a series of data errors, inconsistencies across databases and questionable methodological choices. Further analyses commissioned by the AHA, the Association of American Medical Colleges and the Federation of American Hospitals and conducted by The Moran Company, Inc. to investigate these questions showed that small changes in method lead to large changes in DRG weights, signaling that the proposed changes are highly unstable (see AHA's technical appendix).

   For instance, the following, more minor, inconsistencies were identified:

   - CMS inadvertently included organ acquisition costs in the data used to set weights for DRGs. These costs should be excluded. This error has a material effect on the resulting weight calculation for transplants. For example, CMS publishes a weight of 5.5466 for DRG 302 (Kidney Transplant), but with this correction The Moran Company calculates a weight of 3.0102.

- CMS was inconsistent in its treatment of certain categories of hospitals between their calculation of the FY 2007 HSRVcc weights and the proposed CS-DRG weights, making it hard to directly compare the results. For example, hospitals in Maryland were included in the FY 2007 MedPAR data used for the HSRVcc weight calculation and excluded from the CS-DRG calculation.
- The Moran Company used transfer-adjusted charges prior to calculating weights. It was CMS' policy to do this. However, it is unclear whether the weights published for CS-DRGs included this step.

- Data cleaning steps used were not always consistent with standard CMS practices (e.g., removal of cases with 0 charges, low volume DRGs, etc.).

- The cleaning steps applied to the cost report data were not consistent with the cleaning steps applied to the MedPAR claims data, which resulted in different hospitals being included in data sets used for the calculation of the weights and the calculation of the scalers to the weights. For example, hospitals in Maryland and hospitals without cost reports for FY 2003 were excluded from the cost report data used to calculate the scalers and included in the MedPAR file used to calculate the weights.

2. **Trimming:** CMS trimmed the cost center CCRs at 1.96 standard deviations from the geometric mean. We believe that this skews the CCRs, as the hospitals with high routine charge mark-ups are systematically removed from the calculation. This results in the exclusion of 198 hospitals' routine CCRs, accounting for over 26 percent of total routine charges. It also creates a mismatch between the CCRs used and the charges they are applied to, as the hospitals that are trimmed out of the CCRs are still included in the charges that are then reduced to costs and determine the cost shares.

3. **Weighting:** CMS also hospital-weighted rather than charge-weighted the calculation of the CCRs which in turn are used to calculate the scaling factors used to convert the charge-based relative weights to "cost." There are several issues with this approach:

    - This approach gives an equal weight to each hospital in the national cost-to-charge ratio calculation even though hospitals can range in size from fewer than 25 to more than 1,000 beds.
    - This method is inconsistent with the method of averaging used to develop the cost center-specific DRG weights to which the scaling factors are applied. For this part of the analysis, CMS calculated hospital-specific DRG relative weights, but then used a case-weighted average to develop the national value.

    - The hospital-weighted approach results in a 1 percent to 54 percent difference versus a charge-weighted approach in the resulting scaling factors used for the conversion to cost.

The above errors in the calculations over-weight CMS' routine cost shares and under-weight the ancillary cost shares, creating erroneously large swings in DRG weights. Table 1 illustrates how these methodological problems affect the factors used to scale the cost center-specific relative weights. This table shows the impact of trimming the cost center CCRs at 3.0 rather than 1.96 standard deviations from the geometric mean and charge-weighting rather than hospital-weighting the calculation of the national average CCRs that are used in developing the scalers.

Table 1
Impact of Methodological Changes on "Scalers"
Published versus Revised with Methodological Changes

Scaler	CMS Published	Methodological Changes			Percent Change vs. Published
		Trimming Only	Weighting Only	Weighting/ Trimming	
Routine days	0.2881	0.2882	0.2646	0.2490	-14%
Intensive days	0.1919	0.1933	0.1668	0.1636	-15%
Drugs	0.0877	0.0884	0.0939	0.0970	11%
Supplies	0.1150	0.1142	0.1325	0.1383	20%
Therapeutic	0.0384	0.0381	0.0390	0.0388	1%
Operating room	0.0812	0.0838	0.0861	0.0888	9%
Cardiology	0.0241	0.0246	0.0351	0.0371	54%
Laboratory	0.0670	0.0659	0.0681	0.0687	3%
Radiology	0.0427	0.0437	0.0460	0.0474	11%
Other services	0.0639	0.0600	0.0677	0.0712	12%

Source: Moran Company analysis.

These methodological problems have a large impact on the relative weight calculations at the DRG level. Table 2 shows, for key DRGs, how these methodological problems affect the DRG weights and, therefore, hospital payments.

Table 2
DRG Weights with Current Methodology vs. HSRVcc with Various Corrections
High Volume DRGs with Largest Changes in Weights Due to Corrections

				New DRG Weights: Published vs. Corrected			Change vs. Old Weights		
DRG (v24)	DRG Title	Number of discharges	Current Charged-based Weights w/v24 Grouper	CMS Published HSRVcc Weight	HSRVcc w/ Technical Corrections Only	Corrected, Weighted and Trimmed CCRs	DRG Weight Change Current Method vs. Published	DRG Weight Change Current vs. Corrected, Weighted, and Trimmed	Published vs. Corrected, Weighted, and Trimmed
430	PSYCHOSES	74,871	0.6561	1.2316	1.2416	1.1110	87.7%	69.3%	-9.8%
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	56,042	0.8983	1.0105	1.0099	0.9635	12.5%	7.3%	-4.7%
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	119,513	3.4630	3.8279	3.8366	3.6573	10.5%	5.6%	-4.5%
277	CELLULITIS AGE >17 W CC	118,691	0.8676	1.0015	1.0026	0.9578	15.4%	10.4%	-4.4%
87	PULMONARY EDEMA & RESPIRATORY FAILURE	96,506	1.3854	1.5310	1.5324	1.4699	10.5%	6.1%	-4.0%
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	224,491	0.8611	0.9538	0.9544	0.9162	10.8%	6.4%	-3.9%
294	DIABETES AGE >35	97,122	0.7750	0.8642	0.8636	0.8307	11.5%	7.2%	-3.9%
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	246,948	0.8213	0.9041	0.9042	0.8701	10.1%	5.9%	-3.8%
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	159,894	1.5939	1.7331	1.7359	1.6680	8.7%	4.6%	-3.8%
243	MEDICAL BACK PROBLEMS	100,498	0.7888	0.8680	0.8693	0.8363	10.0%	6.0%	-3.7%
554	OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX	77,003	2.0890	1.9483	1.9560	2.0085	-6.7%	-3.9%	3.1%
110	MAJOR CARDIOVASCULAR PROCEDURES W CC	57,436	3.8616	3.6419	3.6558	3.7563	-5.7%	-2.7%	3.1%
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	119,991	1.4508	1.1670	1.1732	1.2380	-19.6%	-14.7%	6.1%
544	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	444,118	1.9514	1.8941	1.9047	2.0147	-2.9%	3.2%	6.4%
551	PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR	53,717	3.0391	2.6339	2.6481	2.8453	-13.3%	-6.4%	8.0%
552	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX	81,744	2.0837	1.7670	1.7771	1.9468	-15.2%	-6.6%	10.2%
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	91,848	1.1117	0.7862	0.7913	0.8717	-29.3%	-21.6%	10.9%
557	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV DX	123,550	2.8755	2.1323	2.1499	2.4236	-25.8%	-15.7%	13.7%
515	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	58,009	5.2591	4.1471	4.1795	4.7999	-21.1%	-8.7%	15.7%
558	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX	191,677	2.1920	1.4299	1.4456	1.7238	-34.8%	-21.4%	20.6%

Source: Moran Company analysis of FY 2007 proposed inpatient PPS rule. Uses FY 2005 MedPAR.
Notes: High volume DRGs defined as over 50,000 cases. Those included in the table were those with the greatest absolute change in weight moving from the CMS published DRG weight to the DRG weight calculated by trimming CCRs at 3.0 standard deviations, using weighted CCRs, and correcting for technical errors.

These changes have a material impact on hospital payment. CMS' method for weighting and trimming redistributes $1.4 billion dollars among hospitals. Charge-weighting the CCRs and trimming them at three standard deviations would reduce the shift in dollars to $900 million – a reduction of ***half a billion dollars***, or 33 percent. This highlights the need for more work to validate each methodological step to understand how it affects payment and ensure it adds to "accuracy."

4. **Failure to Calculate Costs at the Claim Level:** CMS chose to use *charges* to initially calculate the relative weights at the DRG level and then a national scaler to make the conversion to "cost-based" weights. The national scaler converts the 10 cost center charge-based weights to one national weight using the actual share of costs across departments. CMS maintains that this adjusts for differential mark-ups across hospital departments. In contrast, MedPAC estimated *costs* at the claim level to calculate relative weights. CMS provided no validation of the methodological shortcut they propose.

5. **Cost Centers:** CMS aggregates charges into 10 cost centers for each DRG, then applies a cost-center level CCR (derived from the cost reports) to charge figures (from claims data). But because hospitals often report charges on the cost reports differently than charges on the

claims, the cost-center level CCRs are calculated based on a different set of charges than the charges to which the CCRs are later applied. We believe this may materially distort the DRG weights and needs to be thoughtfully considered and accounted for in any methodology. If CMS is going to move to cost-based weights, regardless of the methodology, hospitals will need time to align their mapping of cost centers into departments or cost categories for purposes of cost reporting with that of claims reporting.

6. **Validation:** As mentioned above, CMS provided no analysis to validate that the proposed changes result in better payment policy. While measuring improved payment accuracy is difficult, the large degree to which the weights fluctuate given methodological changes alone indicates the need for further analysis and study. CMS should construct a process to test the sensitivity of weights to various methodological assumptions and publicly share the result, including:

   - Compare CMS weights to MedPAC's HSRV-cost approach;
   - Compare CMS weights to an approach using standardized costs (as opposed to HSRV);
   - Compare CMS weights to weights calculated by estimating costs at the claims level using the 10 cost center approach;
   - Evaluate alternative methodologies for estimating costs (e.g., method used by New York state's Medicaid program);
   - Compare stability of weights over time; and
   - Determine whether payment policy is improved.

   Assessment of "payment accuracy" conducted by The Moran Company as well as The Health Economics and Outcomes Research Institute (THEORI), a division of the Greater New York Hospital Association, finds the CMS HSRVcc approach to be not at all to marginally better than the current system. Fixing the major methodological flaws yields minimal improvement, according to THEORI. CMS' HSRVcc approach actually creates new areas of care where systematic incentives for specialization could occur. This analysis raises significant questions about CMS' approach and further analysis should be conducted before any changes to the current charge-based methodology are made. These analyses will help determine the most effective and administratively feasible approach for a shift to cost-based weights in FY 2008.

NEW PATIENT CLASSIFICATION: SEVERITY OF ILLNESS

CMS also proposes moving to an entirely new patient classification system beginning in FY 2008 *or earlier*. Currently, Medicare uses 526 DRGs to classify all Medicare patients. CMS considered use of 3M's all-patient refined DRGs (APR-DRGs) as an alternative to its current DRGs, which would increase the number of categories to 1,258. However, CMS ultimately

proposed refining the APR-DRG system by consolidating APR-DRGs into fewer categories. This would result in a new DRG system with 861 consolidated severity-adjusted DRGs, or CS-DRGs.

The OHA believes that the need for and best approach to changing the patient classification system has not been concretely and objectively demonstrated. More careful analysis is needed, along with greater access to the specifics of CMS's methodology and the new GROUPER. Below we discuss our detailed concerns and questions about this proposal.

CS-DRG METHOD CONCERNS

1. **Validation:** It is unclear whether there is a need for a new patient classification system. More work is needed to assess the proposed system and others that might be considered. As with the HSRVcc proposal, CMS provided no analysis that shows that the proposed changes result in an improved hospital payment system compared to the existing DRG system or APR-DRGs.

   CMS must test the degree to which the variation in costs within cases at the DRG level is reduced under both CS-DRGs and APR-DRGs. Payment classifications that still exhibit a high degree of cost variation should be identified and potentially revised. We suggest comparing the distribution of the coefficient of variation at the DRG level for various grouping approaches.

   For instance, CMS chooses to collapse the tier-four cases within major diagnostic categories (MDCs). It is unclear whether all of the tier-four cases are clinically cohesive enough to be combined and whether consolidation adequately considers variations in resource requirements. CMS also aggressively collapses the DRGs with low Medicare volume such as obstetrics, psychiatric and substance use services without any discussion of the potential ramifications for other payment systems, such as other Medicare PPSs, Medicaid and the private sector that often bases payment off the Medicare inpatient DRG system. CMS believes that a new patient classification system that distinguishes more-sick from less-sick patients will reduce the "cherry picking" of healthy patients, but there may be other, easier ways to accomplish this. For example, CMS embarked on a new way to differentiate patients last year based on the absence or existence of a major cardiovascular diagnosis but did not discuss the possibility of other similar, less disruptive changes to the system as an option in this year's rule.

   Even more fundamentally, today's DRG system was created to distinguish the resource use required among patients. It has been modified over time to reflect changes in clinical practice and technology. The APR-DRG system is based on severity of illness, not necessarily the resource use required. The impact of a move to CS-DRGs – an APR-DRG hybrid – is unclear. But the implications of moving from a resource-based system to a severity-based payment system must be more fully explored and understood.

2. **Budget Neutrality Adjustment:** CMS suggests in the proposed rule that it would reduce payments to hospitals by instituting a budget neutrality adjustment to offset the fact that case

mix may increase because of improved coding rather than actual changes in acuity. However, CMS did not propose an adjustment or even a methodology for determining an adjustment. CMS often institutes such adjustments that are based on assumptions but never checked or later corrected. We recommend that CMS hold off on such an adjustment until there is evidence that one is needed.

3. **Availability of the GROUPER:** The proprietary nature of the proposed CS-DRG GROUPER is of concern. The current DRG GROUPER logic has been in the public domain since the inception of the PPS. Without the new GROUPER logic, it is virtually impossible for OHA or anyone else to thoroughly analyze the system and comment – without access to the new GROUPER, we have no understanding of how and why patients fall into certain CS-DRGs and cannot evaluate whether it represents policy improvement. If CS-DRGs are adopted and the GROUPER remains proprietary, the OHA would be limited in our ability to educate and assist our member hospitals. Moreover, a single company's monopoly would be both more expensive and more difficult to integrate into our hospitals' existing systems. Maryland hospitals report a GROUPER price of $20,000 per hospital with the ultimate price varying based on criteria such as whether it is used on a mainframe or PC. We urge CMS to make any new classification system widely available to the public.

4. **Too Few Diagnoses and Procedures Considered:** We are concerned that CMS' GROUPER does not use all diagnoses and procedures that affect a patient's severity of illness and/or the resources utilized. The current DRG GROUPER only considers nine diagnoses and up to six procedures. Hospitals submit claims to CMS in an electronic format. The HIPAA compliant electronic transaction 837i standard allows up to 25 diagnoses and 25 procedures. Many fiscal intermediaries are ignoring or omitting the additional codes submitted by hospital providers since these additional diagnoses and procedures are not needed by the GROUPER to assign a DRG.

   Capturing all diagnoses and procedures meeting the definitions of reportable secondary diagnoses and procedures will provide a more complete picture of patient complexity. As CMS considers methodologies for refining the patient classification system, the number of secondary diagnoses may be an important factor in determining differences in patient characteristics. This is particularly true of patients with many chronic illnesses that add to the complexity of treating them.

OHA RECOMMENDATIONS

The hospital field supports meaningful improvements to Medicare's inpatient PPS. We believe the OHA, the AHA and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs which will provide an equal incentive to treat all types of patients and conditions. 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. Moving forward requires thoughtful change. Specifically, the OHA supports the following:

- **One-year Delay:** The OHA supports a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. The OHA and the hospital field are committed to working with CMS over the next year to address these concerns.

- **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:** The OHA does not support a new classification system at this time, 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. For example, of the 2,566 hospitals that would experience an increase in payment using the HSRVcc[1] methodology alone, 48 percent would experience a net loss when CS-DRGs and HSRVcc are done together. Of the 859 hospitals that have a decrease in payment under the HSRVcc methodology alone, 33.9 percent would become overall winners when CS-DRGs and HSRVcc are done together.

- **Three-year Transition:** Any changes should be implemented with a three-year transition, given the magnitude of payment redistribution across DRGs and hospitals. We recommend that CMS provide a three-year transition with a blend of the old DRG weights and the new DRG weights. In the first year, hospitals would be paid based on an average of DRG weights: 75 percent of the old weights; 25 percent of the new weights. The second year would be 50 percent of each, and the third year would be 25 percent of the old weights and 75 percent of the new weights. Another method of transition is dampening the reduction for DRGs with significant decrease in relative weights similar to the dampening of APC weights in the outpatient PPS. Dampening could be more feasible – especially if a significant change to the classification system is made – because it does not require CMS to calculate payments using two different systems.

  We further believe that a stop loss should be instituted as part of this transition. This would be similar to the approach currently used under the inpatient psychiatric PPS whereby no hospital can receive less than 70 percent of what they would otherwise have been paid under the old system. In combination with the DRG blend or dampening, this would result in less significant losses in the first year than in the last year of the transition. To avoid having to run all claims under both DRG weights, CMS could

[1] Source: Moran Company analysis of 2004 MedPAR under FY 2007 payment policies using weighted CCRs and trimming CCRs at 3.0 standard deviations.

establish a payment-to-cost ratio for each hospital in FY 2006 and use that as a base against which to compare payments under the new system.

- **Collaborative Approach to Moving Forward**: The OHA commits to working with CMS to develop and evaluate alternatives for new weights and classifications.

DRG RECLASSIFICATIONS

DRGs: Pancreas Transplant. We agree with the proposed coding changes for DRG 513 (Pancreas Transplant), which removes the requirement that pancreas transplant patients also have kidney disease. This change is consistent with the newly approved National Coverage Determination (NCD) to cover pancreas transplants alone as reasonable and necessary under limited circumstances for patients with Type I diabetes.

DRGs: Dual Array Implantable Neurostimulators for Deep Brain Stimulation. We oppose CMS' recommendation to keep the implantation of dual array implantable neurostimulators for deep brain stimulation in DRG 1 (Craniotomy Age >17 with CC) and DRG 2 (Craniotomy Age >17 without CC). CMS should recognize the higher resources associated with this technology.

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.

DRGs: Cardiac Resynchronization Therapy, Defibrillators (CRT-D). We agree with the proposal to add code 37.74 (Insertion or Replacement of Epicardial Lead [Electrode] into Atrium) to the DRG logic so that all types of defibrillator devices and lead combinations would be included in the following DRGs:

- DRG 515 (Cardiac Defibrillator Implant without Cardiac Catheter);
- DRG 535 (Cardiac Defibrillator Implant with Cardiac Catheter with AMI/Heart Failure/Shock); and
- DRG 536 (Cardiac Defibrillator Implant with Cardiac Catheter without AMI/Heart Failure/Shock).

This change would bring the DRGs into alignment with the change in coding advice to assign code 37.74 in conjunction with implantation of CRT-D defibrillators.

Application of Major Cardiovascular Diagnoses (MCVs) List to Defibrillator DRGs. We oppose the proposal to delay refining defibrillator DRGs based on MCVs. We believe it is appropriate for CMS to apply a clinical severity concept similar to the approach used in FY 2006 to refine cardiac DRGs to an expanded set of DRGs (e.g., defibrillator DRGs) based on the presence or absence of an MCV.

DRGs: Hip and Knee Replacements. For FY 2006, new codes were created to differentiate between new and revised hip and knee replacements. In addition, more specific codes were created to identify the joint components replaced. After publication of the FY 2006 inpatient PPS final rule, a number of commenters advised CMS that the DRG logic for DRG 471 (Bilateral or Multiple Major Joint Procedures of Lower Extremity) included knee and hip procedures that are not bilateral or do not involve multiple major joints. We agree with CMS' proposal to remove the codes from DRG 471 that do not capture bilateral and multiple joint revisions or replacements.

DRGs: Severe Sepsis. We agree that providers have found the coding of systemic inflammatory response syndrome (SIRS), sepsis and severe sepsis confusing in the last few years. The classification of these conditions has changed several times during this period. We concur that data have not been consistent and that a new DRG for severe sepsis would be inappropriate. However, we recommend that a change be made so patients with severe sepsis associated with respiratory failure requiring mechanical ventilation may be properly recognized. The ICD-9-CM classification instructions require that these patients be coded with the systemic infection as the principal diagnosis. The infection codes do not group to DRG 475 (Respiratory System Diagnosis with Ventilator Support) despite the use of resource-intensive mechanical ventilation (procedure code 96.7). This results in a significant loss of reimbursement for these patients.

Since the change in coding sequencing of these patients, the Coding Clinic Editorial Advisory Board has discussed this issue several times. In addition, several proposals have been submitted to the ICD-9-CM Coordination and Maintenance Committee to allow the sequencing of respiratory failure as the principal diagnosis. To date, no changes have been made. At this point, reverting the sequencing instructions would be confusing to coders and would once again disrupt trend data.

Instead, we recommend considering mechanical ventilation as a pre-MDC DRG on the basis of the procedure code. If this is not possible, we recommend that CMS add systemic infections (038.xx,) as acceptable principal diagnoses for DRG 475 when reported in conjunction with mechanical ventilation or tracheostomy.

DRGs: Complications/Comorbidities (CC) Categories 403-404. Effective October 1, changes have once again been made to the definition of the fifth-digits for categories 403 (Hypertensive Chronic Kidney Disease) and 404 (Hypertensive Heart and Chronic Kidney Disease). Prior to October 1, 2005, a fifth digit of "0" indicated "without chronic renal failure," while a fifth digit of "1" indicated "with chronic renal failure." While all patients in categories 403 and 404 had chronic kidney disease linked to hypertension, only those with a fifth digit of "1" had progressed to the point of kidney failure. Effective October 1, 2005, the definition of the fifth digits changed to "with or without chronic kidney disease." This was confusing since all patients in categories 403 and 404 by definition were supposed to have a chronic kidney condition. The change also blurred the distinction between the patients with more severe kidney failure and those with less kidney damage. The most recent change for this year once again changes the meaning of fifth digit "0" 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. More importantly, 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 codes 403.10, 403.90, 404.10 and 404.90, we recommend that CMS instead rely on the supplemental code from category 585 (Chronic Kidney Disease) to recognize the CC.

Implementing a Modern Clinical Classification System. We continue to agree with CMS' assessment in the May 9, 2002 hospital inpatient PPS notice of proposed rulemaking that ICD-10 is an improvement over ICD-9-CM and will provide greater specificity and detail. We believe that CMS should continue with plans to implement ICD-10. Implementing the significant DRG changes is a temporary fix, and a more refined DRG system can only be accomplished with more specific clinical classification systems, capable of painting a more complete picture of a patient's condition and the services provided to treat that condition – namely ICD-10-CM and ICD-10-PCS.

LONG-TERM CARE HOSPITAL (LTCH) DRGS

The OHA is very concerned about the proposed reweighting of the long-term care hospital (LTCH) DRGs for FY 2007. The projected payment cut resulting from the reweighting – 1.4 percent – in combination with the payment cut resulting from the recent LTCH PPS final rule for 2007 – 7.1 percent – will cause substantial volatility for LTCH providers, and ultimately restrict access for patients needing long-term acute care services. It would be extremely difficult for any provider group to withstand an 8.5 percent cut in one year. By pursuing these changes, CMS is misinterpreting MedPAC's estimate of 2006 Medicare margins for LTCHs and creating an extremely unstable regulatory environment for LTCHs. MedPAC projected a 7.8 percent Medicare margin for LTCHs in 2006 and recommended no market basket update for FY 2007. However, this MedPAC projection does not include two major policy changes that also decrease Medicare margins for LTCHs: the projection excludes the impact of the "25% Rule" limiting payments to co-located LTCHs and the new reductions associated with the LTCH short-stay outlier policy. Therefore, CMS goes too far with this proposal to reduce Medicare payments even further.

Given these considerations, we urge the agency to forgo the proposed 1.4 percent cut and instead implement the reweighting in a budget-neutral manner.

This would appropriately redistribute allocated funds among the payment categories to reflect current costs and omit the inappropriate modification of total payments due to unrelated considerations. **It is irrational to treat the LTCH PPS differently than other Medicare payment systems by failing to reweight the LTCH PPS in a budget-neutral manner.**

At this time, CMS should focus on developing further patient and facility criteria for LTCHs to ensure that patients who are clinically suitable continue to have access to the LTCH setting. We strongly support CMS' pursuit of a scientific foundation for these expanded criteria and are eager to review the recommendations currently under development by CMS' contractor the Research Triangle Institute.

HOSPITAL QUALITY DATA

The Deficit Reduction Act of 2005 (DRA) expands quality reporting requirements for hospitals to be eligible to receive a full market basket update. The proposed rule states that to qualify for their full market basket update, hospitals would have to pledge to submit data on all 21 measures currently part of the Hospital Quality Alliance's (HQA) public reporting on www.HospitalCompare.hhs.gov for patients discharged on or after January 1. Hospitals failing to submit data for the first calendar quarter of 2006 by August 15 would receive an inpatient update equal to the market basket minus two percentage points. Hospitals that fail data validation tests for data submitted for the first three calendar quarters of 2005 would also lose the two percentage points from the market basket update.

The OHA, the AHA and our member hospitals fully support the HQA's effort to make more information on hospital quality available to the public, and we join with CMS in wanting to make it happen quickly and accurately. However, as written, the proposed rule 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.**

The DRA gave the Secretary of the Department of Health and Human Services (HHS) the authority to further expand the measures that must be reported to qualify for full market basket update in future years. **We strongly urge CMS to select measures only from those used by the HQA for public reporting.** To choose different measures would thwart efforts to streamline quality reporting, add to the "babble" of quality measurement that currently exists in health care and dilute efforts to create a single source to share solid reliable information with the public. In addition, whenever the Secretary intends to expand the set of measures linked to payment, **CMS should consider publishing the proposal at least one full year prior to the start of the fiscal year.** This will enable hospitals and their vendors to put the needed data collection processes in place to be able to provide the requested data.

Further, we agree with CMS that it is critical that the collected data be validated. The process used to validate the HQA data was reviewed by the Government Accountability Office, which concluded that there was "a high overall baseline of accuracy," but recommended several changes to improve the validation process. CMS proposes to look at the validation results for

data submitted on patients who were discharged during the first three calendar quarters of 2005. CMS has hired a contractor to randomly select five patient records per quarter. That contractor selects the patients, asks the hospital to send a copy of the medical record for the hospitalization of the patients that occurred during that period, and then reabstracts the same data that the hospital abstracted from the medical record. A comparison is made between the data the hospital submitted and the data the contractor abstracted, and if there is at least an 80 percent agreement, the hospital is said to have passed validation. In the proposed rule, the hospital would have to have at least 80 percent agreement across the 15 medical records that the contractor reabstracted. This methodology assumes that the contractor has correctly reabstracted the data and that discrepancies must mean erroneous data submission on the part of the hospital. However, that is not always the case. This validation process is still in its infancy and seems to be working to correctly validate the information submitted by many, but unfortunately not all, hospitals. Significant problems have occurred for some hospitals of which we are aware.

Some data validation problems have actually begun with the data submission process. Hospitals and their data collection vendors submit data to the Quality Improvement Organization (QIO) data warehouse in a good-faith effort to get the information submitted in the right format, with all of the right labels and coding. An "error report" is generated that is supposed to alert the hospital if it appears data were received in a way that is not consistent with the requirements. The hospital is supposed to receive this report in time to make any necessary corrections. However, the report can be hundreds of pages long with a multitude of meaningless notations. A significant problem in data transmission might have occurred, but the indications of it are buried in this voluminous report and may not be discovered until it is too late for the hospital to make a correction. In addition, the data collection vendors on whom the hospitals rely to format and submit the data correctly do not have access to these error reports, nor do they have any other mechanisms for checking to make sure that the data they sent was received correctly. This has inevitably led to errors not being caught in time. When these errors are then left in the database, the CMS contractors' reabstraction of the data does not match up with what is recorded for the hospital in the database, leading to the hospital failing validation.

Another common problem results when the contractor has asked for the medical record pertaining to a particular patient, but has not specified which admission it wanted. Since it is not uncommon for heart failure patients to be readmitted for care, the omission of the specifics on which admission was being reabstracted has inevitably led to the hospital copying and submitting data on one admission, and the contractor trying to make that match up with the data for a different admission – and the data simply will not match up.

There also have been many reported instances in which the contractor conducting the reabstraction of the data failed to find information that was clearly in the medical record – a simple human error, but one that should not be used to penalize the hospital.

CMS was made aware of these problems with the validation process and it has begun to work to improve the process reliability so it can be used to support payment decisions. However, in the first three calendar quarters of 2005, the validation process did not have sufficient integrity to warrant hospital payments being withheld based on the validation results. At this juncture, we firmly believe that the problems with the validation process itself need to be resolved before any

payment decisions are made solely on the basis of the contractor's work. **We strongly urge CMS to review, on a case-by-case basis, any incidence where a hospital's payment would be put in jeopardy as a result of the validation process. It should allow the hospital to submit information showing that it made a good-faith effort to supply the data warehouse with accurate information so that the public could be informed about the quality of its care. If the hospital has made a good-faith effort, it should receive full payment regardless of whether the data are deemed accurate enough for public display.** In addition, CMS should instruct its QIO data warehouse to accept any significant corrections so that the public can have a full and accurate picture of hospital quality.

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 remain very concerned that the threshold is too high. According to the analyses conducted by AHA, 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.

The OHA appreciates 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. The OHA strongly opposes using this methodology to estimate the outlier threshold.** The AHA conducted a series of analyses to identify a more appropriate methodology. Below we put forth for CMS' consideration a methodology that incorporates both *cost* inflation and *charge* inflation. The OHA believes the use of more than one indicator will make the threshold calculation more accurate and reliable.

First, we inflated 2005 charges by 15.71 percent (the inflation factor used by CMS in the proposed rule) and then reduced the charges to costs. Instead of using the cost-to-charge ratios (CCRs) from the CMS Impact File, we used the CCRs from the March 31, 2006 HCRIS release. In addition, we accounted for the nine-month lag from the end of a cost-reporting period until the FI is able to update the CCR. We accomplished this by projecting forward from the most recent fiscal period in the March 31 HCRIS update to the fiscal period(s) expected to be used for the calculation of the CCR(s) determining federal FY 2007 outlier payments.

The cost inflation factor for projecting CCRs was determined from the cost reports of a cohort of 3,253 matched hospitals for periods beginning in federal FYs 2002, 2003 and 2004. All three

cost reports were available for each hospital from the recent update of HCRIS. The 2002-2004 aggregate annual rate of increase in the cost per discharge for these hospitals was 5.69 percent[2]. This cost inflation factor and the CMS charge inflation factor of 7.57 percent were used to project CCRs over the time periods described above. The projected CCRs were applied to projected federal FY 2006 charges to simulate the determination of costs for FY 2007 outlier payments. **The estimated fixed-loss amount that would result in 5.1 percent outlier payments under this methodology is $24,000.**

The OHA strongly urges CMS to adopt this methodology, which is applicable regardless of what DRG changes are made or not made in FY 2007. We estimate that the fixed-loss threshold necessary to achieve 5.1 percent in FY 2006 should have been set at $21,275 as compared to the $23,600 actually utilized. We believe CMS underspent the funds set aside for outliers by an estimated $3 billion over FYs 2004, 2005 and 2006. **This is a real cut in payments to hospitals that cannot be recouped. If CMS leaves the threshold at $25,530, rather than dropping it to $24,000, we believe that CMS will again significantly underspend by over $300 million.** We urge CMS to adopt our recommended methodology to lower the outlier threshold. Attached is the full analysis, conducted by Vaida Health Data Consulting.

CORE-BASED STATISTICAL AREAS (CBSAS)

In adopting the Core-based Statistical Areas (CBSAs) in FY 2005, a small number of hospitals that were classified as urban in FY 2004 became classified as rural in FY 2005. Because moving from a Metropolitan Statistical Area (MSA) to the rural statewide average would have resulted in a significant decline in these hospitals' wage indexes, CMS implemented a three-year transition period (FYs 2005-2007). The OHA supports the continued transition for these hospitals to give them the opportunity and time to reclassify.

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

[2] An audit adjustment was applied to costs from "as submitted" cost reports. The audit adjustment was determined by comparing 2,729 "as submitted" cost reports from the December 31, 2003 HCRIS database with the settled reports of the same hospitals in the March 31, 2006 HCRIS update.

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.

Definitions and Covered Employees. In filling out the interim-survey, our members found that the placement of certain employees caused confusion. Examples include surgical technicians, paramedics who are employed by the hospital and usually work in the emergency department, and unit secretaries who are also known as ward clerks. CMS clarified after the proposed rule was released that these employees should be placed in the "all other" category for the interim-collection. Moving forward, CMS should re-evaluate where these employees belong. **However, such changes should not be made to the ongoing collection, as it would necessitate the resubmission of the first calendar quarter's data to ensure that both quarters could be used for FYs 2008 and 2009.** If CMS believes that such changes are warranted, then the hospitals will need notification prior to the release of the final inpatient PPS rule in order to meet the August 31 deadline for submissions.

Cost Centers. We agree with CMS' "bright line" clarification for this collection that only nursing personnel within the cost centers listed should be included in that category for the purposes of consistency. It is significantly less work for hospitals to focus on certain cost centers, and we continue to support this methodology. **We believe that the vast majority of nursing personnel within a hospital fall within these cost centers and do not believe that CMS should include every cost center that may have a few nursing personnel included in it.**

However, CMS should consider refining the list for future collections. Every hospital has a different method for attributing costs to the cost centers, thus there are probably a few cost centers that contain a significant number of nursing personnel for certain hospitals that were not captured for this collection. Given the shortened comment period in combination with the magnitude of the other changes proposed by CMS in the inpatient PPS rule this year, we were unable to extensively research which cost centers CMS should add. We suggest that CMS accept comments on any potential changes to the cost center list before making such changes. **In addition, we believe that additional cost centers should *not* be added to the ongoing collection as it would necessitate the resubmission on the first calendar quarter's data to ensure that both quarters could be used for FYs 2008 and 2009.** If CMS believes that such changes are necessary for the current collection, then hospitals would need notification prior to the release of the final inpatient PPS rule in order to meet the August 31 deadline for submissions.

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.**

However, hospitals will 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 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, 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. **The OHA 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. 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.**

HOSPITAL REDESIGNATIONS AND CLASSIFICATIONS

Section 508 Reclassifications. Section 508 of the *Medicare Modernization Act* (MMA) provided $900 million over three years for a one-time geographic reclassification opportunity, which expires March 31, 2007. Because the 508 reclassifications expire mid-year and hospitals may not receive Section 508 funding at the same time as any other form of reclassification, CMS has proposed special provisions for accepting or denying partial-year reclassifications for FY 2007.

In FY 2006, CMS stated that individual hospitals reclassified under Section 508 would be allowed to request regular reclassification for the portion of the three-year period that the hospital is not receiving Section 508 funding, or to turn down the Section 508 reclassification for the first half of FY 2007 and receive regular individual reclassification for the full three years.

CMS also stated that Section 508 hospitals that would like to be part of a group reclassification could turn down their 508 reclassification for the first half of FY 2007 and join a group for the full three-year period. Or the hospitals could maintain Section 508 reclassification while the rest of the group gets their "home wage index" for the first half of the year. The entire group then could reclassify together for the rest of the three-year period.

In the proposed rule, CMS clarifies that "home wage index" means that hospitals could receive the wage index they otherwise would have, absent the group reclassification. For some hospitals, this might literally be the wage index for the area in which they are located. For others, this may mean an individual reclassification to another area.

Section 508 hospitals, and those involved in a group reclassification with a Section 508 hospital, would normally have been required to accept or reject reclassification within 45 days of the publication of the proposed rule; however, the complications with the occupational mix adjustment will prevent this. **We appreciate and support CMS' flexibility around the expiration of Section 508 and the reclassification deadlines given the unusual circumstances this year.**

GEOGRAPHIC RECLASSIFICATIONS

Urban Group Reclassifications. The OHA supports CMS' proposal to allow hospitals located in counties that are in the same CBSA as the county in which they seek redesignation to be considered to have met the proximity requirement. By failing to include CBSAs in the proximity criteria, CMS has excluded one group of hospitals, those located in Palm Beach County, FL, from being able to reclassify to the Fort Lauderdale-Pompano Beach-Deerfield Beach division of the Miami CBSA. **Given that CBSAs are actually more refined classifications than Combined-statistical Areas, we believe that the inclusion of CBSAs in the proximity criteria would be consistent with CMS' policy goals and protect hospitals from unintended consequences.**

Critical Access Hospitals in Lugar Counties. As a result of changes in the labor market area definitions made in response to the results of the 2000 census, counties in which a number of Critical Access Hospitals (CAHs) are located became "treated" as urban instead of rural under the inpatient PPS because of a statutory provision modifying the status of rural counties with certain commuting patterns to metropolitan areas. In its FY 2005 final rule, CMS interpreted this provision as applying to CAHs located in these counties (known as "Lugar counties" after the Senate sponsor of the provision) and allowed these facilities a grace period to seek reclassification as rural in order to retain their CAH status.

While accommodating CAHs in this manner, the agency also took the position that any CAH being reclassified would no longer be eligible for pass-through payments for the services of certified registered nurse anesthetists (CRNAs). Its reasoning was that the facility was no longer "located in a rural area (as defined for purposes of section 1886(d) of the Social Security Act)" as the pass-through statute requires, but were only reclassified as rural.

In response to comments received on the FY 2006 proposed rule, CMS announced a policy change in the final rule for FY 2006 stating that Lugar county designation would not affect a CAH's rural status because the statutory provision creating such counties only applies to hospitals paid under the inpatient PPS (CAHs are paid under a separate, cost-based system). This policy change had the effect of eliminating the need for these CAHs to seek either geographic reclassification or a waiver of the Lugar statute (which CMS has maintained it has no authority to do). **In effect, under this new reading of the law, the provision creating Lugar counties does not apply *at all* for purposes of CAH eligibility.**

Despite this policy change, CMS continues to maintain that a CAH located in a newly-designated Lugar county cannot qualify for CRNA pass-through payments. This position is at odds with the agency's view that *it is geographic reclassification that renders a CAH ineligible for such payments* – since, under CMS' revised policy, a CAH located in such a county need not seek geographic reclassification to be a CAH. Apparently, it is CMS' view that these CAHs can never qualify for CRNA pass-through payments, whether they have sought reclassification (under the old policy) or not (under the new policy). **We believe that all CAHs located in a newly-designated Lugar county should receive pass-through payments, regardless of whether they sought reclassification, and urge CMS to revise its regulations accordingly.**

WAGE INDEX BUDGET NEUTRALITY

CMS eliminates the CAH data from the wage index file it uses to compute the national average hourly wage (NAHW). For FY 2007, 1,191 CAHs representing approximately 24 percent of all inpatient PPS hospitals (as of FY 2000) – 55 percent of all rural hospitals in FY 2000 – have been eliminated from the file. Because CAHs have lower average hourly wages (AHWs) than the average PPS hospital, the elimination of this data results in an overstated NAHW. While the NAHW has been increasing, the systematic withdrawal of low-wage hospitals has artificially inflated the NAHW to some extent. This artificial increase is included in the negative budget neutrality adjustment that consequently reduces payment, resulting in the national inpatient PPS operating payments being understated by an estimated $1.52 billion over five years (2003-2007). **Thus, we believe that CMS should apply a positive budget neutrality adjustment in FY 2007 to compensate for the underpayments.** The understatement increases each year as more hospitals become CAHs and more data are eliminated from the wage index data. However, we believe that this could be a one-time adjustment as we expect very few hospitals to convert to CAH status now that the necessary provider designation is no longer an option.

LOW-VOLUME HOSPITAL PAYMENT ADJUSTMENT

Section 406 of the MMA created a payment adjustment under the inpatient PPS to account for the higher costs per case of low-volume hospitals. The law defined eligible hospitals as those located more than 25 miles from another facility with fewer than 800 total discharges annually. The rule proposes to maintain a 25 percent increase, the maximum allowable, in payments to hospitals with fewer than 200 discharges. For those hospitals that have between 200 and 800 discharges, CMS proposes to maintain its current policy, applying no payment increase. Only

two hospitals will receive this adjustment in FY 2007 according to CMS estimates. **The OHA is concerned that CMS is ignoring congressional intent and denying a group of hospitals – those with more than 200 discharges but fewer than 800 discharges – access to this necessary payment increase.**

SCH/MDH Changes in Qualification Status

The proposed rule would require an approved sole community hospital (SCH) or Medicare dependent hospital (MDH) to notify the appropriate CMS Regional Office of any change affecting its classification as such. To date, it has been the FIs responsibility to evaluate hospitals' continuing qualification for SCH or MDH status. CMS expects the hospital to now self-disclose any material changes in circumstances or potentially face a retroactive cancellation of their designation once an FI discovers its ineligibility.

This appears to be an inappropriate shift of the burden from the FIs to hospitals. For instance, hospitals are neither involved in, nor have any control over, the building of new roads or new hospitals and thus should not be accountable to report such changes. It also would be very difficult for hospitals to know when and for how long there were prolonged severe weather conditions that closed area roads, or to note changes to posted speed limits and traffic patterns. In addition, some of the qualifying criteria, such as inpatient admissions at other regional hospitals, would be hard to monitor as the hospitals do not have this sort of data on their competitors. Requiring hospitals to constantly monitor whether they continue to meet these requirements would impose a tremendous and unreasonable administrative burden on hospitals. **The OHA recommends that this function remain a responsibility of the FIs, who are in a better position to monitor these circumstances. If CMS requires hospitals to report changes in circumstances, then the specific types of situations should be noted and should only include aspects of their operation that are within their control (e.g., number of beds).**

CMS' proposal to retroactively withdraw SCH or MDH status if a hospital does not appropriately self-report a change in circumstances could be financially devastating. CMS should at minimum give consideration to whether the hospital had knowledge of the disqualifying circumstance. Hospitals should not have to repay CMS based on the difference between the inpatient PPS or outpatient PPS payment and the SCH or MDH payment when they did not know that they no longer qualified for the program. Instead CMS should develop a prospective process for withdrawing the hospitals' SCH or MDH status. We believe that a 30-day timetable for losing SCH/MDH status is unrealistic given the financial implications of such a change and the inability for a hospital to plan for this outcome. **CMS should re-evaluate the proposed timetable for canceling SCH/MDH status when a hospital is found to be disqualified or self-reports disqualification and consider revoking the hospitals' status as of the following cost-reporting period.**

SCH/MDH Volume Decrease Adjustment

An SCH or MDH may apply for special payments if it experiences a decrease of 5 percent or more in its total number of inpatient discharges that was out of its control from one cost-

reporting period to another. If the hospital qualifies, it must demonstrate that it took measures to scale back its nursing force commensurately. The adjustment is intended to cover the fixed costs that the hospital is unable to reduce in the year following the volume decrease. CMS believes that only "core staff and services" should be covered by these special payments. To date, CMS has used the AHA's HAS/Monitrend Data Book to compare the hospital's staffing to other similar hospitals in the area to determine if the hospital is staffing its routine and intensive care units appropriately. However, the Data Book has not been updated since 1993. CMS has been using the 1989 publication. Thus, CMS proposes using the occupational mix adjustment data currently being collected for wage index purposes to calculate nursing hours per inpatient day for a hospital in question and local peer hospitals.

The occupational mix adjustment was only partially implemented in its first three years, primarily due to the questionable data and results. The current collection, which is occurring again under rushed circumstances, may also result in questionable data. **We do not believe that it is wise to assume that the occupational mix adjustment data will be appropriate for this use. The OHA believes that the data within the AHA annual survey should be sufficient for CMS to determine the nursing levels per patient day.**

RURAL REFERRAL CENTERS

If a hospital wants to become a Rural Referral Center (RRC) but does not have 275 or more beds, it must meet two mandatory alternative criteria plus one of three additional criteria. The proposed rule would update the alternative criteria for RRC designation in FY 2007.

Until recently, the median case-mix index values were very stable. The chart below illustrates the volatility over the past few years in the values for two regions:

Region 7 West South Central	
FY 2005	1.1371
FY 2006	1.3532
FY 2007	1.2445
Region 6 West North Central	
FY 2005	1.0855
FY 2006	1.2252
FY 2007	1.2856

While it is not clear why this is occurring, it does suggest a possible methodological problem. **Thus, we recommend that CMS undertake additional analyses to determine the cause of the recent fluctuations.** This is particularly important given the possible disruption to case-mix patterns as a result of a new patient classification system such as the CS-DRG proposal.

CRITICAL ACCESS HOSPITALS (CAHS)

On November 14, 2005, CMS issued interpretive guidelines on the relocation of CAHs as a follow-up to the FY 2006 inpatient PPS final rule that established the "75% test" – serving 75

percent of the same population, providing 75 percent of the same services and employing 75 percent of the same staff – for necessary provider CAHs. The guidelines not only extended the 75% test to *all* CAHs, but it also altered the definitions of "mountainous terrain" and "secondary road."

We believe that these guidelines go well beyond the regulations included in the FY 2006 rule that provoked numerous critical responses from individual CAHs, associations and congressional representatives. The "mountainous terrain" and "secondary road" definitions are overly prescriptive and the 75% test does not provide reasonable flexibility based on natural variation in demographics, patient needs distribution patterns, normal employee and board attrition, and necessary changes in services to meet community needs. **Rural hospitals that move a few miles are clearly the same providers serving the same communities.**

Many CAHs are planning to rebuild in the near future to improve site safety and quality of care by adding fire and smoke barriers, upgrading infrastructure to support utilities and air handling, modernizing telecommunications to support health information technology, or making other essential upgrades. Facilities expect to relocate when they rebuild for a multitude of reasons: to be closer to a highway, to connect to municipal water and sewer, because of seismic safety concerns, or other similar concerns. **Such improvements will undoubtedly result in higher quality care, better patient outcomes and more efficient service, yet CMS' guidelines discourage these improvements.**

CMS' guidelines will not only impose an unnecessary burden on CAHs, but will preclude many of them from securing financing for needed capital improvements. The hospitals themselves, their hospital districts and their lenders cannot risk investing in a hospital that will be unsure of its status until a year after moving. **CMS should create a preliminary approval process to give assurances to those involved in the project that the CAH relocation will be approved if it meets the assertions made in the attestation submitted to CMS.**

Again this year, almost 60 congressional representatives signed a letter to CMS showing their support for their CAHs and urging changes to these guidelines. We agree with their recommendations and reiterate our suggestion from last year that a safe harbor be established for hospitals relocating within five miles of their existing locations. These providers are not only clearly serving the same communities, but trying to improve the quality of and access to needed health care services. A safe harbor will reduce the administrative burden on not only the hospitals, but CMS and the state survey agencies as well. **We urge CMS to create a safe harbor for CAHs moving a short distance and to make significant changes to these guidelines based on the feedback from CAHs around the nation as detailed in our letter under separate cover to Thomas Hamilton, director of the survey and certification group.**

GRADUATE MEDICAL EDUCATION (GME) PAYMENTS

Exclusion of Didactic Training. The proposed rule states that resident training that occurs at non-hospital sites must be related to patient care if a hospital wishes to count that time for direct medical education (DGME) and indirect medical education (IME) payment purposes. Resident time spent in didactic activities that often occur in associated medical schools – such as

educational conferences, journal clubs and seminars – would specifically be excluded. CMS noted that its statement in a previous letter on this topic "implying that didactic time spent in non-hospital settings could be counted for direct GME and IME ... was inaccurate." CMS also noted that time spent in these activities could be counted for DGME purposes if they occur in a hospital; however, the counting prohibition applies for IME payments regardless of where the educational activity occurs.

We strongly urge CMS to rescind the purported "clarification" in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare DGME and IME payments. The stated rationale for the exclusion of this time is that it not "related to patient care." This position is in stark contrast to CMS' 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."[3]

We strongly agree with CMS' 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. In addition, it would be very difficult to separate out time spent at these activities. **We urge CMS to withdraw this change 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.**

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

Definition of "Labor." **The OHA supports CMS' proposal to modify the definition of "labor" at 489.24(b) to allow a certified nurse-midwife or other qualified medical personnel operating under their scope of practice, as defined in hospital medical staff bylaws and in state law, to certify that a woman is in false labor.** This change recognizes that licensure and scope of practice should remain under the purview of state law and regulation. Further, this change provides hospitals with the staffing flexibility needed to maintain access to and the efficiency of vital obstetrical services, particularly in hospitals located in areas of the country that may find it difficult to attract and retain physicians, such as rural areas.

Hospitals without Dedicated Emergency Departments (ED). Under the proposed rule, a hospital with "specialized capability" is required to accept appropriate transfers under EMTALA regardless of whether it has a dedicated ED. **Guidance is still needed on the definition of specialized capability.** The EMTALA technical advisory group (TAG) has the ability to make recommendations for clarifying guidance, and we look forward to working with its members on this topic. In addition to questions related to the availability of on-call physicians and inpatient psychiatric resources, this proposed regulation calls into question application to inpatient rehabilitation facilities and long-term acute care hospitals.

[3] September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins.

The OHA agrees that a physician-owned, limited-service hospital should be treated as a hospital "with specialized capability or facilities" under EMTALA without regard to whether it has an ED. However, in the DRA-mandated HHS interim report to Congress on its development of a strategic plan regarding physician investment in specialty hospitals, the Secretary suggested that this interpretation of EMTALA "may result in an increase in the number of specialty hospitals accepting transfers of emergency patients on nights and weekends." (CMS uses "specialty" to mean the hospitals covered under Congress's moratorium, i.e., physician-owned, limited-service hospitals providing primarily cardiac, surgical or orthopedic services.) **As presented in our statement to the EMTALA TAG when this question was considered, we believe it is unlikely this will result in improved access for patients to the specialty care they need.**

It is important to separate the capabilities of the practicing physicians from the capabilities of the facility in which they are practicing. While the physician expertise housed in the physician-owned, limited-service facility could be capable of meeting the needs of community hospital patients, the facility is seldom designed or operated in a manner to support this level of practice. Although physician-owned, limited-service hospitals hold themselves out as "hospitals," many of these facilities actually have a range of capabilities more similar to a hospital department or ambulatory surgical center. These hospitals often do not have emergency capabilities, as they are geared toward elective cases of minor severity. Their capabilities are typically limited to a single major diagnostic category, and they staff for minimal inpatient capacity. Many of these facilities minimize resource consumption by being almost a Monday through Friday operation. For these reasons, it generally would not be in the best interests of community hospital patients to be transferred to these facilities.

At the same time, many physician-owned, limited-service hospitals have withdrawn specialist services from the community at-large. As their physicians maintain an increasing amount of their practice at these hospitals or other sites outside the community hospital (e.g., ambulatory surgical centers), they are much less willing to accept on-call responsibility for the broader community's emergency needs. While withdrawing specialist services from on-call coverage, these same physician-owned, limited-service hospitals presume to rely on the community hospital for back-up in the event of complications requiring around-the-clock access to emergency care and inpatient admission to the community hospital. With the change in physician practice patterns and the increased number of physicians requesting only courtesy admitting privileges at community hospitals, relying only on the professional obligations attached to admitting privileges is not sufficient to assure appropriate transfer arrangements and the availability of physicians to provide emergency specialty capacity. **Every physician-owned, limited-service hospital that relies on the community's emergency services capacity should be obligated to support it.**

In addition, this policy does not address the problem of patients at physician-owned, limited service hospitals who suffer from complications appearing in a hospital ED with no warning call, no medical history, no operative report, no information on the anesthesia used and, often, no ability to reach the treating surgeon for consultation. **Physician-owned, limited-service hospitals should be required to have agreements with the community hospitals they plan to rely on in the event that they do not have the capacity to treat a particular patient.**

Specifically, the OHA recommends the following:

- **A physician-owned, limited-service hospital should be required to have a pre-existing agreement with the community hospital(s) it intends to rely on for emergency back-up services.**

- **The Secretary should establish the terms that must be addressed by an agreement, including:**

  - **Procedures for an appropriate transfer for patients not covered under EMTALA** (e.g., inpatient or outpatient whose condition develops into an emergency beyond the capability of the limited-service hospital and consequently needs to be transferred to a full-service hospital);
  - **Continuity of care** (e.g., telephone consultation with the receiving hospital and physician, sending the patient's medical records along when transferred, etc.); and
  - **Support for maintaining full-time emergency capacity at the community hospital, including on-call coverage** (e.g., physician-owned, limited-service hospital physicians serve in on-call panels at the community hospital, or the physician-owned, limited-service hospital provides financial support to the community hospital to maintain on-call coverage).

NEW TECHNOLOGY

Section 503 of the MMA provided new funding for add-on payments for new medical services and technologies and relaxed the approval criteria under the inpatient PPS. This important provision was enacted to ensure that the inpatient PPS would better account for expensive new drugs, devices and services. However, CMS continues to resist approval of new technologies and considers only a few technologies a year for add-on payments. **The OHA also is disappointed that CMS has not increased the marginal payment rate to 80 percent rather than 50 percent, consistent with the outlier payment methodology, as previously requested by the AHA.**

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

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

The National Committee on Vital and Health Statistics (NCVHS) and Congress, in committee language for the MMA, recommended that the Secretary undertake the regulatory process to

upgrade ICD-9-CM to ICD-10-CM and ICD-10-PCS. Congress' call for action recognized that procedure classification codes serve to identify and support research and potential reimbursement policies for inpatient services, including new health technology, as required under the *Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.*

To date, despite these recommendations, as well as the recommendations of several federal health care agencies and offices and health care trade and professional associations, HHS has not yet moved forward to adopt the ICD-10 classification upgrades. We believe that absent a switch to ICD-10 soon, there will be a significant data crisis in the U.S. This coding crisis will affect the efficiency of the current coding process, adding significant operational costs. In addition, failure to recognize this looming problem will only impede the efforts to achieve President Bush's goal for an electronic health record by 2014.

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

Category 00 is now full, and the C&M committee is entertaining proposals for codes in category 17. At the April C&M meeting a proposal was presented that would in effect leave only 80 codes available in this category. Many of the specific body system chapters are already filled (e.g., cardiac and orthopedic procedures). In recent years, as many as 50 new procedure codes have been created in a single year. This means that it is possible for ICD-9-CM to completely run out of space in one-and-a-half years. We concur with the NCVHS recommendation to issue a proposed rule for adoption of ICD-10. We also would support an implementation period of at least two years following issuance of a final rule.

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

OTHER FUTURE CONCEPTS

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. HHS intends to identify

several regions in the United States with high health care costs where there is significant interest in reducing those costs and improving health care quality.

Significant progress has been made in making quality information more transparent. The AHA, the Federation of American Hospitals and the Association of American Medical Colleges partnered with CMS and others to form the Hospital Quality Alliance (HQA). The work of the HQA has led to the voluntary reporting and sharing with the public of 21 quality measures on the *Hospital Compare* Web site, and more measures of hospital quality and patient satisfaction are planned for the future. This effort has been tremendously successful, with nearly all inpatient PPS hospitals voluntarily reporting quality information. **Efforts to further expand public availability of hospital quality information must continue to be pursued through the HQA.**

While progress has been made regarding quality transparency, similar information on hospital pricing is less accessible. 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).

People deserve meaningful information about the price of their hospital care. Hospitals are committed to sharing information that will help people make important decisions about their health care. Sharing pricing information, however, is more challenging because hospital care is unique. Hospital prices can vary based on patient needs and the services they use; prices reflect the added costs of hospitals' public service role – like fire houses and police stations – serving the essential health care needs of a community 24 hours a day, seven days a week; and most hospitals cannot yet provide prices that reflect important information from other key players like the price of physician care while in the hospital or how much of the bill a patient's insurance company may cover. But more can, and should, be done to share hospital pricing information with consumers.

Providing *meaningful* information to consumers about the price of their hospital care is the most significant challenge hospitals, and CMS, face in increasing transparency of hospital pricing information. Objectives for improving pricing transparency should include:

- Presenting information in a way that is easy for consumers to understand and use;
- Making information easy for consumers to access;
- Using common definitions and language to describe pricing information for consumers;
- Explaining to consumers how and why the price of their care can vary; and
- Encouraging consumers to include price information as just one of several considerations in making health care decisions.

The AHA recently released a position statement on hospital pricing transparency, supported by the OHA, outlining steps to be taken to improve the pricing information available to health care consumers. The following four steps represent the AHA's roadmap for pricing transparency.

1) A federal requirement for states, working with state hospital associations, to expand existing efforts to make hospital charge information available to consumers.

- Thirty-two states already have statutes requiring hospitals to report pricing information that is made available to the public either by posting to a hospital, hospital association or government Web site, issued in a government or hospital association report, or made available to consumers upon request; five additional states voluntarily do so.
- State efforts on price transparency vary, from making individual hospitals' master list of charges available to the public (e.g., California), to making pricing information on frequent hospital services available to the public (e.g., Missouri, Florida, Nevada, North Carolina), to making information on all inpatient services available to the public (e.g., Colorado, Kentucky, Oregon, Pennsylvania, Wisconsin).

2) A federal requirement for states, working with insurers, to make available in advance of medical visits, information about an enrollee's expected out-of-pocket costs.

- This information is especially important to the majority of consumers who already have some type of health insurance coverage. Their likely interest is in knowing the amount for which they personally are financially responsible. This information is provided today to consumers by their insurance company – it is called an "explanation of benefits, or EOB – but is only given after care is provided. To help inform consumers in advance of their out-of-pocket obligations, insurers could provide an "advance EOB." This information could be shared with an insured individual by phone or electronically

through an insurer's Web site. Aetna is currently piloting a project like this for physician services in Cincinnati.

3) A federal-led research effort to better understand what type of pricing information consumers want and would use in their health care decision-making.

We have learned much based on research about what kind of information consumers want about the quality of their health care. But we know less about what consumers may want to know about pricing information. Consumers need different types of price information, depending on whether and how they are insured. The following illustrates different consumer needs:

- **Traditional Insurance.** Because traditional insurance typically covers nearly all of the cost of hospital care, people with this type of coverage are likely to want information about what their personal out-of-pocket cost would be if they receive care at one hospital versus another.

- **Health Maintenance Organization (HMO) Insurance.** People who have HMO coverage will have even more specific price information needs. They have agreed, in advance, to adhere to certain limits on their choice of physician or hospital in exchange for broad-based coverage of their health care needs. A person with HMO coverage typically faces no additional cost for care beyond their premium and applicable deductibles and copayments, but must agree to use physicians and hospitals that are participating in that HMO plan. These individuals likely have little, if any need for specific price information.

- **High-Deductible or Health Savings Account (HSA) Insurance.** People with HSAs have more interest than a typically insured person in price information. These types of plans are designed to make consumers more price-sensitive and to encourage consumers to be prudent "shoppers" for the care they need. A typical plan of this type has a deductible of $2,500. But consumers with HSA coverage are likely to be more interested in price information for physician and ambulatory care than for inpatient hospital care for several reasons:

    - Many patients admitted to the hospital were first seen on an emergency basis in the hospital emergency department. These are not price-shopping patients, but patients who found themselves in need of emergent care and either came or were brought to the nearest hospital emergency department.
    - For patients admitted to the hospital for a scheduled or elective procedure, inpatient hospital price information may be less important because most, if not all, hospital admissions result in a cost that exceeds the typical HSA deductible of $2,500, and therefore, are covered by most HSA plans.
    - People with HSA coverage may be most interested in comparing prices and shopping for care to be delivered that leads up to meeting their deductible (typically $2,500). People with this type of coverage may be most interested in prices for physician office visits and other ambulatory care for which they are likely to be responsible for paying the full cost.

- **Uninsured Individuals of Limited Means.** People without insurance who have limited means for paying for the health care services they have received need to know how much of their hospital or physician bill they may be responsible for. In the case of hospital care, the information they need must be provided directly by the hospital, after the hospital can ascertain whether a patient may qualify for state insurance programs of which they were unaware, free care provided by the hospital, or other financial assistance.

4) A hospital-led effort to create consumer-friendly pricing "language" – common terms, definitions and explanations to help consumers better understand the information provided.

More can be done to explain pricing information to consumers clearly and consistently. Hospitals will lead an effort to create common terms, definitions and explanations of complex pricing information. This will include sharing innovative and understandable ways for displaying pricing information for use by consumers.

The four points of this roadmap include an appropriate role for HHS, which should provide incentives to the states to improve transparency at the state and local level. HHS, through the Agency for Healthcare Research and Quality (AHRQ), is in the best position to complete research on what consumers want and would use in purchasing health care services.

HOSPITAL VALUE-BASED PURCHASING

The DRA required CMS to develop a plan to implement hospital value-based purchasing (pay for performance) beginning in FY 2009. The plan must consider the following issues:

- Measure development – the ongoing development, selection and modification process for measures of quality and efficiency in hospital inpatient settings;
- Data infrastructure and refinement – reporting, collecting and validating of quality data;
- Public reporting – disclosure of information on hospital performance; and
- Incentives – the structure of payment adjustments, including the determination of thresholds for quality improvements that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the payments.

Hospitals remain committed to providing safe, effective, patient-centered, timely, efficient and equitable care to all patients, and the OHA is committed to working with CMS on the development of a value-based purchasing system for Medicare. It is critically important that the system be well thought out.

The HQA is not only accomplishing its goal of making standardized, easy-to-understand information available to the public, but also is reducing the measurement "babble" that had been

generated by a large variety of separate organizations asking hospitals to produce quality information. These disparate data requests impede rather than support quality improvement. Conversely, the HQA has brought focus to hospitals' improvement efforts.

Significant resources already have been invested in the HQA effort and the *Hospital Compare* Web site by all of the participants. Nearly 4,200 hospitals – representing more than 99 percent of all eligible Medicare PPS hospitals and over 600 CAHs – have committed to this process, leading the way by sharing data with their communities and the public. **This is a solid foundation on which we must continue to build, and it should be the foundation for any pay-for-performance program included in legislation. To base the pay-for-performance initiative on the work of a group other than the HQA would be duplicative, wasting significant knowledge and expertise.**

Smaller hospitals will face challenges, regardless of the measures chosen for use in a pay-for-performance system. The limited number of patients in small hospitals means that their performance rates can be volatile. In designing a system that rewards excellence, this type of volatility can lead to inappropriate conclusions about the quality of care at these hospitals and affect whether they qualify for a reward under an incentive program. At the same time, omitting small hospitals from a program may suggest to some patients that they do not provide care that is comparable in quality to that of larger organizations. The implications of this volatility in their data must be carefully considered so that hospitals with small sample sizes can participate and receive appropriate recognition for the excellence they achieve.

Payment rewards should be based on evidence-based measures of adherence to quality improving "processes." By using evidence-based *process* measures (e.g., aspirin provided at arrival to patients with acute myocardial infarction; antibiotics provided one hour prior to surgery), *every* provider has the opportunity to succeed, thereby improving the overall quality of the system. Incentive approaches should incorporate rewards for both attainment of a certain threshold of performance and improvement in performance.

We are concerned about premature efforts to tie payments to issues that could change incentives, such as efficiency. We believe that, for now, pay-for-performance initiatives should focus solely on quality improvement. There is no common definition of efficiency of care for hospitals. Efficient over what period of time: the course of a hospitalization or a stated period? Also, efficient for whom: the hospital … the patient … the government … other payers? Each answer would lead to the development of different measures of efficiency and very different conclusions about whether care was efficient.

In addition, measuring and rewarding performance based on a particular definition of efficiency may have considerable consequences for patients. For example, just a few years ago, HMOs developed criteria for efficient care that their physicians and other providers were told to follow. But the resulting headlines referencing denials of tests and treatments, and the accompanying public outcry, led to a fall out in traditional, staff-model HMOs.

Much more work needs to be done to define what should be encouraged in terms of efficient care before it is incorporated into payment policy.

Incentive approaches to payment should use a system of rewards to increase payments or reduce regulatory burden for successful providers. Because the Medicare inpatient PPS already pays less than the cost of care for more than one-third of hospitals, incentives involving penalties should not be used. Additionally, rewards should be sizeable enough to cover the costs of implementing process changes and allow for reinvestment in quality improvement efforts.

To be effective, incentive approaches must align hospital and physician incentives, encouraging all to work toward the same goal of improving quality and providing effective, appropriate care. This is imperative. Incentive approaches rewarding improvement can be successful only if physician and hospital performance can be successfully aligned, in terms of both performance and finances.

HEALTH INFORMATION TECHNOLOGY (IT)

The proposed rule states that it "supports the adoption of health IT as a normal cost of doing business to ensure patients receive high quality care." It also notes that the quality and efficiency benefits of health IT may provide a policy rationale for promoting the use of health IT through the Medicare program. Consequently, CMS asks for comments on:

- Its statutory authority to encourage adoption and use of IT;
- The appropriate role of IT in any value-based purchasing program; and
- The desirability of including use of certified health IT in hospital conditions of participation.

The OHA strongly believes that health IT is a very important tool for improving the safety and quality of health care, and our members are committed to adopting IT as part of their quality improvement strategies. They also view IT as a public good that requires a shared investment between the providers and purchasers of care.

Health IT is a very costly tool, requiring both upfront and ongoing spending. A 2005 AHA survey of hospitals and health systems found that the median amount hospitals invested on health IT in one year was more than $700,000, 15 percent of total capital expenses. Hospitals spent even greater amounts – a median of $1.7 million or 2 percent of all operating expenses – on operating costs. Survey respondents identified the upfront and ongoing costs of IT as the greatest barriers to further adoption. The survey also found that hospitals with negative margins and those with lower revenues use less IT. [4]

The proposed rule highlights the anticipated benefits of health IT as laid out by the RAND Corporation. However, it overlooks another of the study's major findings – that the financial

[4] "Forward Momentum: Hospital Use of Information Technology." Washington, DC: AHA (2005).

benefits of IT investments accrue more to the payers and purchasers of care than the hospitals and health systems that pay for them.[5]

Simply put, our members have not seen financial returns greater than the costs of implementing clinical IT systems, particularly in the short term. They adopt clinical IT because it is the right thing to do for improving patient safety and quality of care, not because it saves them money. Thus, while IT may be a "normal cost of doing business," it systematically raises those costs. **Given that they reap many of the financial benefits of IT, the OHA believes that the payers and purchasers of care should share in the costs of IT.**

Finally, we learned through the HIPAA process that efficient health information exchange requires all parties to upgrade their systems and work from a common set of standards. As we moved toward implementation of health IT in hospitals, payers – including the federal government – must modify their own systems to accept electronic data.

Statutory Authority. The broad question of whether CMS has statutory authority to encourage adoption and use of health IT will depend on the specific mechanisms it selects. For example, CMS has some authority to pursue demonstration projects. However, more systematic approaches, such as value-based purchasing or payment adjustments, would require legislative action.

Value-based Purchasing. As noted elsewhere in this comment letter, the OHA believes that any value-based purchasing program should not be punitive. **With regard to IT, only programs that add funds to the inpatient PPS should be pursued because IT is costly, requiring both upfront and ongoing expenditures.** Decreasing payments to those that have not been able to afford IT further limits their ability to invest. A budget-neutral approach also ignores the reality that health IT systematically increases hospitals' costs.

The OHA also believes that value-based purchasing programs should build off the consensus measures endorsed by the broad spectrum of organizations – including CMS – that participate in the HQA. In general, the HQA favors measures that address quality outcomes, rather than the tools used to get there.

Health IT can play a role in reducing the burden of quality reporting. Presently, electronic health records (EHRs) and other clinical IT systems do not automatically generate quality measures. Most hospitals still require special calculations – including expensive manual chart abstraction and use of third-party contractors – to submit quality data. CMS could advance the quality agenda by investing in the development of algorithms for the calculation of the quality measures it wants reported from EHRs and encouraging vendors to include them in their products.

Rather than including health IT in a value-based purchasing program, **CMS could support adoption of health IT through a payment adjustment funded with new money.** For

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[5] R. Hillestad, J. Bigelow, A. Bower, F. Girosi, R. Meili, R. Scoville, and R. Taylor. "Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, and Costs," *Health Affairs*, September 1, 2005; 24(5): 1103 - 1117.

example, it could increase payments to hospitals that use health IT that improves the safety and quality of care by 1 percent. This kind of payment adjustment represents Medicare's share of the necessary investment to achieve this goal and would recognize the greater costs of a "wired" health care system. The OHA will pursue legislation authorizing such a payment adjustment. Other mechanisms, such as loan guarantees and grant funds, are needed to help hospitals finance the upfront costs of implementing health IT.

Conditions of Participation. The OHA firmly believes that **CMS should not include health IT in the Medicare conditions of participation (COP) for hospitals.** The COPs address the basic, essential infrastructure needed to ensure patient safety and must be clearly understood. Successful implementation of quality-enhancing IT requires careful planning and changes to work processes. The hospital field is still developing its understanding of how to implement these systems correctly. In addition, the commercial health IT applications available do not always meet hospitals' needs. The evidence on health IT does not yet support this level of requirement and would amount to an unfunded mandate. A recent report supported by the AHRQ found that the existing research on the quality benefits of health IT is limited to a handful of leadership institutions that generally developed their own systems. And, while promising, the results are not yet generalizable to the average community hospital using the vendor systems currently on the market.[6]

While the OHA appreciates the efforts of the Certification Commission on Health Information Technology (CCHIT) to provide the market with better confidence in vendor product, we do not believe those efforts are sufficiently advanced to warrant inclusion in any adoption incentives CMS might pursue. CCHIT is only at the beginning stages of looking into certification of hospital inpatient products. CCHIT's work on ambulatory products is more advanced but, while it shows promise, has not yet proven itself in the marketplace.

HOSPITAL-ACQUIRED INFECTIONS

In the proposed rule, CMS has asked for ideas about how to effectively implement the DRA provision requiring the agency to identify instances in which the reliable application of science and appropriate processes of care should prevent infections, and to ensure that Medicare does not pay more for the hospital care of patients who becomes infected as a result of their care than it does for patients who are infection free.

It is difficult to identify the confluence of known science and effective care processes to prevent infections. **We believe that until a broad array of expertise is brought together to consider what conditions, procedures and circumstances should be targeted for this change, it is impossible to know how to most effectively implement the provision.** As the representative of America's hospitals and health systems, the OHA would be pleased to be part of those discussions.

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[6] "Costs and Benefits of Health Information Technology." Agency for Healthcare Research and Quality Publication No. 06-E006 (April 2006).

We believe that the right starting point for this work is to build off CMS' substantial investment in the Surgical Care Improvement Project (SCIP). Surgical wound infections are among the most common and hazardous hospital-acquired infections. There is a readily available community of expertise among the broad group of organizations involved in SCIP, including the American College of Surgeons, the American Society of Anesthesiologists, the Association of periOperative Registered Nurses and the Centers for Disease Control and Prevention, among others. The existing SCIP partners' expertise can help identify a few surgical procedures that might be most appropriate for the change Congress envisioned. We believe these are likely to be relatively "clean" surgeries, meaning surgeries on patients whose conditions or wounds have not already put them at higher risk for infection, and patients who do not already have a variety of complicating conditions that would place them in higher paying DRGs. Additional expertise on coding and the DRG GROUPER also is needed for these discussions to help address questions of what data are helpful and readily available to determine which infections were acquired in the hospital versus the community, and which codes actually lead to enhanced payments.

In addition, there is good evidence to suggest that even when reliable science and appropriate care processes are applied in the treatment of patients, not all infections can be prevented. Therefore, we suggest that by utilizing the SCIP program as the basis for responding to the congressional mandate, CMS could choose not to penalize a hospital if, despite their best efforts, an infection occurs. For example, if a hospital's performance on the SCIP surgical wound infection prevention measures show that it reliably performs the necessary infection prevention steps all or nearly all of the time, CMS might not make any change to the current payment system for that hospital.

Submitter : Dr. Paul Wertsch

Date: 06/12/2006

Organization : AMA

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

I 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.

Submitter : **Ms. Mary Cronin**

Date: 06/12/2006

Organization : **BESLER Consulting**

Category : **Health Care Industry**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1642-Attach-1.DOC

#1642
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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-P
Room C4-26-05
Central Building
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1488-P

Dear Dr. McClellan:

BESLER Consulting (BESLER) welcomes 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; Proposed Rule,* 71 Federal Register 23996 (April 25, 2006).

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

- **"DRG Reclassifications":** "Cost Center Charge Group" - Questions in this regard are as follows:
    1. Did CMS study the financial impact of combining multiple cost report cost centers into the ten "charge groups" denoted in the proposed rule? Were there any other combinations reviewed, and if so, were the outcomes similar? CMS should elaborate on the process it went through to derive the ten charge groups?

    2. The proposed methodology assumes that all hospitals map their data consistently within the specified cost centers. An example of the potential mismatch of data is in the Cardiology charge group. Currently, cost centers 53 and 54 are grouped there and many providers have cardiology type services, such as cardiac cath in cost centers other than 53 and 54; therefore, there is a mismatch of data. Another example is cardiac stents, are they being reported in the supply or cardiac cost center? It is unclear if hospitals are reporting these types of items consistently.

3. CMS should publish a crosswalk of revenue codes for the charge side that is used to map MedPar data to the charge groups and assure that the cost report data utilized has been reviewed by the Medicare fiscal intermediaries to assure consistent reporting taking into account issues as noted above with cardiac stents, etc. (CMS should use final settled cost report data not submitted). The intermediaries should assure that there is consistent revenue code mapping on the cost reports that coincide with the revenue mapping utilized in the MedPar logic. An alternative would be to establish a mechanism to allow hospitals to review the cost report data being utilized and submit changes, where applicable, to their Medicare fiscal intermediaries for review and implementation.

4. The consolidated severity-adjusted DRG methodology needs to accommodate distinctions based on complexity.

- **"HSRV Weights":** BESLER Consulting is not opposed to moving from a charge-based weight system to a cost-based weight system; however, we believe the current proposed methodology needs further examination in order to determine the best methodology to develop cost-based weights.

1. Did CMS consider the mismatch of MedPar data and cost report data for the following category? If so, the outcome should be reported and if not, this mismatch of data should be analyzed for potential impact on the relative weight calculations:
   - Claims with routine only charges (no ancillary charges) were deleted from the MedPar data; however, the cost for these claims should be in the cost report data and they may be grouped 100% to routine cost centers on the cost report as well.

2. CMS should not implement the HSRV methodology without the consolidated severity-adjusted DRG methodology. Furthermore, CMS should not implement the severity DRG methodology until the grouper for such DRG system is publicly available for hospitals to properly analyze the impact for comment purposes. Implementing the HSRV weight methodology before the severity DRG system seems to be backwards since a DRG classification takes place before a weight is assigned.

3. Given the redistributive impact on Medicare payments that both the HSRV weight and severity DRG will have on hospitals (along with the occupational mix being implemented at 100%), CMS should give consideration of phasing in the HSRV weighting methodology and severity DRG over a significant transition period. Such an approach would be consistent with other significant changes in Medicare payment methodologies, such as PPS capital.

4. An adjustment to the standardized rates for changes in coding should not be implemented unless there is a reconciliation mechanism in which the estimated amount can be compared to an actual amount and the difference be incorporated in another year's data.

- **"Out-Migration Adjustment":** This calculation is in its third year of existence. CMS had stated, in the IPPS final rule for FY 2005, that the data for this adjustment would be made available via the public use files. This data has not been released as of the date of these proposed regulations. A step by step calculation, similar to both the average hourly wage and occupational mix adjustments would allow hospitals to verify their amounts, and monitor their overall adjustment.

- **"Out-Migration Adjustment":** Hospitals that reclass to another area are not eligible to receive the out-migration adjustment. CMS should allow hospitals that reclass and receive a diluted reclassified wage index to receive the out-migration adjustment provided it does not exceed the actual wage index for the area to which they are reclassified.

- **"Hospital Redesignations and Reclassifications":** With regard to section 508 of the Medicare Modernization Act, CMS should continue the legislation **but** require all potential qualifying hospitals as well as those currently reclassed to file an application. This would allow CMS to treat this legislation similar to the traditional reclass requirements of both individual and county reclass applications. The 508 should also be continued to prevent large shifts in commuting patterns which will create losses for the hospitals. If CMS allows the legislation to expire, hospitals that had originally qualified but will now witness a reduction in their wage index value greater than 20 percent should be "grandfathered" in to the CBSA that the hospital reclassed into as a result of the 508.

- **"Wage Index"/"Operating Payment Rates":** CMS should propose now to extend the imputed rural floor to coincide with the existence of a rural floor. This would then put all 50 States on a "level playing field." The remaining States, not involved with the imputed rural floor calculation, have been receiving the rural floor benefit for many years and will continue to benefit in the future.

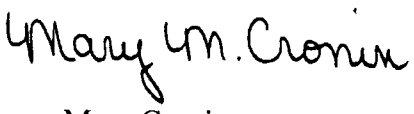
- **"Outliers":** CMS is currently paying less than 5.1% for outliers (as was the case for FY 2005, as well) and CMS does not currently make retroactive adjustments when total outlier payments that fall below estimated amounts. However, in the proposed FY 2007 rule, the outlier threshold is set to increase based upon "simulations using FY 2005 Medicare data" and the need to ensure that 5.1% of total IPPS payments are paid as outliers. The increase to FY 2007 outlier threshold is inconsistent with the prior two year outlier trend of actual payments falling below the 5.1% target; therefore, CMS should

ensure that the final FY 2007 rule includes a reduction to the outlier threshold to preserve hospital's rights to their fair share of outlier payments in the absence of a reconciliation process to the 5.1% target.

- **"GME Payments":** CMS should allow the time spent in didactic activities at non-hospital sites as long as a written agreement is in place with the non-hospital site and the hospital incurs "all or substantially all" of the cost since the hospitals are incurring the cost of residents.

Thank you for this opportunity to comment.

Respectfully submitted,
BESLER Consulting



Mary Cronin
Director

Submitter : **Mr. stuart skloot**

Date: 06/12/2006

Organization : **Lenox Hill Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

attachment

CMS-1488-P-1643-Attach-1.DOC

#1643

CMS-1488-P

Hospital Specific Relative Value Cost Weights (HSRV)

Submitter: Stuart L. Skloot, CPA
Administrative Director of Financial Planning

Organization: Lenox Hill Hospital
New York, New York

Issue: HSRV

Background:

The proposed rule attempts to more accurately calculate service intensity weights, (SIWs) so that Medicare reimbursement is better aligned with the cost of delivering services. The current methodology aggregates all charges, routine and ancillary for SIW purposes. The relationship between cost and charges varies between hospital departments. The markup for room and board charges (routine cost) may be significantly different than for ancillary departments such as operating room and laboratory. Since the cost related to different DRGs is comprised of significantly different proportions of these routine and ancillary costs the use of an aggregate RCC, (ratio of cost to charges) could result in SIWs that over or under reimburse specific DRGs. The proposed rule would utilize separate RCCs for ten major departments. The application of departmental specific RCCs is intended to reduce the bias that CMS believes currently exists in the system.

The proposed rule recalculates SIWs to remove the bias that results in the over reimbursement of DRGs that utilize a significant number of expensive medical supplies such as stents, defibrillators, pacemakers, and orthopedic and spinal implants. The analysis done by CMS and MedPAC leads to the conclusion that the markup for these supplies is higher than for other services. As a result the use of the current SIWs, based on aggregate charges over reimburses these DRGs and under reimburses medical DRGs. The SIWs under Hospital Specific Relative Value Cost Weights (HSRV) are intended to eliminate this bias. Under the system the SIWs for services such as interventional cardiology, other cardiac services, and orthopedic and spine surgery are reduced and SIWs for medical DRGs are increased.

General:

The shift in reimbursement between DRGs, based upon the new HSRV is significant. Payment for cardiac services will decrease dramatically and payment for medical services will increase if the proposed rule takes effect. The accuracy of the new methodology is dependent on the proper matching of cost and charges on both the Medicare cost report and patient bills. The charge for every service including room and board, medical supplies, etc. is posted to the patient bill under a specific revenue code. When the cost report is prepared total hospital cost and charges are used to calculate an RCC, by cost center. The cost related to Medicare patients is calculated by applying these RCCs to Medicare charges assigned by cost center. The generation of accurate cost is dependent upon the proper matching of Medicare charges to the RCCs and the complete billing of Medicare charges.

Issues:

The cost related to medical supplies may not be properly matched to the associated charges and Medicare charges. With the advent of new highly efficient inventory systems medical supplies are often purchased on consignment and delivered directly to the ordering department. This has the potential of creating a mismatch between the cost of supplies and charges. Supply costs are reclassed out of the respective departments into central services. Central services is then allocated to the user departments based on costed requisitions. Expensive items such as stents and defibrillators will make up a significant portion of the statistic and will drive the allocation of other costs (general floor stock).

The classification of the newer costly medical supplies may be inconsistently applied among providers. The national grouping of hospital data for these heterogeneously defined cost centers may result in distorted departmental RCCs that when applied to Medicare charges will result in inaccurate costing.

There is a proportion of Medicare charges, (such as late charges or charges that are associated with an incorrect patient identifier) that are not properly posted to patient bills. Since room and board charges are usually generated daily and automatically there are very few that are not properly posted. The same is not true for ancillaries such as medical supplies. As a result the cost (and SIW) related to DRGs that include a higher proportion of ancillary charges may be understated and for medical DRGs that uses a higher proportion of routine charges, overstated.

Conclusion:

Since the impact of the HSRV system results in a significant redistribution of provider payments it is imperative that the new weights are accurate. The discussion above identifies a number of issues that would cause the new weights to be inaccurate. These inaccuracies impact disproportionately on DRGs that utilize new technology/expensive medical supplies and may explain the precipitous decline in the SIWs for these DRGs.

In order to avoid an improper redistribution of Medicare payments and the disruption this would cause CMS should not implement the HSRV until more accurate data is available. Providers must be given clear instructions on how to report cost of the new medical supplies and implantables on the cost report and Intermediaries must verify the accuracy of this information before HSRV is implemented.

Submitter : **Mr. Bryan Jackson**

Date: 06/12/2006

Organization : **Arkansas Methodist Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1644-Attach-1.DOC

#1644

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 April 25, the Centers for Medicare & Medicaid Services (CMS) published its Proposed Rule covering the Medicare Inpatient Hospital Prospective Payment System (IPPS) for Fiscal Year 2007. The proposal includes two of the most consequential changes in the Medicare payment methodology since the implementation of the IPPS in 1983.

First, the rule would significantly alter the way in which CMS weights DRGs. Currently, the weights are charge-based. Under CMS' proposed rule, that would change in FY 2007 to a methodology which bases the weights on a newly developed hospital-specific relative value cost center (HSRVcc). We agree that basing DRGs on costs rather than charges may result in more appropriate payments; however CMS offers no compelling evidence that its approach to converting charges to costs using the national cost center cost-to-charge ratios (CCRs) rather than hospital specific data is anything more than the most expedient pathway.

CMS also proposes moving to an entirely new patient classification system beginning in FY 2008 *or earlier*. Currently, CMS uses 526 DRGs to classify all Medicare patients. Your agency considered use of3M's all-patient refined DRGs (APR-DRGs) as an alternative to its current set of DRGs, which would increase the number of categories to 1,258. But, instead it chose to refine the APR-DRG system by consolidating those DRGs into a new DRG universe with 861 consolidated severity-adjusted DRGs, or CS-DRGs.

In our opinion, there is a need for more careful analysis of this reclassification, along with greater access to the specifics of CMS' methodology and the new GROUPER. The current DRG GROUPER logic has been in the public domain since the inception of the IPPS. Without the new GROUPER logic, it is virtually impossible for us or anyone else to thoroughly analyze the system and comment. Without access to the new GROUPER, we have no understanding of how and why patients fall into certain CS-DRGs and cannot evaluate whether it represents policy improvement.

While we fully support a payment system that is fair in all respects to all hospitals, we have not had sufficient time or information to determine if we agree that this proposed change in methodology is indeed fair. To implement this proposed change with only a few months notice and before a thorough review is completed would be capricious and potentially devastating to hospitals like Arkansas Methodist Medical Center (AMMC). An independent consultant engaged by the American Hospital Association (AHA) has estimated the impact to AMMC as a reduction of approximately $2 million, or over 10% of our Medicare inpatient payments. To expect that we could make the operational changes necessary to absorb a 4% reduction in our net patient service revenue with less than six months' notice is unrealistic.

We agree that meaningful improvements need to be incorporated into the Medicare IPPS. However, we also believe that CMS should work in cooperation with various hospital groups in refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions.

Specifically, we support the following:

- **One-year Delay**: AMMC supports a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. Through the AHA, we are committed to working with CMS over the next year to address these concerns.
- **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**: AMMC does not support a new classification system at this time, 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 are committed to working with CMS through the AHA to develop and evaluate alternatives for new weights and classifications.

We appreciate the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact us at 870.239.7101 or by e-mail at ron.rooney@arkansasmethodist.org or bryan.jackson@arkansasmethodist.org.

Sincerely,

Ronald K. Rooney
President

Bryan G. Jackson
Vice President of Finance

Submitter : **Dr. W. Claiborne Dunagan** **Date: 06/12/2006**

Organization : **BJC HealthCare**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1488-P-1645-Attach-1.DOC

#1645

Hospital Quality Data

Measure Selection and Maintenance

We agree that measures selected should be those that are endorsed by NQF and aligned with JCAHO. We also propose that methods for maintaining measures be developed and implemented. Since medical knowledge continues to evolve, the science behind clinical practice guidelines must be monitored for changing evidence that previously accepted clinical practices no longer define the best care. Without this important step, measures cannot continue to evaluate best quality of care delivered to patients. We propose that CMS create a plan including method and frequency of monitoring new evidence that impacts established measures in addition to monitoring for adjustments needed to improve their implementation .

Validation Process

The validation process has to be structured to achieve the intended outcomes, which is to validate that the publicly reported performance numbers are accurate. Currently, the process is simply a data element by data element validation of data abstraction. There are important problems with both the collection and analysis of the validation data, which include but are not limited to the following issues:

1) The method that is used to construct the numerator and denominator on the summary report is unclear. We are unable to determine from the case detail report which data fields are counted in the numerator and denominator. Furthermore, the proposed 95% confidence interval has not been provided to the hospitals and, therefore, we cannot effectively try to reproduce the calculation and decision.

2) CMS is only giving hospitals 10 days to respond to the validation reports. This is not enough time to respond to CMS with an appeal, especially considering the problems that we have encountered with the reports themselves.

3) CMS will not accept documentation from the hospitals after the validation results have been published. Documentation could inadvertently be left out of the chart copies sent to CMS.

4) Some hospitals have failed validation in some quarters due to whole records or pieces of records not being received by CDAC even though the hospital maintains that the records were copied and sent in a timely manner.

Validation Analysis

1) The proposed study design is really a reliability study, not a 'validity' study in that it compares one abstraction vs. another. We have no information that shows how reliable the CMS abstraction is. If their inter-rater reliability is not very high (i.e. > .9), an additional component of variability that is attributable to CMS ratings should be factored into the computation of the confidence interval for the agreement statistic.

2) Percent agreement (concordance) has limitations as a measure of reliability. The percentage is not corrected for chance agreement. Cohen's kappa and other measures of intra-class correlation are better suited to correct for.this type of upward bias.

3) The rationale for performing a full-scale assessment of reliability based on all fields is unclear since the estimated agreement on the 10 measures of interest and its confidence interval are the ultimate criteria for validation.

4) For most hospitals, sample size is too small to make a reliable assessment of the agreement and provides no information about condition-specific indicator accuracy.

Value-Based Purchasing

The Premier Hospital Quality Incentive Demonstration (HQID) project is a step toward evaluating pay for performance, but its design cannot answer the question of whether the quality of inpatient care for Medicare beneficiaries improves with financial incentives. This is because the project design did not include a comparison group. All 262 participant hospitals experienced the test exposure of eligibility for payment incentive. Studies designed to evaluate causal relationships between an exposure (pay for performance) and an outcome (improved quality measures) should include a comparison group that does not receive the exposure. Without a controlled study design, the current HQID project is insufficient to demonstrate whether pay for performance provides an incremental improvement in the performance measures of hospital care over the observed national improvement that began earlier and may have resulted from any or all of the factors in the current complex climate including stricter JCAHO accreditation standards, public reporting, or anticipation of future pay for performance initiatives. In fact, Williams et. al. presented compelling data in a 2005 publication in NEJM that suggested hospital performance on the same standardized indicators of quality of care improved nationally and with similar magnitude of improvement, outside the pay for performance project. (1) Before CMS begins an incentive program, other studies designed to account for these factors are needed to answer the important question of whether pay for performance is an effective and efficient way to improve quality in delivery of health care, and if so, to identify the most cost-effective methods for implementation.

Composite Measurement

The development of composite scores is an area of current active research. It would be prudent for CMS to utilize the resources and findings of other organizations, such as the Agency for Healthcare Research and Quality who have currently engaged a panel of experts to examine this question. As in other measure development, we recommend that measures considered be of open-source design so that they can be both evaluated and improved through research and implemented in a standard manner.

If you have any questions or need further clarification on any of these comments, do not hesitate to contact us.

References

1.Williams SC, Schmaltz SP, Morton DJ, Koss RG, Loeb JM. Quality of Care in U.S. Hospitals as Reflected by Standardized Measures, 2002-2004. N Engl J Med 2005;353:255-64.

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

Organization : **Oakwood Healthcare, Inc**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1646-Attach-1.PDF

#1646

Finance

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48124

313.566.5303

Oakwood

June 9, 2006

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

Re: FY 2007 Medicare Inpatient Prospective Payment System Proposed Rule CMS-1488-P

Dear Dr. McClellan:

Oakwood Healthcare, Inc. (OHI) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule to update the Inpatient Prospective Payment System for FY 2007.

HSRV Weights

OHI is concerned with CMS' proposal to implement its new hospital-specific relative value ("HSRV") payment methodology immediately and fully. As CMS has publicly acknowledged, this proposed change in methodology is the largest change undertaken by the Medicare program since the inception of the prospective payment system in 1983. CMS' estimate of the impact shows that huge amounts of money will be reallocated among DRGs and among hospitals.

There are a number of methodological issues that arise in attempting to develop DRG weights based on "cost." The difference between charge-based weights and cost-based weights is not nearly as clear as the two labels suggest since CMS has necessarily arrived at its "cost" based weights using charge information. This approach is inherently inaccurate since costs are determined through national cost to charge ratios. Those national cost to charge ratios are flawed because they are not weighted to reflect hospital volume, as discussed below. But even if a weighted average had been used, the methodology would still face the very difficult problem resulting from differential mark-ups in charges. Generally, hospitals have tended to mark-up low cost items much more than high-cost items. This will cause understatement of DRG weights for DRGs where high cost items are used such as ICDs or drug eluting stents. CMS has published research that shows that "cost-based" weights derived from an RCC methodology are likely to be less accurate than the current charge-based system:

> If, however, by basing the DRG relative weights on the estimated costs ...," MedPAC intends to employ cost-to-charge ratios to estimate costs, the resultant cost weights will likely be less, not more, accurate than current DRG charge-based weights.

C. Botz et al., "Cost Weight Compression: Impact of Cost Data Precision and Completeness," Health Care Financing Review, Spring, 2006 at 111, 121.

In any event, even if CMS decides to fully implement the HSRV system in this fiscal year, its proposed system is in need of correction. One item requiring reform is the cost-to-charge ratio CMS applies to hospital charges. CMS has developed a separate, national cost-to-charge ratio for each of ten aggregated hospital "cost centers," to which CMS has mapped all of the charges appearing in its MedPAR data. 71 Fed. Reg. at 24008-10. CMS has not used a weighted average to calculate the national cost to charge ratios. *Id.* at 24010. Thus, CMS has created a distortion that exaggerates the importance of smaller hospitals and fails to properly reflect data from larger institutions. This process thus represents a significant departure from the current system, in which *all* MedPAR claims are of equal importance in determining revised weights for a given fiscal year. By virtue of this choice, CMS has caused its weightings to be less accurate, not more, at representing actual hospital costs. Any final HSRV payment system CMS may ultimately choose to implement should derive the cost-to-charge ratio for each cost center using weighted hospital charges. **OHI requests that CMS delay implementation of the new payment system for at least one year.**

Outlier Payment 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 percent 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 five and six percent. Outlier payments are budget-neutral. Each year the Agency reduces the inpatient standardized amount by 5.1 percent and estimates a cost threshold that should result in outlier payments that equal 5.1 percent.

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 percent 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 percent of actual total DRG payments. Further, CMS estimates that outlier payments represented only 4.1 percent of total DRG payments in FFY 2005 and, according to the August 12, 2005 final rule, only 3.52 percent of total DRG payments in FFY 2004 (70 Fed. Reg. 47496). Because outlier payments were less than the 5.1 percent 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.

OHI believes that 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 AAMC, along with the American Hospital Association (AHA), 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. Using this methodology, the threshold should be $24,000 for FFY 2007. 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 Spent In Nonpatient Care Activities as Part of Approved Residency Programs

In the proposed FY 2007 Inpatient PPS Rule CMS purports to "clarify" its policy to exclude the time residents spend in "non-patient care activities" for purposes of calculating Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.

According to CMS these "nonpatient care activities" include didactic activities, such as journal clubs, classroom lectures, and seminars. In determining whether the time can be counted, CMS distinguishes between whether the activity is occurring in a non-hospital or hospital site and applies different rules: CMS states that resident time spent in didactic activities CANNOT be included in either a hospital's DGME or IME resident count if it occurs in a non-hospital site (such as a physician's office, medical school, etc.). CMS asserts that this time is not allowable because the Medicare statute states that in order for the hospital to count resident time in non-hospital settings, it must be "spent in activities related to patient care" (DGME statute) or "in patient care" (IME statute).

For DGME purposes, resident time in "all areas of the hospital complex" may be counted so long as the resident is in an approved program, regardless of whether or not the resident is engaged in patient care activities. CMS states that the hospital complex consists of the hospital and hospital-based providers and subproviders. This position is in contrast to IME payments, in which only time spent in patient care activities may be counted.

CMS states that while they have not explicitly defined "patient care activities" they have applied the "plain meaning of that term" which according to CMS refers to the "care and treatment of particular patients, or to services for which a physician or other practitioner may bill" and "would certainly not encompass didactic activities." This position is in stark contrast with a letter that CMS wrote in 1999 stating that CMS interprets "patient care activities" broadly including scholarly activities. (September 24, 1999 Letter from Tzvi Hefter to Scott McBride). Unlike the nonhospital site statute, there is no legislative requirement that the resident be engaged in "patient care activities" for purposes of counting residents within the hospital setting for DGME payments. Thus, all resident time in the hospital complex may be counted for DGME payments, so long as the resident is in an approved program. There also is no specific reference to patient care activities in the IME legislation. CMS's position excluding resident didactic time in hospital settings for IME payments rests solely on a presumption that because IME payments reflect an adjustment to the DRG payment, these payments inherently are related to patient care and therefore the residents must be engaged in patient care to be counted.

The result of CMS' statements is that no didactic time may be counted for IME payment calculations, regardless of whether it occurs in a hospital or non-hospital site. **OHI disagrees strongly with CMS' position in this year's proposed rule. Didactic activities engaged in which residents participate are an integral part of the patient care experience and therefore such resident time should be counted for both IME and DGME payment purposes regardless of the setting.** In addition, the rule raises a myriad questions concerning how such time would be adequately documented in addition to increasing the administrative burden on hospitals associated with the documentation.

We strongly urge CMS to change its position in the final rule and confirm its interpretation as set forth in its 1999 letter.

Hospital-Acquired Infections

In the inpatient PPS, infections acquired in the hospital and other complications, can sometimes trigger higher payments, either as payment outliers or by assignment to a higher-paying DRG. Approximately 121 sets of DRGs are split based on the presence or absence of a complication or comorbidity (CC), and DRGs with a complication or comorbidity generate higher Medicare payments.

By Oct. 1, 2007, the DRA requires the CMS to identify at least two preventable conditions that categorize a patient to a CC DRG. The CMS wants hospitals to identify conditions that either occur frequently or their presence results in significantly higher costs to treat the patient. The CMS is proposing, effective October 1, 2008, hospitals would not receive additional payment for cases in which one of the selected conditions was not present on admission. Instead, the case would be paid as though the hospital-acquired complication was not present.

The DRA also requires hospitals to submit the secondary diagnoses that are present at admission when reporting payment information for discharges on or after October 1, 2007.

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

The Michigan Hospital Asspciation (MHA) and its member hospitals embarked on a joint project with Johns Hopkins, funded by a $1 million grant from the U.S. Agency for Healthcare Research and Quality (AHRQ) to reduce ICU infections through the MHA Keystone Center. Over two years, 77 hospitals and 127 hospital ICUs voluntarily participated in this project to reduce infections in the ICU. After 18 months, the predictive model suggests that teams saved 1,574 lives, over 84,000 ICU days and over $175 million dollars. Infections from central IV catheters plummeted. The median CR-BSI rate in participating ICUs has now been at zero for almost a year. Ventilator associated pneumonia rates in the ICUs have been cut by 40%. Forty six ICUs have gone for over six months with no ventilator associated pneumonias. Fifty seven ICUs have gone for over six months with no blood stream infections from IV catheters.

OHI believes proactive projects such as these will result in better patient safety and quality. However, hospitals need the training and funding in order to implement these changes.

OHI believes the CMS proposal that complications are solely the result of hospital actions is fundamentally flawed. To reduce hospital payments for a condition present upon admission, but not documented, is too punitive. Rather, it is recommended that the CMS expand demonstration projects such as the MHA Keystone Center to truly improve patient safety and quality for Medicare and all patients.

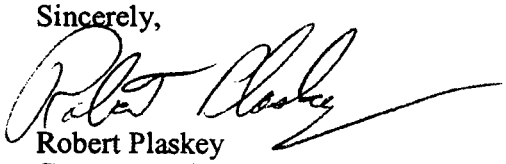
Transparency of Health Care Information

OHI agrees with CMS that there is a national healthcare crisis and lauds CMS' efforts to address the issue. OHI would prefer that CMS direct its efforts towards working with Congress to expand Medicaid and other safety net programs to ensure meaningful health care coverage for the uninsured. While achieving transparency in price information is a worthwhile objective, OHI believes that only limited success can be attained in such an initiative. As CMS is aware, most hospital charges are listed on charge description masters that contain tens of thousands of items. Further, each hospital has its own unique system for establishing charges. For example, whereas one hospital might set its charges for emergency room visits based on patient acuity, another hospital in the same city could set its charges based on the items and services utilized by the patient during the visit. Given the complexity and differentiation between hospital charge structures, price comparisons among hospitals on the basis of charges would be virtually impossible. Disclosure, therefore, of hospital-specific charges will not accomplish CMS' transparency goals.

As an alternative, CMS could report what the national average charges are for certain common procedures. Such an approach would be administratively simple to implement. CMS has all of the data regarding hospital charges for any given procedure in its MedPAR file. Therefore, there would be no additional obligations (or costs) imposed upon hospitals in making this data available to the public. Further, using national data as a benchmark, patients can identify whether charge information they receive from their local hospitals indicates that they live in a region with unusually high charges. Patients aware of such a disparity could encourage their local institutions to reduce their charges to better align with national averages. Thus, disclosure of national charge data could facilitate CMS' goal of reducing charges in regions with exceptionally high charges.

Again, OHI appreciates this opportunity to provide comments to the CMS regarding this proposed inpatient rule and urges you to please take them into consideration. We believe our suggested modifications will result in positive changes for hospitals and the Medicare beneficiaries they serve. If you have questions on this comment letter, please contact me at (313) 586-5642.

Sincerely,



Robert Plaskey
Corporate Director, Reimbursement

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June 11, 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 St. Joseph Health System ("SJHS"), we 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.

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc). It also proposes refining the DRGs to account for patient severity, with implementation likely in FY 2008. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education, among other policies.

While SJHS supports many of the proposed rule's provisions, we have serious concerns about the proposed changes to the DRG weights and classifications. SJHS supports meaningful improvements to Medicare's inpatient PPS. We believe SJHS and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. 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 on SJHS could result in losses of over 5 million dollars. In an attempt to reach common ground, we would support the following:

• **One-year Delay: SJHS** supports a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. SJHS is committed to working with CMS over the next year to address these concerns.

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

• **A New Classification System Only if the Need Can Be Demonstrated:** SJHS does not support a new classification system at this time, 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**: SJHS commits to working with CMS to develop and evaluate alternatives for new weights and classifications.

If you have any questions about our remarks, please feel free to contact Ron DiLuigi, Vice President of Advocacy and Governmental Relations at the address on this letter head.

Sincerely,

Deborah A. Proctor

Deborah A. Proctor
President and Chief Executive Officer

Submitter : **Ms. Jan Niles** **Date: 06/12/2006**

Organization : **Alegent Health**

Category : **Other Health Care Professional**

Issue Areas/Comments

Hospital Quality Data

Hospital Quality Data

See attachment.

#1647

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. Gary Stein** **Date: 06/12/2006**

Organization : **American Society of Health-System Pharmacists**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1488-P-1648-Attach-1.DOC

#1648

June 12, 2006

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1488–P
P.O. Box 8011
Baltimore, MD 21244–1850

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

To Whom It May Concern:

The American Society of Health-System Pharmacists (ASHP) is pleased to respond to the Centers for Medicare & Medicaid Services' (CMS's) April 25, 2006, proposed rule that would revise the Medicare hospital inpatient prospective payment systems (IPPS) and FY 2007 rates. ASHP is the 30,000-member national professional and scientific association that represents pharmacists who practice in hospitals, health maintenance organizations, long-term-care facilities, and other components of health systems.

ASHP believes that CMS' proposed change in the calculation of DRG relative weights using costs instead of charges has the potential be more reflective of actual hospital expenses and will simplify hospital cost reports. However, we are concerned about how hospital – and especially pharmacy – overhead costs will be included. Pharmacists' experience with how pharmacy overhead costs were dismissed in the recent hospital outpatient prospective payment system final rule makes us deeply concerned with how these costs will be treated under the new IPPS.

We are also concerned about how CMS will take into account new drugs and biologicals when the agency moves toward refining DRGs to more fully capture patient severity of illness. We believe that these new therapies should be accurately calculated into the DRGs.

Because the CMS proposal would create significant changes to the IPPS, and because we are unsure how well the agency has considered the accuracy of the data that will be submitted to it, ASHP supports the American Hospital Association's (AHA) call for a one-year delay in the agency's implementation of these changes until a working group of stakeholders can be convened to determine whether the proposed changes truly help create a better payment system.

ASHP appreciates the opportunity to present comments on this important patient care issue. Feel free to contact me if you have any questions regarding our comments. I can be reached by telephone at 301-664-8702, or by e-mail at gstein@ashp.org

Sincerely,

Gary C. Stein, Ph.D.
Director, Federal Regulatory Affairs

Submitter : **Tammy Matthews** **Date: 06/12/2006**

Organization : **Owensboro Medical Health System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1649-Attach-1.DOC

#1049

June 12, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
The Centers for Medicare & Medicaid Services
Department of Health and 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 Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule.

Dear Administrator McClellan:

Owensboro Medical Health System (OMHS) of Owensboro, Kentucky appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule which establishes new policies and payment rates for hospital inpatient services for fiscal year (FY) 2007

DRGs: Severity of Illness

CMS is proposing to move towards severity-adjusted DRGs modeled after the APR-DRGs developed by 3M. This would expand the current 526 DRGs to 861 consolidated severity-adjusted DRGs. A major concern with this transition is that the new APR-DRG weight calculations are based on data that is 3 – 5 years old, and thus will not reflect recent changes and advancements in medical devices and treatments. For example, drug-coated stents have only been in widespread use since 2004 and would not be included in the data utilized for the new calculations.

OMHS has the following concerns regarding the shift to severity-adjusted DRGs:

- The APR-DRGs are based on a proprietary system that limits the full disclosure and transparency of its case mix grouping and severity adjustment rules. Although the proprietary logic of the system created by 3M will most likely be disclosed to the government, healthcare entities are concerned that this model will not be supplied to hospitals, payers, and software vendors that require this information to create their coding and billing software solutions. This is in stark contrast to the open DRG architecture that has been supported by CMS for more than 20 years – a model that is open to public discussion and scrutiny. It is essential that any classification system adopted by CMS meet the minimal standards of public review, discussion, adaptation and transparency.

- The DRG changes could cause severe reductions in coding productivity, and could significantly decrease overall revenue cycle efficiency. The current framework DRG framework coders are using has been in place for over two decades; therefore, the proposed changes would necessitate the retraining of every inpatient coder nationwide. In addition, the increased complexity of the new system will likely make it much more time-consuming to code each case, creating an increase in staffing for most hospitals.

- If the DRG proposal is enacted with the current aggressive timeframe outlined by CMS, there will be very little time for healthcare providers to prepare for the changes,

including modifying their databases and IT systems and training coding and billing staff. Additionally, the change will be happening very shortly before another large shift in healthcare coding and billing with the migration to ICD-10, with is expected to occur within the next 2 – 4 years.

- CMS has not conducted an objective study to severity-adjust the DRG system. Although alternatives to the APR-DRG are available within the market place, it is unclear whether CMS considered any of these alternatives for its Inpatient Prospective Payment System (IPPS). Also, CMS has not conducted any independent studies on the impact of implementing this methodology for either coding and billing productivity or cash flow on hospitals.

- CMS has not allowed considerable time for healthcare providers to perform analyses on potential financial and staffing impacts for the changes to the APR-DRGs. Breakdown of the logic used to create the APR-DRGs for CMS has not been provided to healthcare providers, payers, or software vendors; thus not allowing for a productive analysis of the impact.

OMHS supports a period of **at least one year** to address the proposed changes to the severity-adjusted APR-DRGs as sufficient time and resources are currently not available to perform effective impact analysis. Also, the impending ICD-10 release will require additional staff involvement; therefore it is not recommended that the severity-adjusted DRGs be implemented until the impact of the ICD-10 is known.

HSRV Weights

CMS is recommending changes to the DRG weight calculations based on costs reflected in the hospital cost reports. We would recommend using the most recent data available to calculate the cost based hospital-specific DRG weights. CMS does not clarify how it expects to accommodate both the weight changes to the cost based weights and the change to the severity-adjusted APR-DRGs in the future.

OMHS supports only implementation of the hospital specific DRG weights at this time. OMHS also recommends that the implementation of the hospital specific DRG weights should not coincide with the implementation of the severity-adjusted DRGs. As indicated previously in this letter, considerable time will be needed to notify all healthcare entities, payers, and software vendors and to ensure all the necessary adjustments are made as well as performing all analyses to determine total financial impact of the changes.

Please feel free to contact me at (270) 688-2852 or TMATTHEWS@OMHS.ORG if you have any questions or if you need additional information.

Sincerely,

Tammy Matthews
Financial Analyst

Submitter : **Mr. Ron Diluigi** **Date: 06/12/2006**

Organization : **St. Joseph Health System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1488-P-1650-Attach-1.PDF

#1650

ST. JOSEPH
HEALTH SYSTEM

P.O. Box 14132
Orange, CA 92863-1532
714.347.7500 Tel
714.347.7501 Fax

June 11, 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 St. Joseph Health System ("SJHS"), we 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.

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc). It also proposes refining the DRGs to account for patient severity, with implementation likely in FY 2008. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education, among other policies.

While SJHS supports many of the proposed rule's provisions, we have serious concerns about the proposed changes to the DRG weights and classifications. SJHS supports meaningful improvements to Medicare's inpatient PPS. We believe SJHS and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. 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 on SJHS could result in losses of over 5 million dollars. In an attempt to reach common ground, we would support the following:

• **One-year Delay: SJHS** supports a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. SJHS is committed to working with CMS over the next year to address these concerns.

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

• **A New Classification System Only if the Need Can Be Demonstrated:** SJHS does not support a new classification system at this time, 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**: SJHS commits to working with CMS to develop and evaluate alternatives for new weights and classifications.

If you have any questions about our remarks, please feel free to contact Ron DiLuigi, Vice President of Advocacy and Governmental Relations at the address on this letter head.

Sincerely,

Deborah A. Proctor

Deborah A. Proctor
President and Chief Executive Officer

Submitter :

Date: 06/12/2006

Organization :

Category : **Device Industry**

Issue Areas/Comments

GENERAL

GENERAL

We appreciate CMS addressing the need for an ICD-9-CM procedure code for endoscopic insertion or replacement of bronchial valve(s) and for listing the new procedure code in the addendum for FY 2007. We submit this "See Attachment Comment" to assist CMS with data for making the initial DRG assignment for ICD-9-CM procedure code 33.71, Endoscopic insertion or replacement of bronchial valve(s).

CMS-1488-P-1651-Attach-1.DOC

#1651

emphasys medical, inc.

June 12, 2006

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

Attn: CMS-1488-P

Dear Dr. McClellan:

We are writing on behalf of Emphasys Medical, Inc., and Spiration, Inc., two companies focused on developing minimally invasive surgical therapies to benefit patients with Chronic Obstructive Pulmonary Disease (COPD). Specifically, our companies have each developed different versions of bronchial valves that are each intended for use in treating important patient populations starting with those suffering from prolonged air leaks in their lungs.

We appreciate the Centers for Medicare and Medicaid Services (CMS) addressing the need for an ICD-9-CM procedure code for endoscopic insertion or replacement of bronchial valve(s) and for listing this new ICD-9-CM procedure code, 33.71 Endoscopic insertion or replacement of bronchial valve(s), in the FY 2007 Medicare Addendum, ICD-9-CM, Volume -3, Procedures. We look forward to seeing this code and its DRG assignment listed in the FY 2007 Final Hospital Inpatient Prospective Payment System Rule.

To assist CMS in assigning ICD-9-CM procedure code, 33.71, to a clinically appropriate and resource use appropriate DRG, Emphasys Medical, Inc., and Spiration, Inc., jointly commissioned an independent consultant to conduct an initial analysis using 2005 MedPAR data for procedures that are clinically cohesive with the insertion and replacement of bronchial valves, with the intent that this information may prove helpful to CMS in making an initial DRG assignment for this new ICD-9-CM procedure code.

The 2005 MedPAR analysis began by looking at diagnoses and interventional procedure combinations that were similar clinically and had a resource intensity that would enable the combination to be a proxy with regard to standardized charges and length of stay for an endobronchial insertion or replacement of bronchial valves. The combination of a diagnosis of air leaks and treatment with scarification met the criteria for being a proxy. The results from the analysis indicate that although the resource utilization for scarification (and by inference, valve implantation) appears to be higher than the average for DRG 075 as a whole, it would still be reasonable to temporarily assign the new ICD-9-CM procedure code, 33.71 Endoscopic

insertion or replacement of bronchial valve(s), to DRG 075 until actual cost data can be gathered using the new ICD-9 procedure code.

2005 MedPAR Analysis:

Method -

The 2005 MedPAR analysis began by looking for diagnoses and interventional procedure combinations that were clinically similar and seemed to share a similar resource utilization pattern to that expected for endobronchial insertion or replacement of bronchial valves for the treatment of air leaks.

This exercise identified two diagnosis codes that seemed most applicable:

- ICD-9-CM Dx code 512.0 - Spontaneous tension pneumothorax
- ICD-9-CM Dx code 512.8 - Other spontaneous pneumothorax

In reviewing the associated procedure codes for patients with this diagnosis code, our clinical advisors pointed to one treatment that seemed most applicable as a resource utilization/intensity proxy:

- ICD-9-CM code 34.6: scarification of the pleura

The reason scarification of the pleura was selected as a proxy for patients treated with insertion of bronchial valves is because both procedures are expected to share a similar clinical pathway and hospital resource utilization intensity as briefly summarized below:

Patient acuity:
- Identical underlying disease/condition/diagnosis
- Severity and duration sufficient to warrant intervention

Timing of treatment:
- Only after other less invasive modalities (e.g. chest tube) have failed

Nature of intervention:
- Similar procedure time-
  - Scarification via limited thoracotomy
  - Bronchial valve insertion via bronchoscopy

Expected length of stay:
- >8 days since intervention attempted only after other approaches fail

Patient monitoring:
- Frequent x-ray and other patient management to assess impact of therapy and to watch for complications

Based on these similarities, we expect treatment utilizing bronchial valve implantation in these patients to generate a similar mean standardized charge as treatment with scarification. We anticipate the mean charges for Medical Surgical Supplies may be slightly higher for patients undergoing the implantation of bronchial valves.

Results -

Analyzing the 2005 MedPAR database, this combination of diagnosis codes and procedure code yielded a sample size of 490 patients. All were assigned to DRG 75 - Major Chest Procedures. A comparison of key statistics specific to scarification vs. DRG 75 as a whole is given below:

	Scarification (ICD-9 34.6)	Avg. for DRG 075
Mean ALOS:	13.9 days	9.6 days
Mean Standardized Charges:	$56,711	$49,698
Mean Total Payments:	$19,807	$19,644

Recommendation -

Although the resource utilization for scarification (and by inference, valve implantation) appears to be higher than the average for DRG 75 as a whole, we feel it would still be reasonable to initially assign the new ICD-9-CM procedure code, 33.71 Endoscopic insertion or replacement of bronchial valve(s), to DRG 075 until actual cost data can be gathered using the new ICD-9 procedure codes.

Emphasys Medical Inc. and Spiration, Inc. appreciate the opportunity to provide comments on this proposed rule and issues that will be addressed in the final rule. If we can provide CMS with additional information regarding this matter, please do not hesitate to contact us at 650-216-0126 or 425-497-1700 x160, respectively.

Sincerely,

Garrett Schwab
Garrett Schwab

Director, Clinical Marketing
Emphasys Medical, Inc.

Gregory Sessler
Gregory Sessler

Executive Vice President
Spiration, Inc.

Submitter : **Mr. Leo Brideau** **Date: 06/12/2006**

Organization : **Columbia St. Mary's Inc.**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1652-Attach-1.DOC

#1652

June 12, 2006

Mark B. McClellan, MD, PhD
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, DC 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:

I am submitting the following comments on behalf of Columbia St. Mary's three acute care hospitals, concerning the Fiscal Year 2007 Hospital Inpatient Prospective Payment System and occupational mix adjustment proposed rules.

The proposed rules would make the most significant changes to the Medicare hospital inpatient payment since its implementation in1983.

The major factors in the proposed rule include: changes in the methodologies used to calculate the relative weights of the DRGs; changes in the method for identifying the variation in patients' severity of illness; and the court-mandated expansion of the occupational mix adjustment to apply to 100 percent of the wage index.

These changes, if implemented simultaneously and because of their re-distributional impact, will destabilize the financial status of our organization and many hospitals in America. The estimated impact on Columbia St. Mary's hospitals is **$$$$$$$$$$$$$$$$$$$$$$$$**.

We support the technical recommendations and comments on the proposed rule that were submitted by the American Hospital Association and the Catholic Health Association.

Particularly the recommendations that

1. 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. 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. CMS provides at least a three year transition period of the proposed policies during which hospitals are protected from major payment disruptions.

I appreciate the opportunity to comment on the proposed FY 2007 IPPS rule. 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,

Leo P. Brideau

President & CEO

Columbia St. Marys, Inc.

Submitter : **Mrs. Keri Disney** **Date: 06/12/2006**

Organization : **Parkland Health & Hospital System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1653-Attach-1.DOC

CMS-1488-P-1653-Attach-2.TXT

#1653

June 9, 2006

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

Re: FY07 Proposed IPPS Rules
File code CMS-1488-P
Submitted electronically June 12, 2006 to
http://www.cms.hhs.gov/eRulemaking

Dear CMS Staff:

I am writing to comment on the 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 represent Parkland Memorial Hospital, the safety net public teaching hospital in Dallas, Texas. Parkland is a level one trauma facility with nationally recognized kidney/pancreas transplant and burn centers. Over half of the patients Parkland serves are Medicare or Medicaid recipients, with most of the remaining population uninsured.

DRG Weights Based on Cost - I am encouraged that CMS recognizes the current payment system leaves room for some facilities, including specialty centers, to skim the most profitable patient population, while leaving the sickest patients for organizations such as large public teaching hospitals. Often the organizations who receive the most acutely ill are facilities that struggle to provide high quality patient care while supporting industry needs such as teaching programs or services for the uninsured. The interim solution proposed of basing DRG payments on costs rather than charges is a significant step towards eliminating unintended payment biases.

Alternate DRG System - Parkland strongly encourages CMS to continue analyzing alternate DRG systems. Thoughtful analysis of multiple systems will provide the opportunity to identify and eventually implement a system that fairly pays all

providers, whether a specialty hospital, a rural facility or a public teaching hospital. While Parkland would likely benefit from a system with more DRG choices, such as the HSRVcc system, we encourage CMS to proceed carefully—a solid system that will serve the healthcare industry for many years is preferable to moving quickly and being faced with further changes within the next few years. The cost to CMS and the industry is too great to trade speed for quality.

The HSRVcc system appears to recognize patient acuity much better than the current system. However, there is no recognition of service acuity, which could result in inappropriate payments to facilities. Additionally, DRG assignment should be based on both admitting and discharge diagnoses, at least in part. Services such as tracheostomies will not be reimbursed appropriately unless both diagnoses are factored into the payment system.

The HSRVcc system appears to offer a better solution than the current DRG system of 500+ groupings. However, there are still many uncertainties that can be mitigated through more careful analysis. CMS admitted a number of potential problems in the recent Open Door Forum, including the uncertain impact to teaching and DSH facilities, which could result in underpayments. Because a significant number of hospitals appeared to have aberrant data, CMS trimmed the data used to develop these DRG weights. The weighting methodology used in the calculation process treats each hospital's cost-to-charge ratio equally, not accounting for differences in case volume. Most hospitals charge smaller markups on higher cost devices. Using an overall cost-to-charge ratio could mean a facility doesn't even cover the cost to acquire the device as reimbursement. While a few years of data collections will likely identify biases in any system, it is dangerous to implement a system with known weaknesses, especially to critical providers such as safety net hospitals.

Also disturbing is the proprietary nature of the APR-DRG system. It is obvious that CMS has given great thought to providing as many resources as possible during analysis of this system. This information is critical in understanding impact to hospitals and I greatly appreciate the current resources that have been provided by CMS. I am concerned that access to a proprietary system will be more limited than the current DRG system. This approach would cripple a facility's ability to analyze operations and make appropriate business decisions. I believe CMS must determine what data is available and how broad availability is before a reasonable decision may be made about this classification system.

Furthermore, any system that parses ICD-9 information into a larger number of groupings, will require all applicable ICD-9 diagnosis and procedure codes in order to assign the most appropriate DRG. Currently, CMS stores only 9 diagnosis and 6 procedure ICDs for any claim. Without all appropriate codes, facilities that receive complex cases, such as teaching and DSH facilities will be disadvantaged with the current limitation for ICD-9 codes. I have attached several case studies that reflect care at Parkland. I would appreciate your analysis of these cases under the APR-DRG system as well as any other system considered for implementation in the near future.

Based on the concerns in the preceding four paragraphs, I believe CMS is not ready to move up the time table for implementing an alternative DRG system. I am concerned that the volume of the data involved may even make implementation in FY08 challenging. However, it is clear there are too many unanswered questions to attempt implementation in FY07.

IME FTEs - CMS proposes to exclude the time residents spend in didactic activities, such as journal clubs, classroom lectures, and seminars. The CMS position is that only time spent in patient care may be included in IME. There is a statute that requires residents at non-hospital sites must be excluded from the IME FTE count unless they are participating in patient care activities. However, there is no similar legislative requirement related to residents within a hospital setting. CMS is not meeting legislative intent by arbitrarily applying the statute in a hospital setting.

Additionally, the current position held by CMS, that they have applied the plain meaning of patient care activities, defined by staff as 1) the care and treatment of patients, or 2) services that may be billed, appears in stark contrast with a CMS letter in 1999. This letter, dated September 24, 1999, from Tzvi Hefter to Scott McBride, interprets patient care activities broadly, including scholarly activities. CMS has not yet given a valid reason for such a marked change in direction on this issue.

Parkland supports 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.

In closing, I would like to compliment CMS on the approach to the IPPS rules proposed for FY07. It is obvious that staff have carefully considered legislative intent and assigned appropriate resources to analyze options. The public comments received will no doubt identify areas for further analysis. If CMS takes the same approach to the public comments, I am confident the final rules will preserve and strengthen the Medicare program.

Respectfully,

Keri E. Disney, Director
Government Reimbursement
Parkland Health & Hospital System
5201 Harry Hines Boulevard
Dallas, Texas 75235
(214) 590-4171

LOS PrinDx Principal Diagnosis PrinDx Seq1 PrinDx Seq2 PrinDx Seq3 PrinDx Seq4 PrinDx Seq5 PrinDx Seq6 PrinDx Seq7 PrinDxSeq8 PrinDx Seq9 PrinDx Seq10 PrinDx Seq11 PrinDx Seq12 PrinDx Seq13 PrinDx Seq14 PrinDx Seq15 PrinDx Seq16 PrinDx Seq17 PrinDx Seq18 PrinDx Seq19 PrinDx Seq20 PrinDx Seq21 PrinDx Seq22 PrinDx Seq23 PrinDx Seq24 PrinDx Seq25 PrinDx Seq26 PrinDx Seq27 PrinDx Seq28 PrinDx Seq29 PrinDx Seq30 PrinDx Seq31 PrinDx Seq32 PrinDx Seq33 PrinDx Seq34 PrinDx Seq35 PrinDx Seq36 PrinDx Seq37 PrinDx Seq38 PrinDx Seq39 PrinDx Seq40 PrinDx Seq41 PrinProc PrinProc Seq1 PrinProc Seq2 PrinProc Seq3 PrinProc Seq4 PrinProc Seq5 PrinProc Seq6 PrinProc Seq7 PrinProc Seq8 PrinProc Seq9 PrinProc Seq10 PrinProc Seq11 PrinProc Seq12 PrinProc Seq13 PrinProc Seq14 PrinProc Seq15 PrinProc Seq16 PrinProc Seq17 PrinProc Seq18 PrinProc Seq19 PrinProc Seq20 PrinProc Seq21 PrinProc Seq22 PrinProc Seq23 PrinProc Seq24 PrinProc Seq25

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

Organization :

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1654-Attach-1.DOC

#1654

June 9, 2006

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1488-P
P.O. Box 8011
Baltimore, MD 21244-1850

Letter written by Wayne Powell at SCAI
Contact: Sandy Marks x585

Dear Dr. McClellan:

The undersigned medical societies and associations of medical professionals are concerned about the proposed changes in Medicare's hospital inpatient payment system. The undersigned organizations represent thousands of physicians across the nation taking care of Medicare beneficiaries in our nation's hospitals. We fully support efforts to base payments on the cost of providing services but the proposal does not appear to achieve that goal.

The proposal appears to have methodological flaws and to be based on weak or inaccurate data. For example, the hospital-specific relative value approach exaggerates the redistributive effects of the proposal and biases payments against larger facilities that provide more sophisticated and expensive care to Medicare beneficiaries. The magnitude of the cuts that would be imposed on urban teaching hospitals due to the use of this approach, even those located in primarily rural states, could have significant adverse consequences for patient care.

Significant concerns have also been raised about how data was trimmed, the accuracy of cost data collected by hospitals that had little individual benefit from a thorough accounting for costs under the old payment system, as well as mathematical errors in the calculation of the proposed payment rates. The methodology's assumption that there are similar cost-to-charge ratios for devices that vary significantly in cost should also be supported by research or avoided by developing separate cost categories for those devices.

We fully support the goal of improving payment accuracy for hospital inpatient services, but we also believe that CMS should resolve these problems before it implements changes and that all stakeholders should have the opportunity to review and comment on a modified proposal with accurate proposed payment rates prior to implementation. It would be difficult to accomplish all of this by the deadline for publication of the final rule at the beginning of August.

We are also concerned about how the proposed changes for fiscal year 2007 will be integrated with planned changes for 2008. Payments for some procedures may be dramatically changed in one direction and then the other. The Medicare Payment

Advisory Commission (MedPAC) recommends that all changes be implemented simultaneously and we concur. This potential whiplash effect on fees may lead to poor planning by hospitals.

If the result of these revisions still leaves hospitals with significant changes in the way different procedures are reimbursed, we hope that hospitals will be given sufficient time to adapt to these changes. A significant lead-time before changes are implemented could help hospitals budget accurately and a phase-in of significant changes is warranted. MedPAC is recommending a transition to the new rate setting system and we concur. The hospital reimbursement system has not seen changes this significant for decades and it will take time for hospitals to adapt.

The undersigned medical societies and associations of medical professionals urge CMS to refine its proposed methodology, collect better data on costs, provide hospitals with adequate advance notice of any significant changes, and provide a transition period for significant changes. We thank CMS' leaders for their consideration of this matter and hope that dramatic and unwarranted changes in hospital payments do not affect our ability to provide top quality care to Medicare beneficiaries.

Sincerely,

American Academy of Facial, Plastic and Reconstructive Surgery
American Academy of Neurology
American Academy of Physical Medicine and Rehabilitation
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American College of Cardiology
American College of Cardiovascular Administrators
American College of Chest Physicians
American College of Osteopathic Internists
American College of Osteopathic Surgeons
American College of Radiology Association
American College of Surgeons
American Medical Association
American Medical Group Association
American Osteopathic Academy of Orthopedics
American Osteopathic Association
American Society of Addiction Medicine
American Society of Anesthesiologists
American Society of Echocardiography
American Society of Nuclear Cardiology
American Society of Plastic Surgeons
American Urological Association
Congress of Neurological Surgeons
Heart Rhythm Society
Medical Group Management Association

National Hispanic Medical Association
Society for Cardiovascular Angiography and Interventions
Society for Cardiovascular Magnetic Resonance
Society for Vascular Surgery
Society of Interventional Radiology
Society of Thoracic Surgeons

Submitter : **Mr. G. Richard Hastings** **Date: 06/12/2006**

Organization : **Saint Luke's Health System**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1655-Attach-1.DOC

#1655

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 Ave., 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:

Thank you for the opportunity to comment on the proposed rule cited above (CMS-1488-P). I submit these comments on behalf of Saint Luke's Health System (SLHS) in the Kansas City Metropolitan Region. SLHS consists of eleven hospitals, several physician groups, and other medical services organizations in both Missouri and Kansas. We have 923 staffed beds in the system, 472 of which are located at our largest facility, a tertiary referral center, Saint Luke's Hospital of Kansas City.

First, we concur with the comments submitted by the American Hospital Association (AHA) and the Association of American Medical Colleges (AAMC). Specifically, we support the following:

- One-year delay in the proposed Diagnosis Related Group (DRG) changes
- Valid Cost-based Weights
- A New Classification System Only if the Need Can Be Demonstrated
- Simultaneous Adoption of Any Changes to Weights and Classifications
- Three-year Transition Period
- Collaborative Approach to Moving Forward
- Rescinding the Exclusion of Medical Resident Time Spent in Didactic Activities for the Calculation of Medicare Direct Graduate Medical Education and Indirect Graduate Medical Education Payments

Proposed Changes

It is our opinion that the proposed changes to the DRG weights and the new classification system have been hastily constructed and many flaws are apparent. (See also AHA's comment letter from Rick Pollack, dated June 8, 2006, pages 4 through 9). The new methodologies are not validated, which results in insufficient analysis in consideration of

the impact and implications on healthcare finance and policy. It also appears the methodology for computing costs for the "hospital-specific relative value cost center" (HSRVcc) is inconsistent. For example, the cost data (MCR) and charge data (MedPAR) are not concurrent. Furthermore, CMS chose to eliminate individual cost centers of hospitals because of aberrant data as opposed to excluding the entire facility from the costing process. When the entire hospital is not excluded, the computations are potentially inaccurate. The reasons for the abnormal data have not been investigated by CMS. These anomalies could be the result of an improper matching of costs and charges, which have the capability of distorting other cost to charge ratios within the same facility. Therefore, the entire hospital should be fully included or fully excluded.

Another material flaw is there was no weighting of the cost to charge ratios. When costing procedures, CMS gave the same consideration to the costs of a small rural hospital as were given to the large tertiary hospital. This was true for costing procedures only performed at large tertiary facilities. We believe the process of costing out the DRG's should be hospital specific and more closely resemble what is done to develop the APC weights for the Outpatient Prospective Payment System. Because of these reasons, we fully support a one-year delay in the proposed DRG changes to fully investigate and evaluate alternatives for new weights and classifications in a collaborative manner.

DRG Reclassifications

The proposed rule states that a number of DRG's would experience payment reductions, particularly DRGs involving cardiac care. SLHS has tremendous concerns about these proposed changes, such as the reduction of payments for procedures involving stents – both drug eluting and non drug eluting. The proposed rule notes that the payment reductions could "potentially reduce the incentives … for the further development of specialty hospitals" (71 Fed. Reg., page 24006). However, the reductions will also have a significant impact on community and teaching hospitals such as our largest facility, Saint Luke's Hospital of Kansas City (SLH). Unlike specialty hospitals, SLH has an emergency room, treats a significant number of Medicaid and uninsured patients, accepts complex cardiac cases, and is considered a safety net hospital by the State of Missouri. We have completed an impact analysis of the proposed payments for our MDC-5 surgical DRG's using our Oct, 2005 through May, 2006 Medicare admissions. The results of that analysis are summarized in the table below. Instead of reducing the cardiac DRG payments for all facilities, one option for CMS is to reduce the payments made to facilities that do not provide emergency care 24 hours a day, 7 days a week, 365 days a year.

Proposed Rule for MDC 5 Payment Impact for Saint Luke's Hospital of Kansas City

DRG NO.	Admissions	2006 Annualized Margin	2007 Margin based on Proposed Rates
117	5	-$23,095	-$26,616
118	8	-$50,725	-$66,118
124	152	-$54,304	-$333,037
125	201	-$11,169	-$414,678
479	26	$11,639	-$18,301
515	71	-$26,208	-$663,782
518	50	$9,317	-$156,150
535	26	-$10,808	-$363,414
536	30	-$187,508	-$527,039
547	57	$85,883	-$114,807
548	71	-$126,596	-$394,924

DRG NO.	Admissions	2006 Annualized Margin	2007 Margin based on Proposed Rates
549	36	$132,043	$77,188
550	117	-$99,737	-$244,353
551	45	-$152,347	-$299,028
552	84	-$137,320	-$329,217
553	36	$29,228	-$35,031
554	69	-$308,333	-$383,262
555	153	$150,585	-$409,512
556	45	-$11,027	-$211,464
557	578	-$1,606,889	-$4,457,280
558	585	-$1,427,841	-$4,432,817
Total Impact		-$3,815,210	-$13,803,639

Impact for SLHS

SLHS agrees with the AHA that, "the need for and best approach to changing in the patient classification system has not been concretely and objectively demonstrated. More careful analysis is needed, along with greater access to the specifics of CMS's methodology and the new GROUPER," (Pollack, page 9). Our ability to analyze the proposed rule effectively and accurately has been compromised because we do not have access to the GROUPER. However, based on the information available to us, the results of the analysis we have conducted is very troubling. As seen in the table above, we conducted a margin analysis using only Major Diagnostic Category 5 surgical DRG's for FFY 2007, based on the data available to us. The impact to SLH for this single MDC is projected to be a loss of nearly $14 million. The overall loss for SLH, including all major diagnostic categories, is projected to be $4.5 million in Federal Fiscal Year 2007 (FFY 2007) as a result of the changes in this rule. The simple fact this rule results in such a monumental redistribution of revenue warrants much more analysis and consideration before such a wholesale change is implemented.

New Patient Classification System: Severity of Illness

Along with the AAMC, we appreciate CMS's acknowledgment for the need to better account for patient severity in the IPPS (71 Fed. Reg., page 24026). We concur with CMS's decision that the changes made to the 2007 IPPS significantly improve recognition of severity between patients based on the presence or absence of a major cardiovascular condition (MCV) but it fails to recognize the impact of complexity of treatment. It is imperative that the IPPS also account for service complexity in patient care. Many of our patients are more resource intensive and require high cost services even though they are less severely ill. We strongly urge CMS to develop a system that includes severity of illness *AND* service complexity in order to appropriately account for the variances in cost to provide quality care for Medicare beneficiaries.

Conclusion

Saint Luke's Health System, in conjunction with the American Hospital Association, and the Association of American Medical Colleges, supports meaningful improvement to Medicare's inpatient prospective payment system. However, any improvements revising the DRG weights should be based upon hospital specific costing data and reflect not only severity of illness but complexity of treatment. As the proposed rule does not reflect either of these, we suggest a one-year delay in the implementation of the proposed DRG changes to fully investigate and evaluate alternatives for new weights and classifications.

SLHS appreciates the opportunity to submit comments on *CMS-1488-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems*. If you have any questions about our comments or the data we have included, please do not hesitate to contact Scott Pester, System Reimbursement Director for SLHS, at 816-932-5734, or Jodi Faustlin, Government Affairs Manager for SLHS, at 816-932-8160.

Sincerely,

G. Richard Hastings, FACHE
President and Chief Executive Officer
Saint Luke's Health System

Submitter : **Dr. Thomas Royer** **Date: 06/12/2006**

Organization : **CHRISTUS Health**

Category : **Health Care Provider/Association**

Issue Areas/Comments

DRG Reclassifications

DRG Reclassifications

see attachment

DRG Weights

DRG Weights

see attachment

Impact Analysis

Impact Analysis

see attachment

CMS-1488-P-1656-Attach-1.DOC

CHRISTUS
Health

#1656

June 12, 2006

Honorable Mark B. McClellan, MD, PhD
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 443-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

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

Dear Dr. McClellan,

CHRISTUS Health appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed changes to the Hospital Inpatient Prospective Payment System. Ranked among the top ten Catholic health systems in the United States, CHRISTUS Health includes more than 40 hospitals and facilities in six American states and Mexico. It is our mission to provide quality healthcare to those communities which we serve.

In your proposed rule, you requested comments on the proposed changes to the Diagnosis Related Group (DRG) system. Specifically, we would like to comment on the proposed adoption of severity-adjusted DRGs and the cost-based weighting of DRGs.

At CHRISTUS Health, we support the adoption of severity-adjusted DRGs, such as CMS proposed based upon 3M's APR-DRG methodology. A severity-adjusted system would provide a fair and equitable reimbursement system that appropriately accounts for more severe cases. Likewise, the proposed system will provide valuable assistance to acute care hospitals, such as those in the CHRISTUS Health, that are committed to providing valuable care to patients regardless of their condition or financial status.

While CHRISTUS Health has some concerns over the proposed cost-weighting methodology, we understand the impetus for the changes and are confident that a suitable solution can be reached. On this issue, we would like to offer the following thoughts and concerns:

- CHRISTUS Health is a large system covering o ver 60 communities, in some areas our acute care hospitals serve a large number of cardiac patients. In these areas, the dramatic reimbursement cuts created by a cost-weighting system will have a large financial impact on acute care hospitals. Any major changes to the reimbursement system must be done in a manner that will minimize the financial impact on community acute care hospitals.

- We share the concerns expressed by the American Hospital Association and others that question the accuracy of the cost-weighting methodology as stated in the proposed rule. In

Advocacy & Public Policy
100 NE Loop 410 • Suite 800 • San Antonio, TX 78216
Tel 210.321.8017 • Fax 210.321.8095

order to minimize the impact on acute care hospitals, CMS must ensure that its methodology is accurately measuring relative costs prior to moving forward with major reimbursement changes that will negatively affect acute care providers.

- In order to minimize the impact of adopting a cost-based weighting system, it must be implemented in conjunction with the adoption of severity-adjusted DRG refinements. Both proposals must operate together in order to achieve the objectives CMS seeks. Implementing one proposal before the other will create a skewed system, creating needless hardships on acute care providers until both proposals are fully implemented.

- Once the new DRG system is finalized, it is imperative that hospitals be granted ample time to adjust to the system. These proposals will dramatically alter the finances of acute care hospitals, particularly those that serve a large number of cardiac patients. While the changes may be reasonable in the end, in order to avoid needless complications, hospitals will need ample time to ensure that they have the technology and other tools available to seamlessly adjust to the reimbursement changes. It is not feasible for hospitals to begin planning for these changes based upon a proposed rule, particularly when the exact timing and implementation procedure is still in question. Complicating matters is the looming possibility that the cost weighting methodology may be altered due to the aforementioned concerns regarding the accuracy of the weighting methodology as proposed in the rule.

In conclusion, CHRISTUS Health appreciates the efforts CMS has undertaken to refine Medicare DRGs to more accurately reflect costs and account for the severity of cases. However, we caution that these changes, particularly the cost weighting refinements, may have a more dramatic effect on acute care hospitals than CMS intended. To minimize these potential effects, we ask CMS to take care in ensuring that the methodology used to determine the relative costs weights is an accurate reflection of relative costs. In addition, we suggest that both the severity-adjusted DRG proposal and the cost-weighting proposal be implemented as a package on the same timetable. This timetable must provide acute care providers with ample time and opportunity, after the final system changes are decided upon, to ensure their ability to seamlessly adjust to the new reimbursement system. This adjustment will include refining the hospital's billing system to add the newly created DRGs and alter the components of certain DRGs as outlined in the proposed rule, as well as training staff on changing coding procedures.

As always, CHRISTUS Health stands ready to work with CMS in properly addressing any issue they may have with the acute care healthcare delivery system. Please do not hesitate to call on us if we may be of assistance.

Sincerely,

Thomas C. Royer, M.D.,CEO

Advocacy & Public Policy
100 NE Loop 410 • Suite 800 • San Antonio, TX 78216
Tel 210.321.8017 • Fax 210.321.8095

Submitter : Mr. Joe Casey

Date: 06/12/2006

Organization : Sturdy Memorial Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1657-Attach-1.DOC

ATTACHMENT TO #1657

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, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule.

Dear Dr. McClellan:

On behalf of Sturdy Memorial Hospital, 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.

In summary I am writing in support of the following:

- The change in DRG weighting from the current system to the HSRVcc methodology in FY07 as proposed.
- The proposed delay in implementation of a severity adjusted DRG methodology until at least FY08.
- Inclusion of Critical Access Hospitals in the wage index calculation.
- Changes in the methodology to calculate the outlier threshold.
- Improvements to the chart validation process related to hospital quality data collection.

HSRV Weights

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc).

I strongly support the change from the current charge based DRG weighting system to the proposed HSRVcc system in FY07. While I understand that other parties are commenting on imperfections in the cost weighted system proposed by CMS, we should not loose sight of the greater imperfections in the current charge-based system. The proposed DRG weights under the HSRVcc methodology more closely represent the cost of providing services than the current charge-based system. Hospitals that provide more routine medical admissions as opposed to high-end, high-margin (especially cardiac) surgeries and services have been being disadvantaged for years under the current charge-based system. The move to a cost-based system should be effective in FY07 regardless of whether perfected. Even as proposed it is more reflective of the costs of providing services which should be the foundation for payment under the Medicare system.

DRGs: Severity of Illness

I support the proposed changes to Medicare's inpatient PPS to improve and refine the system, however, implementing a new DRG system (as opposed to just changing the weights) requires significant resources in terms of purchasing grouping software and training affected employees. I therefore support a delay until at least the beginning of FY08 of any changes to the actual DRG system to account for severity of patient illness.

Wage Index - ***Exclusion of Critical Access Hospitals***

Recently the Connecticut Hospital Association conducted an analysis of the impact of excluding the approximately 1,200 Critical Access Hospitals (CAHs) from the wage index file. The results of this analysis indicated that the National Average Hourly Wage for FFY 2007 is overstated by .707%. This results in an understatement of the various wage indexes throughout the country. Based on the analysis, the Massachusetts Hospital Association estimated that the impact of this change on Massachusetts hospitals IPPS payments for the five years (2003-2007) was a decrease of $36 million.

MedPAC has previously recommended that the CAH data be included in the wage index file (at least in the denominator). Since these hospitals in rural areas still compete for scare hospital resources in rural areas as the IPPS hospitals CAH data should continue to be included in the wage index file.

I would ask CMS to use estimated CAH data to compute the FFY07 National Average Hourly wage; to obtain wage index data from CAHs and subject that data to the same rigorous intermediary review as is done for IPPS hospitals and to include the CAH data in future wage index calculations (at least in determining the National Average Hourly Wage). A Medicare Occupational Mix factor of 1.0000 could be assigned to these hospitals.

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. I am concerned that the

threshold is too high. According to AHA analyses, 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. Using the proposed charge inflation methodology results in an inappropriately high outlier threshold and a real payment cut to hospitals. I disagree with using this methodology to estimate the outlier threshold and urge CMS to adopt the alternative methodology proposed by AHA to calculate the outlier threshold.

Hospital Quality Data - ***Chart Validation***

I encourage CMS to allow hospitals to challenge any mismatches in the chart validation that they may have with CDAC in order to score as high as they possibly can in any quarter, learn from the process, and remedy any identified problems to prevent them from occurring in subsequent quarters. Additionally, I recommend that CMS consider a validation process that would focus more resources on those hospitals that are having difficulty in passing the validation thresholds on a consistent basis. Finally, going forward, CMS should prospectively establish and communicate to the field which quarters will be used in the calculation of the validation threshold.

If I can provide you with any additional information regarding our comments, please do not hesitate to contact me at (508) 236-8150.

Sincerely,

Joseph Casey
Chief Financial Officer

Submitter : **Mr. Dominick Gio** **Date: 06/12/2006**

Organization : **Wyckoff Heights Medical Center**

Category : **Hospital**

Issue Areas/Comments

Hospital Quality Data

Hospital Quality Data

1. Response: Wyckoff Heights Medical Center (WHMC) understands and supports CMS s desire to improve the quality of care rendered to its Medicare population by participating healthcare facilities nationwide. WHMC also understands the use of incentives to achieve desired goals and supports the current Hospital Quality Data program (RHQDAPU initiative) to improve care for the selected measure sets. However, WHMC believes that the proposed penalty increase (from 0.4% to 2.0%) is drastic and may result in severe penalties, which may negatively impact on financially struggling facilities. The burden of assuring adequate staffing, implementing technology upgrades and abstracting data is already great for operations with limited resources (human, technological, financial). For those institutions, a further loss of revenue will undermine our ability to accomplish the desired goal of improved quality of care. We recommend no penalty increase.
2. Response: In light of the foregoing, WHMC believes that the requirement to have hospitals backtrack to collect data for the 2006 first quarter for new measures to meet the August 15th deadline is onerous. We recommend going forward so that new data collection commence with discharges for the 2006 third quarter which begins July 1, 2006, enabling facilities adequate preparation time.

Value-Based Purchasing

Value-Based Purchasing

1.Response: WHMC supports the drive to improve safety and quality of care especially in cases relating to hospital-associated conditions. With respect to hospital-associated infections (HAIs) the hospital has in place initiatives for the prevention of infections. Several of these are based on guidelines from the Institute for Healthcare Improvement [IHI] including initiatives for preventing the spread of infection. Each of these initiatives requires hospital funding. For example, during 2005 the hospital joined the GNYHA (Greater New York Hospital Association)/UHF (/United Hospital Fund) collaborative initiative to reduce Central Line-associated Bloodstream Infections (CLABs) and embarked on an aggressive program to improve patient safety and care in this area. As participants in this initiative, the hospital is implementing the IHI CLABs bundle. WHMC has made substantial hospital-wide investment in supplies and equipment to expedite staff compliance with the elements of the CLABs bundle. The hospital has likewise been working on implementing other IHI guidelines for preventing HAI. For example the IHI Ventilator-Associated Pneumonia (VAP) Bundle has been implemented for several years, as have the IHI guidelines for the Prevention of Surgical Site Infections (SSI). The ongoing implementation of these and other internal initiatives (e.g. VAPs, post-operative wound infections) and systems to prevent the spread of infection and thereby reduce HAIs, also require funding. During this past year such initiatives have included a campaign to improve healthcare worker influenza vaccination rates, and the implementation of infection control department systems to assure the most rapid possible institution of isolation precautions for patients colonized or infected with multi-drug resistant organisms, and other communicable conditions or diseases.
To reiterate, these initiatives to prevent HAIs and to control the spread of infection resulted in associated costs to the hospital. The hospital is well aware that HAI s and other hospital- associated conditions are associated with increased cost, and higher-paying DRG. Notwithstanding that fact, the hospital eventually loses money on these conditions as was demonstrated by Richard Shannon, MD of Alleghany Hospital PA at the 4/5/06 GNYHA/UHF Audioconference. He cited the following cost for CLABs cases:
a. Cost = $92,000/case
b. Loss = $26,000/case (not reimbursed)
Multiply this loss by several cases and the hospital experiences substantial financial loss, not to mention medical liability, patient dissatisfaction and loss of market share due to increased public access to such data.
Since institutions are already losing money for HAIs, for CMS to not pay for these cases is tantamount to punishment rather than being an incentive for improvement. While 0% for HAIs is our goal, it may not be feasible due to factors that include:Breakthrough infections which can occur even after all preventive measures have been taken there should not be a penalty for these cases.Instances where patients self-extubate (even with preventive measures taken) and then aspirate leading to the subsequent development of an infection (VAP) this HAI is not provider driven. Likewise, the central line antiseptic dressing or a BioPatch may become loose from perspiration on the patient s skin and provide a window of opportunity for infection to begin before the patch can be replaced.Under some medical circumstances, a central line catheter has to be placed in the groin (femoral vein). This can result in infection even with good technique and preventive measures. Likewise, some patients with malnutrition, those with pre-existing disease such as diabetes, peripheral vascular disease, or older patients with dehydration and immunosuppressed patients will be at risk for infections even when preventive measures are taken. Facilities serving large numbers of such patients would be at an even greater disadvantage.

CMS-1488-P-1658-Attach-1.DOC

1658

WYCKOFF HEIGHTS MEDICAL CENTER

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

VALUE-BASED PURCHASING

1. WHMC supports the drive to improve safety and quality of care especially in cases relating to hospital-associated conditions. With respect to hospital-associated infections (HAIs) the hospital has in place initiatives for the prevention of infections. Several of these are based on guidelines from the Institute for Healthcare Improvement [IHI] including initiatives for preventing the spread of infection. Each of these initiatives requires hospital funding. For example, during 2005 the hospital joined the GNYHA (Greater New York Hospital Association)/UHF (/United Hospital Fund) collaborative initiative to reduce Central Line-associated Bloodstream Infections (CLABs) and embarked on an aggressive program to improve patient safety and care in this area. As participants in this initiative, the hospital is implementing the IHI CLABs bundle. WHMC has made substantial hospital-wide investment in supplies and equipment to expedite staff compliance with the elements of the CLABs bundle. The hospital has likewise been working on implementing other IHI guidelines for preventing HAI. For example the IHI Ventilator-Associated Pneumonia (VAP) Bundle has been implemented for several years, as have the IHI guidelines for the Prevention of Surgical Site Infections (SSI). The ongoing implementation of these and other internal initiatives (e.g. VAPs, post-operative wound infections) and systems to prevent the spread of infection and thereby reduce HAIs, also require funding. During this past year such initiatives have included a campaign to improve healthcare worker influenza vaccination rates, and the implementation of infection control department systems to assure the most rapid possible institution of isolation precautions for patients colonized or infected with multi-drug resistant organisms, and other communicable conditions or diseases.

   To reiterate, these initiatives to prevent HAIs and to control the spread of infection resulted in associated costs to the hospital. The hospital is well aware that HAI's and other hospital-associated conditions are associated with increased cost, and higher-paying DRG. Notwithstanding that fact, the hospital eventually loses money on these conditions as was demonstrated by Richard Shannon, MD of Alleghany Hospital PA at the 4/5/06 GNYHA/UHF Audioconference. He cited the following cost for CLABs cases:

   a. Cost = $92,000/case
   b. Loss = $26,000/case (not reimbursed)

   Multiply this loss by several cases and the hospital experiences substantial financial loss, not to mention medical liability, patient dissatisfaction and loss of market share due to increased public access to such data.

   Since institutions are already losing money for HAIs, for CMS to not pay for these cases is tantamount to punishment rather than being an incentive for improvement. While 0% for HAIs is our goal, it may not be feasible due to factors that include:

   - Breakthrough infections which can occur even after all preventive measures have been taken – there should not be a penalty for these cases.

- Instances where patients self-extubate (even with preventive measures taken) and then aspirate leading to the subsequent development of an infection (VAP) – this HAI is not provider driven. Likewise, the central line antiseptic dressing or a BioPatch may become loose from perspiration on the patient's skin and provide a window of opportunity for infection to begin before the patch can be replaced.
- Under some medical circumstances, a central line catheter has to be placed in the groin (femoral vein). This can result in infection even with good technique and preventive measures.
- Likewise, some patients with malnutrition, those with pre-existing disease such as diabetes, peripheral vascular disease, or older patients with dehydration and immunosuppressed patients will be at risk for infections even when preventive measures are taken. Facilities serving large numbers of such patients would be at an even greater disadvantage.
- Unknown factors prior to admission can result in infection after admission including patients engaging in behaviors that increase their risk.
- In addition, infection rate reporting is not risk-stratified (except for surgical site infections) and this stratification system is not perfect. So too, neither VAPs nor CLABs have been risk stratified. This limits adequacy of criteria used to determine penalty.

WHMC recommends moving away from a focus on the occurrence of an infection, and even away from infection rates, and to instead move toward reviewing compliance with processes, i.e. measure and monitor compliance with the steps or elements of the IHI Bundles.

2. Although WHMC understands the goals of the three structural measures, fiscal constraints placed on hospitals make it difficult to implement all three measures. If a penalty is placed on hospitals that cannot meet the requirements, this will cause additional negative impact on these facilities. There should be a consensus on measures among all the agencies. Healthcare institutions want to comply with the measures and improve quality as well as patient safety. Requiring hospitals to create and report on different combination of measures for the same diagnosis makes reporting requirements extremely burdensome.

   With respect to evidence-based hospital referrals, healthcare facilities should not have payor incentives or penalties associated with evidence-based hospital referrals. Reduction in scope of services would reduce case mix, restrict medical education opportunities and centralize access to services away from the community making access to patient services more difficult.

HOSPITAL QUALITY DATA

1. Wyckoff Heights Medical Center (WHMC) understands and supports CMS's desire to improve the quality of care rendered to its Medicare population by participating healthcare facilities nationwide. WHMC also understands the use of incentives to achieve desired goals and supports the current Hospital Quality Data program (RHQDAPU initiative) to improve

care for the selected measure sets. However, WHMC believes that the proposed penalty increase (from 0.4% to 2.0%) is drastic and may result in severe penalties, which may negatively impact on financially struggling facilities. The burden of assuring adequate staffing, implementing technology upgrades and abstracting data is already great for operations with limited resources (human, technological, financial). For those institutions, a further loss of revenue will undermine our ability to accomplish the desired goal of improved quality of care. We recommend no penalty increase.

2. In light of the foregoing, WHMC believes that the requirement to have hospitals backtrack to collect data for the 2006 first quarter for new measures to meet the August 15th deadline is onerous. We recommend going forward so that new data collection commence with discharges for the 2006 third quarter which begins July 1, 2006, enabling facilities adequate preparation time.

Submitter : **Ms. Brett Curran** **Date: 06/12/2006**

Organization : **The Methodist Hospital**

Category : **Hospital**

Issue Areas/Comments

DRG Reclassifications

DRG Reclassifications

See Attachment

#1659

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. Diane Canova**

Date: 06/12/2006

Organization : **Sudden Cardiac Arrest Association**

Category : **Consumer Group**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1660-Attach-1.DOC

#1660

Sudden Cardiac Arrest Association

June 12, 2006

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

RE: CMS-1488-P; Proposed Changes to the Hospital Inpatient Payments Systems and FY 2007 Rates

Sent via E-Rulemaking

Dear Dr. McClellan:

I am writing on behalf of the Sudden Cardiac Arrest Association (SCAA), a not-for-profit organization that includes cardiac arrest survivors and their families, medical professionals, first responders and others seeking to increase awareness, encourage training for immediate bystander action, increase public access to defibrillation and promote the use of available medical devices and therapies, principally, implantable cardioverter defibrillators (ICDs).

Over 325,000 people die of sudden cardiac arrest annually in the United States. SCAA members know firsthand the impact of the number one killer in America today. They have lost loved ones to sudden cardiac arrest (SCA) or they have experienced SCA themselves and were resuscitated. These survivors are the beneficiaries of improved science and medical technology, including pacemakers and ICDs. Continuous improvements in technology and medical devices, coupled with realistic Medicare reimbursements will assist even greater numbers of people to live longer and fuller lives.

Medicare payment rates should accurately reflect the cost of services provided; inaccurate rates could limit hospitals' capabilities to perform services, and thus limit patient access to some therapies, including ICDs. Hospitals have worked for years to build medical environments that provide the highest standards of patient care for those suffering with heart disease, including sudden cardiac arrest. Changes to the Medicare system must not impede the current state-of-care nor decrease access to critical technology.

SCAA is concerned that the potential impact of reduced Medicare payments may disproportionately impact cardiovascular patients needing high technology solutions, especially sudden cardiac arrest victims and patients that have had

ICDs implanted. If the cost of technology for complex cases is not sufficiently reimbursed by Medicare, then hospitals may be less inclined to provide all necessary services for patients experiencing sudden cardiac arrest, or in need of an ICD implant. Careful consideration needs to be focused on medical needs, therapies and the technology of complex case, including SCA and ICD implants.

Sweeping changes of this nature need thorough analysis, stakeholder input, and time and consideration prior to being implemented. Additionally, intended and unintended consequences need to be carefully examined to determine adverse impacts on patients.

To ensure continued access to high quality care for Medicare beneficiaries, appropriate payment is critical. We urge CMS to reconsider its timetable for implementation to allow additional time for full review. In the meantime, please continue with the current charge-based system.

The Sudden Cardiac Arrest Association appreciates your efforts to improve the inpatient payment system. While changes may ultimately be necessary, please remember that behind the numbers, behind the surgeries and medical devices, are real people, relying on Medicare to give them a second chance at life … literally.

Sincerely,

Diane M. Canova
Executive Director
Sudden Cardiac Arrest Association
1133 Connecticut Ave., NW
11th Floor
Washington, DC 20036
(202) 957-8089
diane.canova@earthlink.net

Submitter : **Larry Rues**

Date: 06/12/2006

Organization : **Researh Family Medicine Residency**

Category : **Physician**

Issue Areas/Comments

GME Payments

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.

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
Larry Rues MD

Submitter : Mr. John Shaw

Date: 06/12/2006

Organization : Next Wave

Category : Health Care Industry

Issue Areas/Comments

DRGs: Hip and Knee Replacements

DRGs: Hip and Knee Replacements

Under separate cover, Lynn-Marie Wozniak of our staff addressed a technical refinement to ICD-9-CM code combinations which will assure that all appropriate code combinations that identify true Bi-lateral/Multiple Joint Replacements (current DRG 471) are recognized, and those that only represent multiple component revision procedures on the same knee will remain in the Revision of Hip or Knee Joint (current DRG 545).

Major changes are proposed for Hip and Knee Joint Replacements in the FFY2008 proposal to implement All-Payor Refined based Consolidated Severity Adjusted DRGs (APR/CSA DRGs.) Some of these proposed changes are true refinements (separating Hip and Knee replacements, inclusion of co-morbidity Severity of Illness); however, several will serve to introduce new bias into Medicare Hospital DRG payments. The first is collapsing Base DRGs for initial joint replacement (DRG 544), revision joint replacement (DRG 545), bi-lateral/multiple joint replacements during the same stay (DRG 471), and deep infections requiring debridement (DRG 217). The second is eliminating payment for most complications experienced by these patients, regardless of whether they were present on admission, occurred many years ago, occurred at this hospital or elsewhere, or were avoidable or not. (Note: These are addressed in more detail in our comments on DRGs: Severity of Illness and the attached case study Evaluating the Proposed Consolidated Severity Adjusted DRGs for FFY2008: Examples from Hip and Knee Joint Replacement.)

Specific recommendations to correct the new bias for Hip and Knee Replacements include:

" Knee revisions - "level 2" knee replacements should be increased to level 3 if it is a revision, as is done for level 2 hip revisions. In addition, a diagnosis of Obesity, including diagnosis codes of any Body Mass Index over 30, should be increase severity to level 2 for all these patients, as is done for hip replacement patients. These patients require additional O.R., nursing, and therapy resources, and are frequently referred to regional referral centers. "Typical" revisions would than be paid appropriately vs. cost.

" Maintain Base DRGs for Bi-lateral Hips and Bi-lateral Knees, as well as patients with deep infections requiring debridement. (Revision cases would be paid appropriately through a severity bump with the above recommendation.) Failure to do so will create new incentives for adverse admission selection, and underpay hospitals that treat these difficult patients.

" The Severity lists do NOT include most diagnoses that are considered "complications" (e.g. most of the 996xx - 99998 range of codes). We strongly support including these codes, since they represent pre-existing or predictably higher risks upon admission for difficult patients who are typically referred to regional centers. Failure to do so will create new incentives for adverse admission selection, and underpay hospitals that treat these difficult patients.

Other refinements in this area should also be considered. Prior analysis demonstrated that joint revision patients with major osseous defects and those with deep infection of the surrounding bone require significantly more care to prepare the underlying bone to mechanically and safely support the joint prosthesis. These issues should be added to FFY2008 analysis.

CMS-1488-P-1662-Attach-1.PDF

#1062

"We Understand Health Care"

June 12, 2006

Mr. Marc Hartstein
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1488–P
P.O. Box 8011
Baltimore, MD 21244–1850

http://www.cms.hhs.gov/eRulemaking

Re: File code CMS–1488–P.

Dear Mr. Hartstein:

We are a health services research and consulting group specializing in using data to classify patients into categories for policy, management, financing, and quality improvement. Our staff worked on the design, refinement, and implementation of various Diagnosis Related Group (DRG) payment systems at national and state levels since the 1970's. Our comments update those we made in 1994 (when "Severity" DRGs were last proposed) and intervening years.

We comment on several issue areas for the proposed FFY2007 and FFY2008 Medicare Acute Hospital payment rates. We separate each of these issues, and incorporate this page, specific comments, and appropriate attachments for each:

- DRGs: Hip and Knee Replacements
- DRGs: Spinal Fusion
- HSRV Weights
- DRGs: Severity of Illness
- Transparency of Health Care Information
- Value-Based Purchasing

Our staff has hands-on knowledge of both proposed refinements and alternative approaches. We hope that these insights assist your ongoing efforts to implement a payment system that fairly aligns payments with the costs of providing needed patient care to Medicare Beneficiaries. Please contact us for any additional input you need over the next year to address these issues.

Sincerely,

John D. Shaw

John D, Shaw
President

Enc.

24 Madison Avenue Ext. ● Albany, NY 12203 ● (518) 452-3351 ● Fax (518) 452-3358 ● www.nextwave.info

DRGs: Hip and Knee Replacements:

Under separate cover, Lynn-Marie Wozniak of our staff addressed a technical refinement to ICD-9-CM code combinations which will assure that all appropriate code combinations that identify true Bi-lateral/Multiple Joint Replacements (current DRG 471) are recognized, and those that only represent multiple component revision procedures on the same knee will remain in the Revision of Hip or Knee Joint (current DRG 545).

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Specific recommendations to correct the new bias for Hip and Knee Replacements include:

- Knee revisions - "level 2" knee replacements should be increased to level 3 if it is a revision, as is done for level 2 hip revisions. In addition, a diagnosis of Obesity, including diagnosis codes of any Body Mass Index over 30, should be increase severity to level 2 for all these patients, as is done for hip replacement patients. These patients require additional O.R., nursing, and therapy resources, and are frequently referred to regional referral centers. "Typical" revisions would than be paid appropriately vs. cost.

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Other refinements in this area should also be considered. Prior analysis demonstrated that joint revision patients with "major osseous defects" and those with "deep infection" of the surrounding bone require significantly more care to prepare the underlying bone to mechanically and safely support the joint prosthesis. These issues should be added to FFY2008 analysis.

Evaluating the Proposed Consolidated Severity Adjusted DRGs for FFY2008
Examples from Hip and Knee Joint Replacement

The Centers for Medicare and Medicaid Services (CMS) has committed to Congress and MEDPAC to modify the hospital payment system to better align costs and payments. This would reduce current incentives for "crème skimming" (seeking out profitable patients) and at the same time, reduce underpayment to hospitals for treating difficult and complex patients (both referred and complicated readmissions). The proposed changes from current Diagnosis Related Group (DRG) definitions in use through FFY2007 to the proposed Consolidated Severity Adjusted DRGs (CSA-DRGs) fix some of the current cost/payment misalignments, but create new ones that must be corrected before they are implemented. Specifically the proposed CSA-DRGs:

a. + Adjust better for patient severity
b. - Adjust less for treatment complexity
c. - Remove current payment differentials for patients with complications

The proposed CSA-DRGs 414-419 for Hip and Knee Joint Replacements are presented below as examples of how the proposed CSA-DRGs will either fix or make current problems worse:

A. The proposed CSA-DRGS adjust better for patient co-morbidity severity

INITIAL JOINT REPLACEMENTS WITHOUT CO-MORBIDITIES

About 40% of these hip and knee patients are straight forward clinically – initial joint replacement with no complicating or co-morbid conditions to make care more difficult. They currently have payment levels set about $ 1,000 over their cost (national average – will differ by locality.) The proposed adjustments would modify payments for these cases so that the margin is less than $200 per case (Table 1.) This will alleviate of the problem of overpaying hospitals that in the past have consciously sought out patients who did not have co-morbid or complicating conditions or require complex treatment.

Table 1 – Initial Joint Replacements without Co-morbidities or Complications

Joint	Est. Cases	% Cases	Est. Cost	FFY07 Est. Pay	FFY07 Est. Margin	FFY08 Est. Pay	FFY08 Est. Margin
Hip	90,677	42%	$ 9,693	$ 10,467	$ 774	$ 9,815	$ 122
Knee	106,870	42%	$ 9,372	$ 10,467	$ 1,096	$ 9,576	$ 204

INITIAL JOINT REPLACEMENTS WITH MINOR (Level 2) CO-MORBIDITIES

Approximately another 34% of the hip and knee patients are initial joint replacements that have minor co-morbid diagnoses that increase treatment costs slightly, but no complicating conditions. Current DRGs pay both hip and knee patients the same amount; however hip patients cost about $ 1,000 more than knee patients. Facilities with a typical 45/55 hip/knee mix will break even. Facilities that treat more hip than knee patients are disadvantaged and vice versa. The proposed adjustments split hip and knee patients into their own DRGs, and adjust the severity level for the minor co-morbidities. This improves payments for both hip and knee patients, and narrows the margin gap between them to about $300 (Table 2.)

Table 2 – Initial Joint Replacements with Only Minor Co-morbidities

Joint	Est. Cases	% Cases	Est. Cost	FFY07 Est. Pay	FFY07 Est. Margin	FFY08 Est. Pay	FFY08 Est. Margin
Hip	66,873	31%	$ 11,004	$ 10,467	$ (537)	$ 11,282	$ 278
Knee	93,359	36%	$ 10,035	$ 10,467	$ 433	$ 10,616	$ 582

INITIAL JOINT REPLACEMENTS WITH MAJOR OR MULTIPLE (Level 3 or 4) CO-MORBIDITIES OR COMPLICATIONS FROM PRIOR SURGERY

About 13% of the hip and knee patients are the more difficult patients (e.g. 711.xx Pyogenic arthritis) who are typically referred to a regional center due to having either major or multiple co-morbid diagnoses or complicating conditions associated with prior surgery. Under the current DRGs, referral centers that

admit these patients lose $ 2,500 – 3,500 on each. The proposal reduces the loss for hip referrals to ($300), and reverses the loss to about a $ 600 gain for knee referrals (Table 3.) A hospital with a typical 60/40 mix of these patients would almost break-even.

Table 3 - Initial Joint Replacements w Major or Multiple Co-Morbid or Complicating Conditions

Joint	Est. Cases	% Cases	Est. Cost	FFY07 Est. Pay	FFY07 Est. Margin	FFY08 Est. Pay	FFY08 Est. Margin
Hip	34,768	16.1%	$ 13,947	$ 10,467	$ (3,480)	$ 13,652	$ (295)
Knee	24,230	9.5%	$ 12,889	$ 10,467	$ (2,422)	$ 13,481	$ 592

B. The proposed CSA-DRGs adjust <u>less</u> for treatment complexity

<u>REVISIONS</u>

About 9% of the hip and knee patients are more complex because they require a revision to a prior joint replacement. A new DRG was implemented in FFY2006 for these cases. In total, payment rates equalized for hospitals with a typical 55/45 hip/knee mix. However, there is a $1,200 difference favoring knees in FFY2007. The proposal <u>decreases overall payments for revision patients</u> (averaging $ 400) by putting the revisions and the initial joint replacements into the same initial hip and knee CSA-DRGs. The severity level of patients undergoing a revision is raised up one level for patients who do not have a significant comorbidity or complicated principal diagnosis – maximum of level 3 for hips but only level 2 for knees. Hip revisions would almost break even, but knee revisions would be underpaid by about $800 average per case (Table 4.) This <u>reverses the direction</u> of the FFY2007 margin difference – an almost $ 2,000 swing.

Table 4 – Revisions to Joint Replacements

Joint	Est. Cases	% Cases	Est. Cost	FFY07 Est. Pay	FFY07 Est. Margin	FFY08 Est. Pay	FFY08 Est. Margin
Hip	21,417	9.9%	$ 13,218	$ 12,677	$ (541)	$ 13,162	$ (56)
Knee	19,419	7.6%	$ 11,998	$ 12,677	$ 679	$ 11,228	$ (770)

<u>BILATERAL OR MULTIPLE JOINT REPLACEMENTS</u>

About 3% of the hip and knee cases undergo bilateral or multiple joint replacements (two hips, two knees, or one of each – during the same patient stay.) Hospital costs are about 50% higher than for a single joint replacement, largely reflecting longer operating room time and the cost of the additional joint implant. When two joints need replacement, physicians and their patients decide clinically whether to replace both joints in a single stay or "stage" them during two separate stays, usually within 6 months. There is a separate DRG through FFY2007 for bilateral cases; however the FFY2008 proposal puts them into the same CSA-DRGs as the initial and single joint replacements. There is only a partial adjustment for a handful of cases (those having BOTH a hip and knee replaced during the same stay), resulting in an <u>average underpayment of ($ 5,100) per case</u>. These difficult cases are typically treated in a few regional referral centers, which will be severely underpaid by the proposal. Added splits for Complications (without or with) are also meaningful for these cases (Table 4.)

Table 4 – Bilateral or Multiple Joint Replacements with and without Complications

Bilat/Mult Jnt. Repl	Est. Cases	% Cases	Est. Cost	FFY07 Est. Pay	FFY07 Est. Margin	FFY08 Est. Pay	FFY08 Est. Margin
*Hip wo	715	0.3%	$15,632	$ 15,934	$ 302	$ 11,356	$ (4,276)
*Hip w	652	0.3%	$ 26,284	$ 15,934	$ (10,350)	$ 12,655	$ (13,629)
Knee wo	10,105	3.9%	14,879	$ 15,934	$ 1,055	$ 10,465	$ (4,414)
Knee w	1,776	0.7%	17,750	$ 15,934	$ (1,816)	$ 11,959	$ (5,791)

**Includes patients with both hip and knee replaced during the same stay.*

C. The proposed CSA-DRGs remove current payment differentials for patients with complications

INFECTED JOINTS WITH DEBRIDEMENT

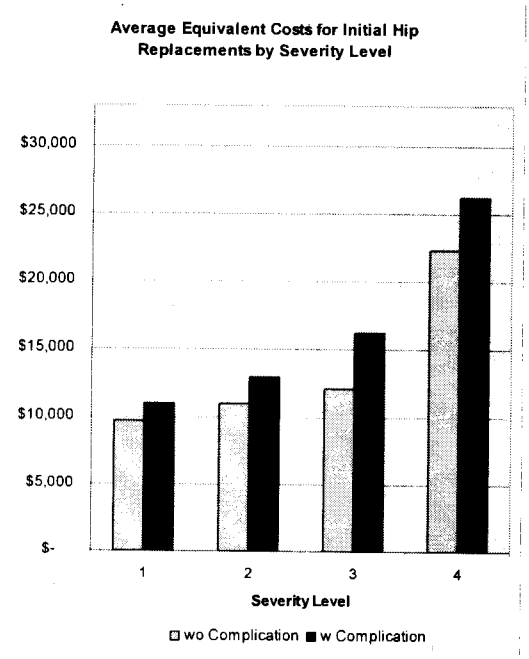
The rest of the cases currently fall into DRG 217 – Debridement. These are some of the most difficult and complex orthopedic patients to treat. Many have deep orthopedic infections not responsive to normal antibiotic treatment. Many have multiple complicating conditions, and on average stay more than twice as long as typical patients. The current DRG 217 is in effect a consolidated "complexity" DRG, consisting of patients who require wound debridement and may or may not have other orthopedic procedures and treatments during the same stay. This is similar conceptually to the level 4 "Severe" CSA-DRGs proposed for co-morbid diagnoses across a Major Diagnostic Category. The proposal eliminates this complexity DRG, and re-assigns patients to other DRGs reflecting their other (not debridement) procedures. The hip and knee patients with wound debridements are underpaid almost ($ 11,000) each (Table 5), which has a serious disproportionate financial impact on the referral hospitals admitting these difficult cases from other hospitals around the region.

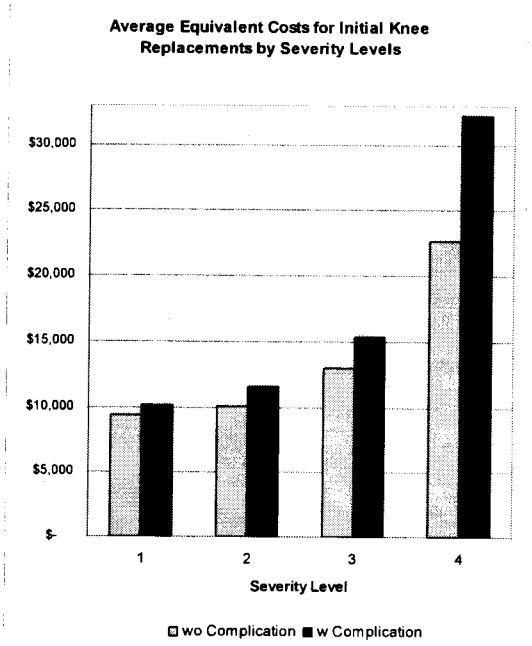
Table 5 – Joint Replacements with Wound Debridements

Joint	Est. Cases	% Cases	Est. Cost	FFY07 Est. Pay	FFY07 Est. Margin	FFY08 Est. Pay	FFY08 Est. Margin
Hip	581	0.3%	$ 25,156	$ 24,857	$ (300)	$ 14,327	$ (10,829)
Knee	395	0.2%	$ 24,355	$ 24,857	$ 502	$ 13,527	$ (10,828)

INITIAL JOINTS – WITH AND WITHOUT COMPLICATING CONDITIONS

As can be seen in the following charts, patients with complicating conditions have more resource needs (costs) than patients without these conditions **for every co-morbidity severity level**.





As a consequence, proposed payment rates set at the average at each severity level will introduce a bias to systematically overpay patients without complications and systematically underpay patients with complications. This new systematic bias will result in unnecessary patient referrals to regional centers for complications that could safely be treated locally. This places an unfair burden on these regional referral centers. They must shoulder the costs of this uncompensated care since they cannot deny access. Most of these complications are present on admission, and are therefore "unavoidable" to the admitting hospital.

These charts and (Table 6) below illustrate that facilities can avoid an extra $ 2,000 in non-reimbursed cost per patient by avoiding admission of difficult patients with complicating conditions.

Table 6 – Cost Difference – Admitting a Patient with and without a Complication (Payment=Same)

	Level 1	Level 2	Level 3	Level 4	Weighted Average
Initial Hip – wo vs. w Complication	$ 1,328	$ 2,012	$ 4,063	$ 3,852	$ 2,152
Initial Knee – wo vs. w Complication	$ 791	$ 1,571	$ 2,383	$ 9,589	$ 1,809

Specific Hip/Knee Recommendations

- Implement "Base DRGs" for both Bilateral Hip Replacement and Bilateral Knee Replacement.
- Retain current DRG 217 across orthopedic cases to capture "severe complications".
- Differentiate major complications within initial hips/knees ($2,000/$1,500 higher) and bilateral hips/knees ($8,200/$1,200 higher), either by splitting each by presence of a major complication or incorporate into determination of "resource intensity levels."
- These high resource need patients average out with less intensive cases nationally and across a large region, but specific referral centers admit a disproportionate number of these difficult patients. Initial payment is appropriate to provide equity to the hospitals willing to admit the difficult patient and to avoid perverse "crème skimming" incentives.

Apply Concepts above to other Orthopedic DRGs and other Major Diagnostic Categories

- DRG intensity adjustments should occur along the dimension that is the most significant resource driver: procedure, medical diagnosis, complicating conditions, co-morbidities. For example:
  - Level 4 co-morbidities are 100%+ more than average for the specific procedure
  - Complex patients in DRG 217 are 100% more costly then the average joint replacement
  - Complex Bilateral joint costs are 50% higher than single initial joint replacements
  - Complex Revision joint costs are 20% higher than initial joint replacements
  - Severity levels 1-2 and 2-3 are 11-27% apart from each other in terms of average cost
  - Complication levels are 15-20% higher for initial joints, 10-50% for Bilateral, in addition to co-morbidity severity levels

Figure 1 – Hip Replacements by Severity Level

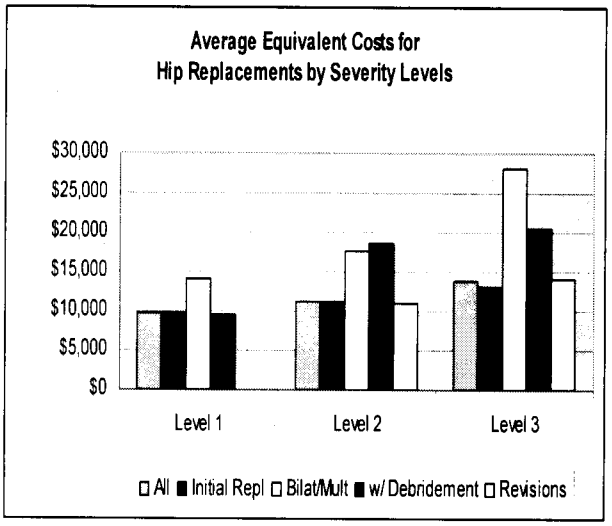
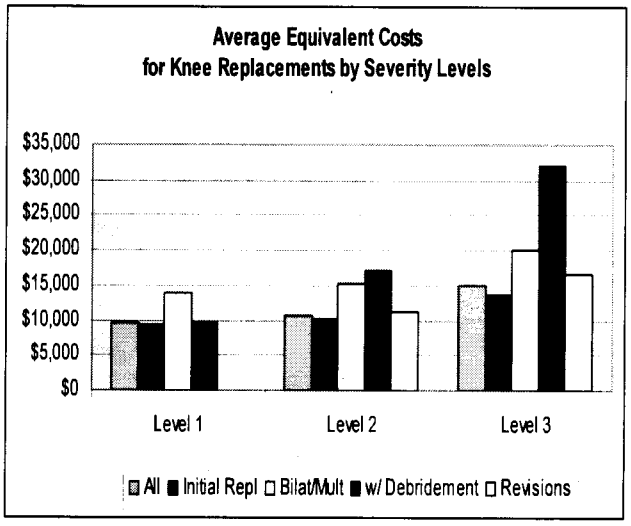


Figure 2 – Knee Replacements by Severity Level



Level 4 cases are not shown here. All level 4 cases collected into a combined CSA-DRG for Level 4 Surgical Orthopedic cases. Levels 1,2,& 3 each have their own CSA-DRGs. The chart above shows how each joint replacement scenario compares in average cost to the total average for each severity level.

- HOW complexity is integrated into the APR/CSA-DRG structure depends on the degree that the complexity affects relative resources and risk for quality indicators and mortality
    - In the example above and as shown in Figures 1 & 2, revisions increase resources approximately the same amount as each severity level, and also increase relative risk, so incorporating them into the determination of severity level is valid.
    - The impact on relative resources for bilateral or multiple joint replacement patients is significantly higher at all severity levels, and therefore require a new "base DRGs" to accommodate them in the APR-CSA structure
- Current DRGs use **both** complications and co-morbidities to determine resource intensity for payment (cc). **Both** must also be incorporated into any new DRGs for payment equity and to avoid perverse incentives for admission/referral selection.
- Most major complications are present on admission. "Avoidability" of these complications should be reviewed retrospectively as part of Pay for Performance initiatives – both at the hospital level and across a region where many occur.
- "No measure of case mix complexity can be equally effective for all the different aspects of case mix complexity."[1] The current structure for APR-CSA DRGs incorporates co-morbidity severity but not complications and only some complexity, and may be appropriate for severity adjusting quality indicators and mortality – their primary use over the past few years. New weights for relative resources for payment appear necessary to include complications and complexity without adversely impacting risk adjustment use. DRG hierarchy changes would only be necessary if the materiality requires it (like DRG 217 in the example above.) These could be collapsed back when using for risk adjustment for quality and mortality.
- While constructing this case study, we noted several severity adjustments that had been implemented for Hip replacements that the data indicates should also be applied to Knee replacements (TKA). These include:
    - A severity adjustment for obesity (and all diagnosis codes for BMI >= 30), the same as done for Hip replacement (APR-DRG "Step 5")
    - Give knee revisions an add-on severity adjustment up to level 3, the same as is done for hip revisions (APR-DRG "Step 13").
- In review of the complicated principal diagnoses (APR-DRG "Step 10") for Hip and Knee replacements, we noted that several other principal diagnoses are predictive of difficult cases and should be included:
    - Pyogenic Arthritis (71105, 71106, 71107)
    - Acute Osteomyelitis (73005, 73006, 73007)
    - Pathological Fractures (73314, 73315, 73316)

[1] Averill RF, et. al. "All Patient Refined Diagnosis Related Groups (APR DRGs) Methodology Overview," 3M Health Information Systems, Wallingford, CT, March, 2006.

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-P-1663-Attach-1.DOC

#1663

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

June 12, 2006

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

Re: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; (71 Federal Register 23995), April 25, 2006.

Dear Dr. McClellan:

On behalf of the Delaware Valley Healthcare Council of HAP (DVHC) which represents more than of the 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 views on the proposed rule "Medicare Program; Proposed changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates." The proposed rule for the Medicare Prospective Payment System (IPPS) includes some of the most significant changes to the Medicare payment system since the program's implementation in 1983. It has been extremely challenging to evaluate the potential impact of the proposed rule given the magnitude of the proposed changes, the lack of clarity with regard to the methodologies that would be used for various aspects of the payment system, inaccuracies in the published data and the lack of data that will be used for the occupational mix adjustment. Nevertheless we have worked closely with the American Hospital Association (AHA), the Hospital and Health System Association of Pennsylvania (HAP) and the Association of American Medical Colleges (AAMC) in analyzing the potential impact of the proposed rule on the hospitals in the Delaware Valley and in preparing these comments for you.

We believe that in order to ensure continued access to high quality health care for Medicare beneficiaries in the Delaware Valley adequate hospital payments under the Medicare IPPS are critical. Furthermore, the Medicare payment system needs to be one that is predictable and stable so that hospitals can plan effectively for the future. It is important that the Medicare prospective payment system be one that allows providers to reasonably estimate payments in advance to inform their budgeting, marketing, staffing and other key management decisions. The proposed system seems to be one that is potentially volatile as we discovered that the financial impact for hospitals in Southeastern PA. could range from a potential 70.8 percent

increase in payments to a 4.9 percent decrease in payments. We are concerned that the rule proposes to implement too many changes, too fast, and does not allow adequate time to fully understand the impact and implications of these changes for facilities over time. Even though DVHC supports the CMS in working toward meaningful improvement to the Medicare IPPS we think that revisions to the system need to be implemented if and only if there has been an opportunity to validate the methodology to confirm that it will not produce huge variations in payments from one year to the next. We have concerns that CMS' current proposal is too narrowly focused on the immediate future without a clear plan and mechanism for developing a payment model that would reward excellence, improve quality and provide safer care.

Our comments primarily focus on seven specific aspects of the proposed regulation: 1) Diagnosis Related Group (DRG) Relative Weights and Severity of Illness; 2) Long-term Acute Care Hospital DRGs; 3) Hospital Quality Data; 4) Outlier Threshold; 5) FTE Resident Count and Documentation; 6) Wage Index Budget Neutrality and Labor-related share; and 7) Other future concepts such as value based purchasing and health information technology. The Delaware Valley Healthcare Council (DVHC) requests that the Centers for Medicare and Medicaid Services (CMS) modify the proposed rule to ensure that inpatient facilities receive adequate reimbursement for their services as follows:

DRG Weights and Severity of Illness

The greatest variance in Medicare IPPS payments when comparing estimated FY 2006 with estimated FY 2007 comes from the impact of the Diagnostic Related Group weights. The DVHC shares a common goal with CMS in refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. However, more time is needed to understand the significant proposed policy changes, which according to an analysis conducted by the AHA would redistribute from $1.4 to $1.7 billion within the inpatient system. While DVHC and HAP support a move to cost-based weights, there are flaws in the CMS proposed methodology, modeling, and technical data used for refining the DRG payment system. Furthermore, 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. We caution the CMS about moving forward without the time to validate and make necessary adjustments to the proposed methodology to ensure that it does not create instability in the Medicare inpatient reimbursement system. Therefore, **DVHC in concert with the AHA and HAP requests a one-year delay in the implementation of changes to the DRG payment system to address vagaries in the analyses and to correct identified flaws before implementation.**

In addition, DHVC believes that more work must be done to assess the need and most appropriate approach for changing the patient classification system. The DVHC agrees with the position of the AHA and HAP that **the need for a new classification system is still unclear and we cannot support movement to a new classification system at this time because the best approach to changing the patient classification system has not been concretely and objectively demonstrated.** 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.

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. Thus, **DVHC agrees with HAP and the AHA's support of a simultaneous implementation of the DRG weight changes and new classification system in the event that CMS decides to adopt any changes to weights and classifications.**

Regardless of whether or not CMS agrees to delay the implementation of changes to the DRG payment system, we think that it is imperative that CMS provide a three-year transition for changes to the DRG payment system such as those in the proposed rule because of the magnitude of the potential change in reimbursement. Hospitals will need time to adjust to a revised system that could significantly impact their Medicare reimbursement. **It will be important for CMS to phase in a system for change to the DRG payments to hold the hospitals harmless and allow time for appropriate adjustment. The DVHC recommends a three-year transition period for implementation of a new DRG payment system.**

Specifically, we concur with HAP's recommendation that CMS provide a three-year transition with a blend of old DRG weights and new DRG weights. In the first year, hospitals would be paid based on an average of DRG weights: 75 percent of the old weights; 25 percent of the new weights. The second year would be 50 percent of each, and the third year would be 25 percent of the old weights and 75 percent of the new weights. Another method of transition is dampening the reduction of DRGs with significant decrease in relative weights similar to the dampening of APC weights in the outpatient PPS. Dampening could be more feasible - especially if a significant change to the classification system is made - because it does not require CMS to calculate using two different systems.

We further believe that a stop loss should be instituted as part of this transition. This would be similar to the approach currently used under the inpatient psychiatric PPS whereby no hospitals can receive less than 70 percent of what they would otherwise have been paid under the old system. In combination with the DRG blend or dampening, this would result in less significant losses in the first year than in the last year of the transition. To avoid having to run all claims under both DRG weights, CMS could establish a payment-to-cost ratio for each hospital in FY 2006 and use that as a base against which to compare payments under the new system.

Long-term Care Hospital (LTCH) DRGs

The AHA and DVHC are very concerned about the proposed re-weighting of the long-term care hospital (LTCH) DRGs for FY 2007. The projected payment cut resulting from the re-weighting – 1.4 percent – in combination with the payment cut resulting from the recent LTCH PPS final rule for 2007 – 7.1 percent – will cause substantial volatility for LTCH providers, and ultimately restrict access for patients needing long-term acute care services. It would be

extremely difficult for any provider group to withstand an 8.5 percent cut in one year. By pursuing these changes, CMS is misinterpreting MedPAC's estimate of 2006 Medicare margins for LTCHs and creating an extremely unstable regulatory environment for LTCHs. MedPAC projected a 7.8 percent Medicare margin for LTCHs in 2006 and recommended no market basket update for FY 2007. However, this MedPAC projection does not include two major policy changes that also decrease Medicare margins for LTCHs: the projection excludes the impact of the "25% Rule" limiting payments to co-located LTCHs and the new reductions associated with the LTCH short-stay outlier policy. Therefore, CMS goes too far with this proposal to reduce Medicare payments even further.

Given these considerations, we urge CMS to forgo the proposed 1.4 percent cut and instead implement the re-weighting in a budget-neutral manner. This would appropriately redistribute allocated funds among the payment categories to reflect current costs and omit the inappropriate modification of total payments due to unrelated considerations. It is irrational to treat the LTCH PPS differently than other Medicare payment systems by failing to re-weight the LTCH PPS in a budget-neutral manner.

At this time, CMS should focus on developing further patient and facility criteria for LTCHs to ensure that patients who are clinically suitable continue to have access to the LTCH setting. The DVHC along with the AHA strongly supports CMS' pursuit of a scientific foundation for these expanded criteria and are eager to review the recommendations currently under development by CMS' contractor the Research Triangle Institute.

Hospital Quality Data

CMS has proposed increasing the current reporting requirement from 10 to 21 quality measures. Hospitals must submit data on all 21 measures to the CMS data warehouse in order to qualify for the annual payment update (APU) for FY 2007. Reporting of the expanded quality measures is proposed to begin with January 1, 2006 discharges and 1st quarter data must be submitted to the CMS by August 15. If not submitted by this date hospitals' market basket update will be reduced by 2%. Preparation and submission of new data elements is a complex process and hospitals employ data vendors, hence, conforming to new data requirements is not as simple as turning on a switch as this data is not readily available to all hospitals. The retroactive nature of the proposal presents a reporting burden and hospitals would be required to spend additional resources without guarantee that the data would be accurate. Expenditure of time and resources with no guarantee of achieving accurate data is not desirable for CMS or hospitals. **DVHC recommends that submission of the new quality measures be prospective and begin with discharges after October 1, 2006.**

Chart Validation

It is important that the addition of new quality measures be constructed with accurate data. Since the primary basis for the publication of quality data is to serve as a tool for beneficiaries, providers and CMS to assess hospital performance, it is critical that the need for accurate data is balanced by consideration of administrative burden and cost to hospitals.

AHA has communicated with CMS problems associated with the proposed chart validation process that are beyond the control of hospitals and a penalty should not be assessed for problems not caused by the hospital. Any reduction in a hospital's Annual Payment Update (APU) is a grave concern and hospitals must be afforded a reasonable process to correct challenged data. **DVHC recommends that CMS institute a case-by-case reconsideration process for any hospital that is subject to a proposed APU reduction as result of chart validation. Also, we recommend that the expanded measures not be included in the formal validation process until after one full year of reporting of the additional measures.**

Reconsideration Process
CMS has indicated that hospitals that do not meet the APU requirements for the applicable fiscal year may appeal this determination to the Provider Reimbursement Review Board and that any such requests for FY 2007 must be made by no later than November 1, 2006. Further, CMS is seeking public comment on the need for a more structured reconsideration process for FY 2008 and subsequent year appeals. Moving the effective date to discharges after July 1, 2006 can avoid many appeals that would result from a retrospective submission date and CMS should not require these data appeals to be held with the Provider Reimbursement Review Board. To do so will overwhelm the current PRRB review process and grind all appeals to a halt.

The DVHC recommends that CMS establish a separate process for reconsideration that requires supportable and reasonable evidence for the start up year. Process could require written notification by a senior officer that details the reasons for the reconsideration request (e.g., vendor transmission failures; charts sent to the CDAC were misplaced or lost). The Quality Improvement Organizations have considerable experience with this type of data and can more effectively conduct this review function, as it is consistent with the QIP's quality improvement efforts.

Development of Future Measures
The DRA requires the expansion to other quality measures. The types of measures that CMS has indicated may be added include: the HCAHPS® patient perception of care survey findings; structure measures as detailed in the recent Institute of Medicine report *Performance Measurement: Accelerating Improvement;* and outcome measures, specifically 30-day mortality for acute myocardial infarction and heart failure patients. **The DVHC recommends that CMS should consider measures used by HQA for public reporting.**

Hospital-specific patient outcomes reports have been publicly available in Pennsylvania for over 20 years and these hospital performance reports cover over 30-based code conditions and 19 DRGs. Based on the 20 years of experience, Pennsylvania hospitals do not believe that use of a 30-day risk-adjusted mortality for acute myocardial infarction and heart failure patients represents the best outcome measures for use as overall quality indicator. **CMS should delay implementation of such measures and continue collaboration with the Hospital Quality Alliance partners to identify outcome measures that better reflect the quality of hospital care.**

CMS states that HCAHPS® results will be considered as part of a future measure expansion. HCAHPS® offer an opportunity to incorporate patient satisfaction measures but like any new measurement tool there must be an implementation schedule that provides for sufficient time for hospitals to become familiar with data submission and how to use as a feedback tool. Such an approach allows for development of more accurate data.

Outlier Threshold

Year after year, the hospital community is in the position of having to argue against the CMS plan to increase the outlier threshold. Once again the DVHC strongly opposes CMS' proposed 8.2% increase in the outlier threshold and urges CMS to establish an appropriate outlier threshold to ensure satisfactory payments for outlier cases. The purpose of providing extra payments for cases with unusually high costs that are determined to be outliers is both to limit the hospitals' financial risk from extreme costs and to remove any financial disincentive for treating Medicare patients with especially serious conditions. We believe that an increase in the outlier threshold from $23,600 to $25,530 as proposed in the rule for FY 2007, will make it even more difficult for hospitals to qualify for outlier payments and will put them at greater risk when treating extraordinary cases. Furthermore, CMS has continued to under spend the 5.1% that is set-aside for outliers. It is estimated that in FY 2005 CMS under spent the funds set aside for outliers by an estimated $1.15 billion and spent only 3.5 percent, or $1.3 billion less that the funds withheld in 2004. Given that CMS did not even spend the entire pool of funds set aside in 2006 with an outlier threshold of $23,600, we recommend that the outlier threshold be lowered not increased. According to an analysis conducted by the AHA, CMS underspent the funds set aside for outliers by an estimated $3 billion over FYs 2004, 2005 and 2006. This is a real cut in payments to hospitals that cannot be recouped. If CMS leaves the threshold at $25,530, rather than dropping it to $24,000 as recommended by the AHA, we believe that CMS will again significantly underspend by over $300 million. It is critical that hospitals receive special payments to cover the extremely high-costs associated with extraordinary cases. **We urge CMS to guarantee that hospitals receive the full 5.1 percent of payments that will be withheld from base inpatient payments by lowering the outlier threshold.**

FTE Resident Count and Documentation

The DVHC represents four Academic Medical Centers in the Philadelphia area and we have concerns about the negative impact that 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 would have on these medical educational programs. In the proposed rule, CMS indicated that "with respect to training in non-hospital settings, the time that residents spend in non-patient care activities as part of an approved program, including didactic activities, cannot be included in a hospital's direct GME or IME FTE resident count." 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". 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. We believe that the position that CMS is proposing to take on this issue is one of interpretation and we strongly disagree with it. The statutory requirement is payment for "activities relating to patient care" and we assert that participation in journals, conferences, workshops etc. as part of a training program, are all "patient care related activities" and therefore should be included in the GME and the IME. **Therefore we strongly urge CMS to rescind the proposal to exclude medical resident time spent in didactic activities from the calculation of Medicare direct graduate medical education (DGME) and indirect medical education (IME) payments.**

Wage Index Budget Neutrality

CMS eliminates the Critical Access Hospital (CAH) data from the wage index file it uses to compute the national average hourly wage (NAHW). For FY 2007, 1,191 CAHs representing approximately 24 percent of all inpatient PPS hospitals (as of FY 2000) – 55 percent of all rural hospitals in FY 2000 – have been eliminated from the file. Because CAHs have lower average hourly wages (AHWs) than the average PPS hospital, the elimination of this data results in an overstated NAHW. While the NAHW has been increasing, the systematic withdrawal of low-wage hospitals has artificially inflated the NAHW to some extent. This artificial increase is included in the negative budget neutrality adjustment that consequently reduces payment, resulting in the national inpatient PPS operating payments being understated by an estimated $1.52 billion over five years (2003-2007).

Recently, the DVHC analyzed the impact of excluding the approximately 1,200 Critical Access Hospitals (CAHs) from the wage index file. The results of this analysis indicated that the National Average Hourly Wage for FFY 2007 is overstated by .707% since these small lower paying hospitals have been deleted from the wage index file. This results in an understatement of the various wage indexes throughout the country. For hospitals in the Philadelphia CBSA, any overstatement of the National Average Wage translates into a decreased wage index and ultimately lowers Medicare reimbursement.

MedPAC has previously recommended that the CAH data be included in the wage index file. We think that CMS should follow the MedPAC recommendation and **therefore we ask CMS to use estimated CAH data to include in the FFY 2007 wage index file to compute the National Average Hourly wage.** A Medicare occupational mix factor of 1.0000 could be assigned to these hospitals for purposes of the wage index calculation. In addition, we suggest that CMS obtain wage index data from CAHs and subject the data to the same rigorous intermediary review as is done for Medicare IPPS hospitals and to include the CAH data in future wage index calculations at least in determining the National Average Hourly Wage.

Lastly, in order to rectify the situation that has resulted in underpayments to hospitals based on the removal of the CAH wage index data from the wage index files from FFY 2003-2006, **we concur with the AHA recommendation that CMS should apply a positive budget neutrality adjustment in FY 2007 to compensate for the previous underpayments.**

Labor Share

Last year, DVHC communicated to CMS that the reduction of the labor-related share from 71.1 percent to 69.7 percent was problematic for hospitals in the Philadelphia Core Based Statistical Area (CBSA). According to the proposed rule, the labor related share would remain at the 69.7 percent that was implemented in FY 2006. This continuation of the reduced labor related share has a negative financial impact for hospitals in our region that are under severe financial stress. **We recommend that CMS return to the previously established labor share of 71.1 percent for hospitals with a wage index greater than one.**

Other Future Concepts

Health Information Technology (HIT)

In the proposed rule, the CMS considers the role of interoperable health information technology (HIT) systems in increasing the quality of hospital services while avoiding unnecessary costs. CMS requested comments on the following:

- statutory authority to encourage the adoption and the use of HIT;
- the appropriate role of HIT in any value-based purchasing program, beyond the intrinsic incentives of the IPPS, to provide efficient care, encourage the avoidance of unnecessary costs, and increase quality of care; and
- the promotion of the use of effective HIT through hospital conditions of participation, perhaps by adding a requirement that hospitals use HIT that is compliant with and certified in its use of the HIT standards adopted by the Secretary of Health and Human Services.

The DVHC strongly believes that HIT is a very important tool for improving the safety and quality of health care, and our members are committed to adopting HIT as part of their quality improvement strategies. They also view HIT as a public good that requires a shared investment between the providers and purchasers of care. However, HIT is a very costly tool, requiring both upfront and ongoing spending. The proposed rule highlights the anticipated benefits of HIT as laid out by the RAND Corporation. However, it overlooks another of the study's major findings – that the financial benefits of IT investments accrue more to the payers and purchasers of care than the hospitals and health systems that pay for them.[1]

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[1] R. Hillestad, J. Bigelow, A. Bower, F. Girosi, R. Meili, R. Scoville, and R. Taylor. "Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, and Costs," *Health Affairs*, September 1, 2005; 24(5): 1103 - 1117.

Simply put, our members have not seen financial returns greater than the costs of implementing clinical IT systems, particularly in the short term. They adopt clinical IT because it is the right thing to do for improving patient safety and quality of care, not because it saves them money. Thus, while IT may be a "normal cost of doing business," it systematically raises those costs. **Given that they reap many of the financial benefits of IT, the DVHC agrees with the AHA that the payers and purchasers of care should share in the costs of HIT.**

Conditions of Participation

DVHC in collaboration with the AHA concluded that it does not make any sense to have the use of HIT as a part of the hospital conditions of participation (COP). The COPs address the basic, essential infrastructure needed to ensure patient safety and must be clearly understood. Successful implementation of quality-enhancing IT requires careful planning and changes to work processes. The hospital field is still developing its understanding of how to implement these systems correctly. In addition, the commercial HIT applications available do not always meet hospitals' needs. The evidence on HIT does not yet support this level of requirement and would amount to an unfunded mandate.

Value-Based Purchasing

Plan for Implementing Hospital Value-Based Purchasing in FY 2009

In its proposed rule, CMS describes several of its efforts over the past several years to improve the quality and efficiency of care delivered to Medicare beneficiaries in America's hospitals. Reference is made to CMS' participation in the Hospital Quality Alliance as a strategy to encourage hospital accountability by making comparative information about hospital performance publicly available and the testing of innovative approaches to improving quality through pilot project such as the Premier Hospital Quality Incentive Demonstration. Pennsylvania hospitals have actively participated in both projects. CMS requested comment on the various components of such a plan (measure development and refinement; data infrastructure; development of incentive methods; and public reporting.

In absence of a specific proposal, meaningful comments cannot be presented. **DVHC recommends that CMS further review the Premier Hospital Quality Incentive Demonstration pilot project, and work with stakeholder groups to propose and model several alternative methods that can be published for a meaningful public review and comment.**

Health IT can play a role in reducing the burden of quality reporting. Presently, electronic health records (EHRs) and other clinical IT systems do not automatically generate quality measures. Most hospitals still require special calculations – including expensive manual chart abstraction and use of third-party contractors – to submit quality data. CMS could advance the quality agenda by investing in the development of algorithms for the calculation of the quality measures it wants reported from EHRs and encouraging vendors to include them in their products.

Rather than including health IT in a value-based purchasing program, **CMS could support adoption of health IT through a payment adjustment funded with new money.** It seems as though at this time a Medicare payment adjustment would be a good mechanism for CMS to employ to provide an incentive for HIT as opposed to it being a hospital condition of performance or one of the pay for performance quality measures. We have concerns about the fact that hospitals are at varying degrees of implementation of HIT and there is a capital expenditure involved.

Thank you for the opportunity to express our views on this important regulation as it will greatly impact on hospital services received by Medicare beneficiaries in the Philadelphia area as well as other parts of the Commonwealth and the nation. We want to emphasize that although we support many of the proposed rule's provisions, we have serious concerns about the proposed changes to the DRG weights and classifications. We urge CMS to consider a one-year delay in implementation to allow the hospital community the opportunity to work with CMS on the development of a predictable, stable system of Medicare reimbursement for the future. Furthermore if significant changes to the DRG payment system are ultimately adopted, there must be a three- year transition period. 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) 575-3755.

Sincerely,

Andrew Wigglesworth
President

Submitter : **Ms. Kay Marsyla** **Date: 06/12/2006**

Organization : **Trinity Health West MI Finance Shared Services**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1664-Attach-1.DOC

#1664

TRINITY HEALTH

June 12, 2006

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

West Michigan Finance Shared Services
1820 44th Street SE
Kentwood, MI 49508

Re: FY 2007 Medicare Inpatient Prospective Payment System Proposed Rule CMS-1488-P

Dear Dr. McClellan:

Trinity Health West Michigan Finance Shared Services (WMFSS), comprised of Battle Creek Health System (23-0075), Mercy General Health Partners (23-0004) and Saint Mary's Health Care (23-0059), welcomes this opportunity to comment to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule to update the Inpatient Prospective Payment System for FY 2007.

WMFSS has several key concerns regarding the proposed discharge notice as summarized below:

Major Changes to Diagnosis-Related Group (DRG) Classification System

***(Federal Register* Pages 24004-24049)**

The CMS is proposing the most significant changes to the calculation of the DRG relative weights since the beginning of the PPS. These changes would result in a dramatic redistribution among both the DRGs and hospitals. For FY 2007, the CMS proposes two major changes: use of hospital-specific relative values (HSRVs) and a modified version of cost-based weights instead of weights based on charges. In addition, the CMS proposes to refine the DRGs to account for patient acuity, with implementation in FY 2008 ***or earlier***.

The revised DRG weights will result in a **significant redistribution** of Medicare inpatient payments among hospitals. Although on a statewide basis, the FY 2007 CMI changes will have a minimal impact, a recent analysis indicates that the impact for individual hospitals will vary from a decrease of approximately 11 percent for some to an increase of approximately 10 percent for others, depending upon the specific mix of services provided at each hospital. For FY 2007, in general, weights for the medical DRGs are increasing while those for surgical DRGs are decreasing significantly.

WMFSS is opposed to the CMS' proposed changes primarily due to a fundamental flaw in the methodology used by the CMS in determining the new relative weights. The CMS inappropriately made the following assumptions:

- A consistent mark-up between hospital ancillary departments, which is not the case. For example, high-cost surgical implants, such as cardiac stents and artificial hips and knees, typically have a significantly lower mark-up than lower cost items, such as general surgical supplies. This results in distorting the relative weights when charges are converted to cost using the same ratio for all departments, and results in inappropriately reducing the relative weights for the high cost surgical implants

- A consistent cost-to-charge ratio for all hospitals throughout the country, which also is not the case. Hospital cost to charge ratios vary widely based on each individual hospital's cost and charge structure. Applying an average cost to charge ratio results in a significant distortion in the calculated hospital cost and the DRGs treated at those hospitals. As a result, hospitals that have a cost to charge ratio higher than the average used by the CMS would have too little cost included in the CMS analysis, while hospitals with ratios lower than the average used by the CMS would have too much cost included in the CMS analysis.

- A further concern is that cost and cost allocation statistics have not been audited in the past eight to ten years as changes created very little impact to the bottom line for the fiscal intermediaries. Even though the hospitals should still be filing accurately, there has been very little oversight in this area.

In addition, the CMS is proposing to implement Consolidated Severity-Adjusted DRGs in FY 2008 *or sooner*. The CMS estimates that the implementation of refined DRGs will, in some instances, offset the impact of the new weighting methodology proposed for FY 2007.

WMFSS opposes the proposed recalculation of DRG weights as it is based on flawed methodology. We urge the CMS to delay implementation of the revised DRG weighting system. If the CMS is utilizing the same "cost" methodology for establishing the FY 2008 weights under the consolidated severity-adjusted DRGs, those weights are equally flawed.

More time needs to be spent on evaluating and refining both of these significant changes. In addition, if these changes do go thru, a transition from the old to the new would give hospitals the best chance of surviving and adapting in this changing environment. Without the hospitals being able to budget such changes, the financial viability becomes severely compromised.

Update of Standardized Operating Amount

(*Federal Register* pages 24419 – 24420)

Although the CMS is proposing a full 3.4 percent market basket update for hospitals that submit quality data WMFSS believes this update is inadequate. **Recent data for 1998 to 2006 indicates that on a cumulative basis, hospital costs increased 37.9 percent during which time Medicare payments increased only 19.7 percent, resulting in an estimated payment shortfall of $4.4 billion for Michigan hospitals.** This is particularly alarming given the fact that approximately 57 percent of Michigan hospitals lose money providing services to Medicare patients. Based on the most current data available, the average Medicare margin for Michigan hospitals is just slightly above break-even, at 0.3 percent. On an aggregate basis, it is anticipated that hospitals will experience further deterioration in their Medicare margins during FY 2007, even without the negative impact that some hospitals will experience due to changes included in the FY 2007 inpatient proposed rule. The continual under-funding by the CMS will further threaten the financial viability of Michigan's nonprofit hospitals and their ability to provide services to Medicare beneficiaries and others.

In addition, WMFSS believes that it is unconscionable for the CMS to require that hospitals submit data on the 21 expanded quality measures on a retrospective basis for discharges that occurred during the first calendar quarter of 2006. Based on the proposed rule, hospitals will be required to submit this data to the Quality Improvement Organization (QIO) Clinical Warehouse by August 15, 2006. **If the IPPS rule is finalized August 1, 2006, hospitals will only have 14 days to code the records and submit or risk losing 2.0% of their FY 2007 update.**

Cost Outliers

(*Federal Register* pages 24149 – 24151)

The CMS is proposing to increase the fixed-loss cost outlier threshold from the current $23,600 to $25,530, which represents an 8.2 percent increase. Although a 5.1 percent pool was set aside each year, the CMS estimates that it spent only 4.1 percent for outliers in FY 2005 and will spend 4.7 percent in FY 2006. As a result WMFSS, the Michigan Hospital Association (MHA), the American Hospital Association (AHA) and other state associations believe the increase in the outlier threshold is unwarranted. **Due to the fact that the CMS did not spend the entire pool of funds set aside for outlier payments during FY 2005 and 2006, we urge the CMS to maintain the outlier threshold at the current level of $23,600.**

Graduate Medical Education

(*Federal Register* pages 24107 – 24115)

The proposed rule makes a number of changes to direct graduate medical education (GME) and indirect medical education (IME), which will impact teaching hospitals.

IME Adjustment — As required by section 502 of the MMA, CMS reduces the IME payment adjustment multiplier from 1.35 to 1.32. This will reduce the IME adjustment from a 5.55 percent to 5.38 percent.

Exclusion of Didactic Training — The proposed rule states that resident training that occurs at non-hospital sites must be related to patient care if a hospital includes time for GME and IME payment purposes. Resident time spent in didactic activities would be specifically excluded. Providing residents with didactic lectures, i.e. grand rounds, medical section meetings, morbidity and mortality lectures, morning reports or literature/journal review activities to name a few; is an integral and required component in training competent and compassionate physicians.

As an integral training component, didactic lectures provide the setting where residents may expand their medical knowledge in specific evidenced based treatment plans which may provide a patient with the most appropriate and cost effective care. In another didactic setting, the resident will be challenged by the teaching faculty to critically review literature for a greater understanding of a particular disease which affects a particular patient population. The knowledge gleaned from each of these well organized and structured activities provides residents with the necessary tools to apply in the various clinical settings of patient care they will encounter. Without these activities, residents may approach patients with a limited medical school "book knowledge" that may ultimately impact patient care safety.

The CMS noted that its statement in a previous letter on this topic "implying that didactic time spent in non-hospital settings could be counted for direct GME and IME ... was inaccurate." The CMS also noted that time spent in these activities could be counted for GME purposes if they occur in a hospital; however, the counting prohibition applies for IME payments regardless of where the educational activity occurs.

As a result of "clarifications" CMS has issued in recent years, for a provider to include in its FTE count for IME and GME purposes rotations to the non-provider setting, the provider is required to compensate the non-provider setting for the cost incurred by the non-provider setting in teaching and supervision activities. Moreover, CMS has stated that the provider is required to compensate the non-provider setting for cost related to the didactic time, not for the time spent in the provision of patient care, since the non-provider setting already is compensated for the provision of patient care. The proposed rule, therefore, establishes a paradox: The very didactic

time for which CMS requires the provider to compensate the non-provider is the time that the provider cannot include in its FTE count. Accordingly, if a provider does not compensate the non-provider setting for costs related to didactic time, the provider should have the right to claim the non-didactic time in its FTE count.

An additional issue in excluding the didactic training is looking at the percentage of time a resident spends on didactic training versus patient care. Residents do not work a standard FTE of 2080 hours per year. Even if all the didactic training for a resident in a given year would be removed from actual time the resident works, the resident would still qualify as a full time equivalent. The administrative burden to provide documentation for hospitals would be extensive.

The proposed rule also includes several minor technical changes relating to documentation requirements, GME aggregation agreements and determination of per resident amounts when teaching hospitals merge.

Although the reduction in the IME payment adjustment for FY 2007 is based upon a statutory change included in the BIPA, the WMFSS opposes this reduction in IME payments and recommends that the CMS maintain IME payments at the current level. This payment reduction will further threaten the financial viability of Michigan's teaching hospitals. Failure to adequately fund teaching programs will result in closures of these programs, as hospitals cannot continue to operate graduate medical education programs, which are vital to ensuring an adequate supply of future physicians, at a financial loss.

We urge CMS to withdraw the change in the proposed rule relating to the counting of didactic time for purposes of GME and IME payments and recognize the integral nature of these activities to the patient care experiences of residents during their residency programs.

Overall Financial Impact of FY 2007 Proposals on Hospitals

According to the CMS impact assessment, the overall changes would provide, on average, a 3.4 percent payment increase to hospitals. Urban hospitals would receive a 3.0 percent average increase, while rural hospitals would receive a 6.7 percent average increase. The CMS estimates that the total impact of these changes for FY 2007 operating payments will result in a $3.3 billion increase over FY 2006.

Although overall, the changes proposed are projected to result in a 3.4 percent payment increase, on average, WMFSS is extremely concerned about the major impact of the changes on individual hospitals. **While some Michigan hospitals are projected to experience increases of 10 percent, others will experience decreases in their total Medicare inpatient payments, especially those providing services with high cost implants.** The unknown impact of the occupational mix adjustment, based on data submitted June 1, adds another level of uncertainty to the hospitals' ability to estimate their Medicare inpatient payments effective October 1, 2006.

OTHER FUTURE CONCEPTS

Health Care Information Transparency Initiative

(Federal Register pages 24120 – 24121)

WMFSS recommends the CMS convene a workshop of AHA and Medicare beneficiaries to identify the core issue to be resolved by the transparency initiative. Once that is identified, the hospital industry can provide input to resolve the problem.

Another option the CMS offered is establishing a Medicare condition of participation to post prices on assistance programs for uninsured. While many hospitals are moving toward transparency in this area, including this as a condition of participation seems punitive and will not resolve the CMS core issue of what hospitals are doing to assist the uninsured. It is important for the CMS to understand that the income level of the uninsured varies by community and charity care policies will also vary. Therefore, the WMFSS objects to the CMS expanding the conditions of participation to include posting of prices on assistance programs to the uninsured.

Value-based Purchasing

(*Federal Register* pages 24095 – 24100)

WMFSS encourages the CMS to develop a workgroup comprised of industry representatives, including physicians, to develop pay-for-performance measures that will work for all parties.

Health Information Technology

(*Federal Register* pages 24100 – 24101)

WMFSS encourages the expansion and increased use of IT in healthcare and believes IT improvement would increase the efficiency while improving outcomes within the healthcare system. However, we believe this is an unfunded mandate and that the CMS should provide additional funding specifically for IT improvements in hospitals, similar to funds provided for hospital financing of buildings and equipment.

Hospital-Acquired Infections

(*Federal Register* Page 24100)

In the inpatient PPS, infections acquired in the hospital and other complications, can sometimes trigger higher payments, either as payment outliers or by assignment to a higher-paying DRG. Approximately 121 sets of DRGs are split based on the presence or absence of a complication or comorbidity (CC), and DRGs with a complication or comorbidity generate higher Medicare payments.

By Oct. 1, 2007, the DRA requires the CMS to identify at least two preventable conditions that categorize a patient to a CC DRG. The CMS wants hospitals to identify conditions that either occur frequently or their presence results in significantly higher costs to treat the patient. The CMS is proposing, effective October 1, 2008, hospitals would not receive additional payment for cases in which one of the selected conditions was not present on admission. Instead, the case would be paid as though the hospital-acquired complication was not present.

The DRA also requires hospitals to submit the secondary diagnoses that are present at admission when reporting payment information for discharges on or after October 1, 2007.

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

WMFSS believes the CMS proposal that complications are solely the result of hospital actions is fundamentally flawed. To reduce hospital payments for a condition present upon admission, but not

documented, is too punitive. Rather, WMFSS recommends that the CMS expand demonstration projects such as the MHA Keystone Center to truly improve patient safety and quality for Medicare and all patients.

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

Sincerely,

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

Submitter : **Mr. Shaw Seely** **Date: 06/12/2006**

Organization : **Baptist Health Systems**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1488-P-1665-Attach-1.DOC

#1665

Shaw Seely, CPA
Director ∃ Reimbursement

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:

We 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.

We at Baptist Health Systems (BHS) represent three hospitals in Jacksonville, Florida. Our hospitals are characterized by a broad spectrum of size and provider types. Our hospital in Nassau County is under 100 beds and although deemed rural by the state, it is in the same CBSA as our other hospitals. Our second satellite hospital in Jacksonville Beach is slightly over 100 beds. The third hospital in the system is considered our flagship hospital and is composed of 600+ beds with an approved graduate medical education program. All BHS hospitals are full service, general acute care, non-profit hospitals.

We are providing comments because the rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since its inception. It also proposes refining the DRGs to account for patient severity in a separate phase. While we support many of the proposed rule's provisions, we have serious concerns about the proposed changes to the DRG weights and classifications.

Industry associations have provided us with estimated effects on reimbursement for each of our hospitals. The estimated effects for us are both dramatic in dollars and inconsistent between hospitals and between phases. These violent swings in Medicare reimbursements

for our hospitals would create havoc financially and operationally while making the budgeting process and long range planning virtually impossible. We fear the estimated negative effects are actually understated.

Our reluctance in accepting these estimates, especially the estimates of the CS-DRG system, is that we believe adequate estimates will require much more time to prepare and validate and are limited based on the lack of sufficient detail in the data base. Like most hospitals, we enter the minimum required coding on our claims that ensures a proper DRG assignment. The depth of the coding information available on the bills is not sufficient to properly determine severity levels.

We do not oppose meaningful improvements to Medicare's inpatient PPS. However, more time is needed to understand the significance of the proposed policy changes by both CMS and by the individual hospitals. We have seen estimates that these changes would redistribute from $1.4 to $1.7 billion within the inpatient system. Industry analysis shows the impact of the proposed changes to be highly unstable, with small changes in method leading to large changes in hospital payment which we at Baptist Health Systems will apparently be victims of also.

We have read and studied the pertinent sections of the proposed rule. We simply are not convinced that there is a compelling argument for adopting these dramatic changes. We believe the alternatives have not been rigorously reviewed and the validity of CMS' proposals to improve the DRG weights and classification system was not sufficiently compelling as the few scarce arguments were ineffectively presented. The proposed rule appears to be primarily a response to the MedPAC recommendations. The proposed changes are an attempt to adopt a simplified method of that presented by MedPAC but the end results were not validated and the resulting short cut does not accomplish the stated intentions.

If the proposed changes to the DRG system are principally to discourage the proliferation of physician-owned, limited service hospitals, there are other alternatives available which would not cause upheaval to the rest of the hospital industry. Payment changes alone will not remove the inappropriate incentives created by physician self-referral to limited-service hospitals. Physicians will still have the ability and incentive to steer financially attractive patients to facilities they own, avoid serving low-income patients, practice similar forms of selection for outpatient services and drive up utilization for services.

CMS should rigorously examine the investment structures of physician-owned, limited-service hospitals. It is imperative that CMS continue the suspension of issuing new provider numbers to physician-owned, limited-service hospitals. We believe adequate restrictions on the corporate identity and inter-relationships of the corporations and physicians can limit further growth of these cannibalizing type providers.

Specifically, we propose the following:

- **One-year Delay:** At minimum, a one-year delay in the proposed DRG changes given 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. Below is a description of several of these flaws:

    - CMS hospital-weighted rather than charge-weighted the calculation of the CCRs which in turn are used to calculate the scaling factors used to convert the charge-based relative weights to "cost." This approach gives an equal weight to each hospital in the national cost-to-charge ratio calculation even though hospitals can range in size from fewer than 25 to more than 1,000 beds. This method is inconsistent with the method of averaging used to develop the cost center-specific DRG weights to which the scaling factors are applied.

    - CMS proposes to aggregate charges into 10 cost centers for each DRG, then applies a cost-center level CCR (derived from the cost reports) to charge figures (from claims data). Many hospitals, including all of Baptist Health System providers, do not group cost report data into cost centers based on revenue codes as detailed on the claims. A single cost center line, even among the 10 designated, may incorporate multiple revenue codes on a claim and likewise, a single revenue code may be found in two or three cost center lines (and thus several of the designated 10 cost centers) on the cost report. Before an application of these RCCs from the cost report would be valid, the cost reports would need to be amended to regroup costs, revenues, and statistics to match the revenue codes used in patient billing claims.

- **A New Classification System-Consolidated Severity:** We do not support a new classification system at this time, 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. Even more fundamentally, today's DRG system was created to distinguish the resource use required among patients. It has been modified over time to reflect changes in clinical practice and technology. The APR-DRG system is based on severity of illness, not necessarily the resource use required. The impact of a move to CS-DRGs –or any new system– would at a minimum create :

- Intense retraining costs not only of the Coding personnel but also virtually every aspect of the inpatient clinical services including nursing, medical staff, and ancillary service personnel and management.

- Outside of the actual direct effect on payments, financial management concerns include Information Systems, budgeting and both short term and long term planning of net income and services.
- Complexities in calculating the effects due to lack of specifics of CMS's methodology compounded by the lack of availability of the new GROUPER to hospitals.

- Significant ramifications to hospitals from other payors, equally immeasurable, that base payment off the Medicare system methods.

- Significant increase in federal administrative costs involving both initial change over and maintaining/processing claims data.

- **Simultaneous Adoption of Any Changes to Weights and Classifications:** If the need for a new, more effective classification system is clearly demonstrated and developed after other alternatives have been studied, it should be implemented simultaneously with the new weighting system to provide better predictability and smooth the volatility created by these two 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.

- **Budget Neutrality Adjustment:** Because the proposed rule did not specify a methodology for calculating an adjustment and because the payment effects have not been adequately determined, any reduction would only be conjecture by CMS on the hospitals' responses and coding behavior. No adjustment should be made in the first year of implementation until actual data indicates an adjustment is needed.

- **Stop Loss Provision:** As was instituted with other major changes made in Medicare payment systems, a stop loss provision should be included as part of the three year transition. The stop loss should guarantee no hospital would receive less than 70 percent of what they would have otherwise been paid under the old system.

- **Outlier Payments:** The proposed fixed-loss cost outlier threshold of $25,530 will likely result in CMS under spending once again, as has historically been documented. Because these outlier dollars are withheld from hospitals to fund these payments, CMS should be more aggressive in ensuring the withheld amounts are actually paid out. By lowering the threshold, we believe CMS can demonstrate good faith effort in ensuring these funds are not underpaid as seen in 2004, 2005, and now projected for 2006.

- **Wage Index Budget Neutrality:** The National Average Hourly Wage (NAHW) is materially overstated due to the elimination of the CAH hospitals. Because increases in the NAHW are offset with the application of a negative budget neutrality adjustment, the national inpatient PPS operating payments are understated. This reduction in payments is artificially created through data manipulation alone; NAHW increases due to the CAHs should not be factored into the budget neutrality adjustment. An alternative would be to stop eliminating CAH hospitals from the data base in calculating NAHW.

- **Occupational Mix Adjustment:** We understand the time pressures on CMS created by the recent court decision and directives. We accept that the YE 2007 application of the first calendar quarter 2006 survey will be finalized without adequate time for review or corrections. However, because we can attest to the significant confusion by hospitals created by the rush applied to the surveys, we strongly suggest CMS allow hospitals to turn in both calendar quarters in August to permit corrections of data and filing by previously non-responsive hospitals.

Again, we appreciate the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me at (904) 202-2874 or shaw.seely@bmcjax.com.

Sincerely,

Shaw Seely, CPA
Director of Reimbursement
Baptist Health Systems

Submitter : **Mr. Kenneth Becker** **Date: 06/12/2006**

Organization : **Catholic Health East**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1488-P-1666-Attach-1.PDF

#1666

CATHOLIC HEALTH EAST

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June 12, 2006

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

Re: CMS-1488-P – Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates *(71 Federal Register 23996).*

Dear Dr. McClellan:

On behalf of Catholic Health East (CHE), I would like to thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule regarding the Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2007 Rates, published April 25, 2006 in the *Federal Register*. Catholic Health East (CHE) is a multi-institutional, Catholic health system located in 11 eastern states from Maine to Florida, including 33 acute care facilities.

Increased payment accuracy in the Medicare system has long been a priority of Congress, CMS, and the Medicare Payment Advisory Commission (MedPAC). In its most recent Report to Congress, MedPAC "focuses on improving Medicare payment accuracy and calibrating payment adequacy to the efficient provider." To achieve a higher degree of payment accuracy in the IPPS, MedPAC recommended four specific changes in March 2005: cost-based weights, hospital specific relative values, improved severity adjustment, and DRG specific outlier financing. These recommendations are not new. MedPAC and its predecessor, ProPAC, have long recommended both the refinement of DRGs and the revision of the methodology for calculating the relative weights. In fact, the recommendations MedPAC made in March 2005 are essentially identical to the recommendations ProPAC made in 1995.

CMS's proposed rule is largely a response to the concerns about payment accuracy raised by MedPAC and echoed in Congress. CMS states that, in developing the proposed rule, it relied heavily upon MedPAC's recommendations, including the proposal to move towards cost-based weights. However, in the proposed rule, CMS did not implement MedPAC's recommendations.

In addition, MedPAC had stated that all four of their suggested changes should be implemented at the same time so that most categories of hospitals would experience only small changes in payments, the exception being physician-owned specialty hospitals. Instead, CMS is proposing to implement the changes piecemeal: the hospital specific relative value cost based weights in FY 2007, and the consolidated severity adjusted DRGs in FY 2008.

CHE strongly supports improving the accuracy and fairness of the Medicare inpatient hospital prospective payment system. However, a number of researchers and other analysts reviewing CMS's proposed rule have found that the new CMS payment methodology is, at best, no more accurate and, in many instances, is less accurate than the current system. In addition, they have found that a number of other approaches to classifying DRGs and developing weights would be far more accurate. Therefore we have strong reservations about the implementation of the proposed rule.

HSRV WEIGHTS

Statisticians, economists and other researchers have a variety of analytical tools at their disposal. Each of these tools has different purposes and produces different types of results. However, researchers must be careful not to choose a particular analytical tool simply because it will prove their preconceived notions or produce the desired outcomes.

CMS is proposing to move from a charge based reimbursement structure to one that is based on costs. Because there can be large variability in the mark-up of charges for services both within and among individual hospitals, moving to a cost based system should, in theory, better align reimbursements with costs of providing care. In crafting the proposed IPPS rule, it appears CMS began with the premise that Medicare should pay less for some "high weight" DRGs, such as cardiac care, and more for some "low weight" DRGs such as eye disorders. Ultimately, the HSRV cost based weights proposed by CMS will shift money away from DRGs that, in general, have a lower cost to charge ratio, such as surgical DRGs to ones that have a higher cost to charge ratio, such as medical DRGs. While CHE is, in theory, supportive of the proposal to move to a cost based reimbursement system, we have the following serious concerns about the specific method proposed by CMS.

CMS provided a detailed explanation of the mathematical process they utilized to develop the proposed cost based reimbursement system. Briefly, CMS utilized FY 2003 hospital cost report data and FY 2004 claims data from MedPAR files as the basis for the cost based reimbursement system. CMS divided the charges in each DRG into ten cost centers and then calculated a hospital-specific cost center weight for each of the ten cost centers for each hospital and each DRG. Essentially this weight is the ratio of the

average cost in each cost center for cases in the particular DRG compared to the average cost in that cost center for all of the hospital's Medicare cases. CMS then combined the individual hospital cost center weights for each DRG to get a set of ten national cost center weights for each DRG. They combined the ten cost center weights for each DRG into a single DRG weight by applying a scaling factor to each of the separate cost center weights and summing them. The scaling factor represents the percentage of total national costs accounted for by each cost center. To determine the percentage of each cost center, CMS converted the charges in each cost center to costs using national cost center charge ratios developed from FY 2003 cost report data. Finally, CMS normalized the national weights as required by law so that the annual recalibration process does not increase or decrease spending. This approach has a number of inherent problems.

First, the data used by CMS to develop the HSRV cost based weights is problematic and therefore we believe the final DRG weights are skewed as a result. CMS is relying on FY 2003 hospital cost report data and FY 2004 charge data from MedPAR to develop the HSRV cost based weights. Unfortunately, the claims data from the MedPAR files and the cost report data are not aligned. Hospitals post charges in MedPAR differently from where they report charges in cost reports; therefore, any cost to charge ratios developed from the cost reports applied to MedPAR data will result in distorted DRG weights. For example, some hospitals reported costs for new technologies under routine cost centers in the cost report, while the matching charges were reported under ancillary cost centers. This understates the cost in the supply category and under-weights the corresponding DRGs.

Additionally, the data from the FY 2003 hospital cost report data and FY 2004 MedPAR claims data also fails to account properly for drug-eluding stents. The FDA approved drug-eluding stents for medical use in April 2003, nearly seven months into the 2003 fiscal year. In practice, hospitals were not fully using drug-eluding stents until closer to the end of FY 2003. Thus, while the FY 2003 cost reports contained only limited cost data on drug-eluding stents, the FY 2004 claims data contained a more abundant amount of charge data on drug-eluding stents, which together, would work to under-weight the corresponding DRG. While we are very familiar with the situation for drug-eluding stents, we would surmise this same scenario exists for other new technologies that came out during FY 2003, which would impact other DRG weights.

Second, the methodology CMS utilized did not take account of all the hospitals that should have been included in the statistical analysis. In developing the cost to charge ratios, CMS used a geometric mean to develop the cost to charge ratios. In setting their trim points for this calculation, CMS eliminated, as outliers, data from approximately 200 hospitals, even though their cost to charge ratios were accurate in many cases. These hospitals tended to be the larger tertiary hospitals, and without data from these entities, the cost to charge ratios were distorted.

Finally, in general, hospitals tend to mark-up higher cost technologies, such as those used to treat cardiac patients, by a lower percentage than they mark-up lower cost technologies. However, in CMS's calculations, a single cost to charge ratio would be

applied to all the supply charges within a single DRG, which results in higher cost technologies, such as drug-eluding stents, being significantly under-reimbursed while less expensive technologies are over-reimbursed

In short, CHE is very concerned about the impact the methodology and the data used by CMS will have on reimbursements. We understand that one reason CMS has for moving toward a cost based reimbursement structure is to remove the payment incentives that exist for certain DRGs that has led to the proliferation of specialty hospitals. However, CMS's methodology has serious flaws and will inappropriately decrease payments to full service hospitals that have significant cardiac or orthopedic programs.

CMS's approach will decrease the quality of patient care and increase mortality. Numerous studies have found an inverse relationship between a hospital's volume of surgical procedures and surgical mortality.[1] With respect to cardiac care, hospitals performing large numbers of cardiac procedures have significantly lower mortality rates than hospitals performing fewer cardiac procedures, because experience improves cardiac care outcomes. CMS's proposed rule would significantly reduce payments for cardiac care.

In order to remain financially viable in the face of these significant losses, hospitals currently treating a disproportionate number of cardiac cases will be forced to reduce the number of cardiac cases and patients will be forced to turn to hospitals with less experience and higher mortality rates for treatment. Thus, CMS's proposed new payment methodology is at odds with improved cardiac care outcomes and reduced mortality rates.

While CHE supports policy changes aimed at curtailing specialty hospitals and, in general, supports a move toward cost based reimbursement, we are seriously concerned about the methodology CMS has chosen to effect this policy change as it has overreaching negative impacts on certain community hospitals. These are the same community hospitals that are negatively impacted by nearby specialty hospitals and that in theory a policy change toward curtailing specialty hospitals was supposed to benefit.

For the above reasons, we request that CMS delay implementation of the HSRV cost weight structure until at least FY 2008. Additionally, we request that when cost based weights are implemented CMS provide a 3 year transition that blends the HSRV cost based weight structure with the charge-based weight structure to allow hospitals to appropriately plan for such a change in reimbursements.

DRGs: SEVERITY OF ILLNESS

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[1] See, e.g., John Birkmeyer, et al., "Hospital Volume and Surgical Mortality in the United States," The New England Journal of Medicine Volume 346:1128-1137 (April 11, 2002) (Concluding that "In the absence of other information about the quality of surgery at the hospitals near them, Medicare patients undergoing selected cardiovascular or cancer procedures can significantly reduce their risk of operative death by selecting a high-volume hospital.").

CMS is proposing to revise the current DRG system to one that recognizes a patient's severity of illness. MedPAC had recommended that CMS implement the APC-DRG system to achieve that goal; however, CMS is proposing to implement a system they developed titled the consolidated severity adjusted DRGs in FY 2008 or possibly sooner.

CMS requested comments on a number of issues regarding this proposal, including whether there are any "potential alternatives to the consolidated severity adjusted DRG system that could also better recognize severity of illness" as they had only considered the one alternative DRG system that they proposed. In addition, CMS has noted there are issues within this proposal that need to be worked out before the policy can be implemented. For example, CMS stated they were aware that the consolidated severity adjusted DRGs do not account for complexity. Therefore, those resource intensive procedures that are performed on a patient that is not severely ill would likely be under-reimbursed under the consolidated severity adjusted DRGs. Noting this was a weakness in the consolidated severity adjusted DRGs, CMS stated that they were intending to "develop criteria for determining when it is appropriate to recognize increased complexity in the structure of the DRG system and how these criteria interact with the existing statutory provisions for new technology add on payments." In addition, CMS has indicated that it "will carefully study the additional impact these DRGs will have on payment accuracy after the proposed refinements in relative weights are implemented, as well as their impacts on hospitals before reaching a final decision."

Given the open-endedness of this proposal, it is difficult to take a position on this proposal. **CHE requests that CMS delay implementation of the consolidated severity adjusted DRG system until further work and research is completed on this proposal. CHE also requests the consolidated severity adjusted DRG proposal be implemented simultaneously with the HSRV cost based weights proposal in order to mitigate the significant negative impact the HSRV cost based weights will have as well as to prevent hospitals from experiencing significant swings in reimbursements from one year to another as these proposals are implemented.**

CMS has also alluded to including a behavioral offset adjustment to counteract the increased documentation and coding that will likely occur as a result of implementation of the consolidated severity adjusted DRGs. **CHE would request that CMS not implement an across the board behavioral offset adjustment, but rather implement a more focused adjustment that addresses individual hospitals for whom a behavioral offset adjustment is warranted.**

Given the enormity of applying the 100 percent occupational mix adjustment to the wage index within such a small time frame, **CHE would request that CMS focus on implementing the occupational mix adjustment and delay implementing the HSRV cost weights and the severity of illness adjusted DRGs.**

HOSPITAL QUALITY DATA

The Medicare Modernization Act of 2003 (MMA) called for hospitals to submit data on quality measures in order to receive their full market basket increase for FY 2006. In

implementing the MMA, CMS required hospitals to provide data on ten (10) quality measures on heart attack (acute myocardial infarction), heart failure (HF) and pneumonia (PNE). The DRA also required the Secretary of Health and Human Services to expand for FY 2007 and beyond the set of measures determined to be appropriate for the measurement of the quality of care furnished by hospitals in inpatient settings beyond the original quality measures that applied in FY 2005 and FY 2006. The DRA increased the penalty for non-reporting hospitals from a 0.4 percent decrease in their market basket increase to a full 2 percent reduction in their market basket increase for FY 2007 and beyond.

CMS is proposing to expand the 10 starter measures to 21 quality measures that will focus on heart attack, heart failure, pneumonia and surgical infection prevention (SIP) for calendar year 2006. Under this proposal, hospitals would be required to submit the quality data for first quarter 2006 by August 15, or they would suffer the 2 percent reduction in the market basket. CMS goes onto say they "do not anticipate significant additional burden on hospitals regarding the starter set of 10 quality measures or the anticipated 21 clinical quality measures because all JCAHO-accredited hospitals are currently required to adhere to these sampling requirements in acute myocardial infarction, heart failure, pneumonia, and surgical infection prevention for accreditation and core measure reporting purposes."

CHE is supportive of CMS's proposal to increase to 21 the clinical quality measures. However, we do not support the time frame in which CMS would implement this proposal. Despite CMS's statement that this would not be burdensome to hospitals, by requiring hospitals to report quality data from first quarter 2006 by August 15, this proposal would in fact be quite onerous to hospitals. First, hospitals would have to submit their first quarter 2006 quality data only two weeks after the final version of the Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates is made public. It is unrealistic to expect hospitals to be able to conduct retrospective chart review, work with the vendors that assist them in processing the required data and resubmit this data within fourteen days. Second, while acute myocardial infarction, heart failure, pneumonia, and surgical infection prevention are focus sets that JCAHO suggests for quality reporting, hospitals are only required to collect and submit data on three of those focus sets. For those hospitals that have not chosen to collect and submit data on the surgical infection prevention focus set, this proposal could prove even more burdensome.

In addition, it is CHE's understanding that some Performance Measurement Systems are not currently allowing retrospective data collection on surgical infection prevention. While the CMS Abstraction and Reporting Tool (CART) would allow for such retrospective review, switching to CART for SIP reporting would require a hospital to spend time learning how to use the CART tool as well as operate two different abstraction systems, again all of which must take place before August 15.

CHE urges CMS to require hospitals to report quality data on the 21 clinical measures beginning with the third quarter 2006 data in order to preserve their full

market basket update. This would prevent hospitals from the onerous and costly requirement of conducting retrospective chart reviews and submitting first quarter 2006 quality data by August 15.

When implementing the provision of the DRA requiring the Secretary of HHS to expand the number of quality measures, **CHE requests that CMS select measures only from those used by the Hospital Quality Alliance for public reporting.** In the future, when the Secretary decides to expand the quality measures, **CHE urges the Secretary to publish the proposed expansion at least one full year prior to the start of the fiscal year in which the expansion would be implemented.** This would enable hospitals to put the needed data collection processes in place to comply with the quality reporting regulations.

CMS has also proposed that the quality data submitted by hospitals for the first three quarters of 2005 be validated for accuracy. Any hospital that fails to have an 80 percent agreement between the data the hospital submitted and the data CMS abstracts will lose two percent from their market basket update. We are concerned about this proposal because this validation process is a change from the current process, some hospitals are still gaining experience with the surgical infection prevention data to ensure that it is valid and reliable and CMS is still improving the reliability of the validation process. Given the significant financial impact that failing the validation process could have on hospitals, **CHE requests that CMS postpone implementation of the proposed validation process until such time as the reliability of the validation process is improved to the level that reimbursements can be based on it.**

If CMS chooses not to postpone implementation of the validation process, then **CHE strongly urges CMS to review, on a case-by-case basis, any incidence where a hospital's payment would be put in jeopardy as a result of the validation process. It should allow the hospital to submit information showing that it made a good-faith effort to supply the data warehouse with accurate information so that the public could be informed about the quality of its care. If the hospital has made a good-faith effort, it should receive full payment regardless of whether the data are deemed accurate enough for public display.** In addition, CMS should instruct its QIO data warehouse to accept any significant corrections so that the public can have a full and accurate picture of hospital quality.

GRADUATE MEDICAL EDUCATION (GME) PAYMENTS

CMS states in the proposed rule that resident training that occurs at non-hospital sites must be related to patient care if a hospital wishes to count that time for direct medical education (DGME) and indirect medical education (IME) payment purposes. Resident time spent in didactic activities that often occur in associated medical schools – such as educational conferences, journal clubs and seminars – would specifically be excluded. CMS noted that its statement in a previous letter on this topic "implying that didactic time spent in non-hospital settings could be counted for direct GME and IME ... was inaccurate." CMS also noted that time spent in these activities could be counted for

DGME purposes if they occur in a hospital; however, the counting prohibition applies for IME payments regardless of where the educational activity occurs.

CHE strongly urges CMS to rescind the purported "clarification" in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare DGME and IME payments. Activities such as educational seminars, classroom lectures and presentation of papers and research results to fellow residents, medical students, and faculty are an integral component of the patient care activities engaged in by residents during their residency programs. In addition, it would be very difficult to separate out time spent at these activities. **CHE urges CMS to withdraw this change 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.**

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

Hospitals without Dedicated Emergency Departments (ED). Under the proposed rule, a hospital with "specialized capability" is required to accept transfers under EMTALA if the receiving hospital has the capacity to treat the individual regardless of whether it has a dedicated ED. **CHE would suggest that CMS provide further guidance on this proposal including the definition of "specialized capability,"** so as to prevent a hospital, such as a psychiatric hospital, from having a legal obligation to treat a patient who has medical problems outside of the hospital's limited scope of practice.

CHE also concurs with the American Hospital Association's recommendations that:

- **A physician-owned, limited-service hospital should be required to have a pre-existing agreement with the community hospital(s) it intends to rely on for emergency back-up services.**
- **The Secretary should establish the terms that must be addressed by an agreement including:**
    - **Procedures for an appropriate transfer for patients not covered under EMTALA** (e.g. inpatient or outpatient whose condition develops into an emergency beyond the capability of the limited-service hospital and consequently needs to be transferred to a full-service hospital); and
    - **Continuity of care** (e.g. telephone consultation with the receiving hospital and physician, sending the patient's medical records along when transferred, etc.).

Thank you for your review and consideration of these comments. If you have any questions, please feel free to contact me at (610) 355-2121.

Sincerely,

Kenneth A. Becker
Vice President, Advocacy & Government Relations

Submitter : **Ms. Melinda Clark**

Date: 06/12/2006

Organization : **SSM DePaul Health Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1667-Attach-1.DOC

CMS-1488-P-1667-Attach-2.DOC

#1667

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:

I write to you as the voice of an acute care 370-bed community hospital in North St. Louis County, Missouri and also as a member of AHA. 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.

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc). It also proposes refining the DRGs to account for patient severity, with implementation likely in FY 2008. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education, among other policies.

While I support many of the proposed rule's provisions, I have serious concerns about the proposed changes to the DRG weights and classifications. The hospital field supports meaningful improvements to Medicare's inpatient PPS. I believe that the AHA and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. 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. Moving forward requires thoughtful change.

Specifically, SSM DePaul Health Center supports the following:

- **One-year Delay:** We support a one-year delay in the proposed DRG changes given 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:** We do not support a new classification system at this time, 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 support the AHA commitment to working with CMS to develop and evaluate alternatives for new weights and classifications.

Thank your for the opportunity to submit the outlined concerns.

Sincerely,

Melinda Clark
President
SSM DePaul Health Center

Submitter : **Mr. Brian Derrick** **Date: 06/12/2006**

Organization : **Albert Einstein Healthcare Network**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attached.

CMS-1488-P-1668-Attach-1.DOC

#1668

Albert Einstein Healthcare Network

Einstein

Jefferson Health System

VIA ELECTRONIC SUBMISSION

June 12, 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 Albert Einstein Healthcare Network 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 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.

Sincerely,

Brian K. Derrick
Chief Financial Officer

Submitter : **Dr. Steven Wahls** **Date: 06/12/2006**

Organization : **Evergreen Family Medicine**

Category : **Physician**

Issue Areas/Comments

GME Payments

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.

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,

Steven A. Wahls, MD, FAAFP

Submitter : **Mrs. Denice Higman** **Date: 06/12/2006**

Organization : **Soyring Consulting**

Category : **Health Care Industry**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1670-Attach-1.DOC

CMS-1488-P-1670-Attach-2.DOC

#1670

June 12, 2006

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

To Whom It May Concern:

The proposed changes in FY 2007 to the Inpatient Prospective Payment System will greatly affect acute care hospitals that are providing care to cardiac patients. Most hospitals are experiencing significant growth and will continue to have growth in cardiac services because of the prevalence of cardiovascular disease in the US population. Soyring Consulting has worked with over 600 hospitals across the country as clients, and the expenses for cardiac procedures and devices frequently exceed payment for these procedures. The proposed change in payment will make it even more difficult for some hospitals to continue these services. Outcomes for heart attacks are closely related to immediate access to care. If hospitals cannot continue to provide state of the art procedures, and patients need to travel farther for these, outcomes will be negatively impacted. As you may know, the costs associated with performing cardiac procedures have increased on a yearly basis; therefore, using cost data that is out of date must be re-evaluated. Not accounting for hospital volume in the payment changes will create an imbalance of reimbursements to each respective hospital. Though accounting for severity could help, weighing severity without regard to complexity after implementing a cost-based methodology will leave hospitals at an impasse for strategic planning purposes. At the very least, hospitals should be given time to phase in these drastic changes to the IPPS to help smooth the potential losses hospitals may incur.

Sincerely,

Denice Soyring Higman RN, BS, MSN
President, Soyring Consulting

Submitter : **Dr. John Jeter** **Date: 06/12/2006**

Organization : **Hays Medical Center**

Category : **Hospital**

Issue Areas/Comments

MedPac Update Recommendation

MedPac Update Recommendation

See Attachment

CMS-1488-P-1671-Attach-1.RTF

CMS-1488-P-1671-Attach-2.DOC

#1671

June 9, 2006

Centers for Medicare and Medicaid Services
CMS-1488-P

This letter is in response to the proposed re-weighting of diagnosis related groups as well as the adjustment of DRGs by severity. Basing reimbursement upon costs rather than charges, and leveling the field between primary and specialty care or "equaling the profit margins," is a common sense strategy. As such, this is a laudable attempt to correct the historic emphasis CMS payment policies have placed on cardiac and other specialty care procedures at the expense of primary care services. And sends a clear message that CMS intends to appropriately compensate those hospitals willing to care for the sickest of patients, rather than benefit those who "cherry pick" for profit.

But waiting until 2008 to implement the severity adjustment is not fair to those hospitals, like Hays Medical Center, who will be negatively impacted by re-weighting but positively impacted by severity adjustment. We believe, as does the Medicare Payment Advisory Commission, that all changes in the inpatient hospital payment system should begin this fall. Allowing specialty hospitals another year of high profits, in the name of "time to adjust," as many not-for-profit community hospitals take yet another financial hit is clearly not equitable.

Further, we believe that simply leveling the field is not enough. Research would suggest that both beneficiaries and the Medicare budget would benefit greatly by weighting reimbursement levels toward primary care. In the April, 2004 study, *Medicare Spending, The Physician Workforce, And Beneficiaries' Quality of Care,* Baicker and Chandra utilize Medicare claims data from the *Dartmouth Atlas* project to conduct a state-by-state comparison of quality and cost. Not surprisingly, a negative relationship between the number of specialists and both cost per beneficiary and generally-accepted measures of quality were demonstrated; more specialty care meant more cost but less quality.

There's a very real axiom in health care administration – form follows finance. Until CMS clearly puts substantially greater financial weight toward the provision of primary care services, providers are forced to continue placing undue emphasis on specialty procedures. And, as a result, there will remain no financial incentive to increase the number of primary care physicians recruited to a community. Or to absorb the significant financial subsidy primary care physician practices require in markets where Medicare represents a high percentage of the payor mix. These proposed changes to the Inpatient Prospective Payment System are a step in the right direction, but do not go far enough in correcting the imbalance between primary and specialty care in heavily Medicare markets. And therefore do not go far enough in reducing the cost, and more importantly, improving the quality of care provided to Medicare beneficiaries.

Sincerely,
John H. Jeter, MD
President/CEO

Hays Medical Center

Jodi A. Schmidt
VP/CDO
Hays Medical Center

June 9, 2006

Centers for Medicare and Medicaid Services
CMS-1488-P

This letter is in response to the proposed re-weighting of diagnosis related groups as well as the adjustment of DRGs by severity. Basing reimbursement upon costs rather than charges, and leveling the field between primary and specialty care or "equaling the profit margins," is a common sense strategy. As such, this is a laudable attempt to correct the historic emphasis CMS payment policies have placed on cardiac and other specialty care procedures at the expense of primary care services. And sends a clear message that CMS intends to appropriately compensate those hospitals willing to care for the sickest of patients, rather than benefit those who "cherry pick" for profit.

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Sincerely,
John H. Jeter, MD
President/CEO

Hays Medical Center

Jodi A. Schmidt
VP/CDO
Hays Medical Center

1672

Submitter : **Mr. Bret Curran**

Date: 06/12/2006

Organization : **The Methodist Hospital Syatem**

Category : **Hospital**

Issue Areas/Comments

DRG Reclassifications

DRG Reclassifications

see attachment

CMS-1488-P-1672-Attach-1.DOC

ATTACHMENT TO #1672

June 12, 2006

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

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

Dear Administrator McClellan:

The Methodist Hospital System appreciates the opportunity to comment on the proposed rule regarding Medicare's inpatient hospital payment system. The Methodist Hospital System is a not for profit Healthcare organization based in Houston, Texas. It has extended the world renowned clinical and service excellence of its founding entity, The Methodist Hospital, through a network of community based Hospitals. The system is affiliated with the Texas Annual Conference of the United Methodist Church. The system is also affiliated with the Weill Medical College of Cornell University, New York Presbyterian Hospital, and is ranked as one of *"America's Best Hospitals"*.

We appreciate and support the efforts of the Centers for Medicare and Medicaid Services (CMS) to improve the inpatient hospital prospective payment system (IPPS) so that it will more accurately allocate payment for inpatient operating costs. At the same time, we have a few concerns that we ask CMS to consider as it works toward improvements of IPPS. Specifically, we want to ensure that any changes of this magnitude are done in a measured way so that hospitals such as us have ample opportunity to adapt to the changes at all levels. Moreover, we need to have full and timely access to all aspects of the revised methodology, as we do now, so that we can continue to make knowledgeable decisions about how to operate economically within IPPS. These issues are addressed in more detail below.

DISCUSSION

A. Timeframe for Change

In the proposed rule, CMS says that it is considering revising the IPPS methodology to use All Patient Refined Diagnosis Related Groups (APR-DRGs) as early as the upcoming fiscal year. We do not believe it is realistic to expect hospitals to be prepared for a change of this magnitude effective in less than 5 months. Implementing APR-DRGs and the consolidated severity adjusted system would require significant

changes to existing IT file structures, expansion of database sizes and structure. It would also require changes to interfaces and IT system configurations to accommodate the changes and level of severity. This effort in addition to the already extended requirements for existing IT change requests would create an exceedingly large amount of risk for IT, its staff, and its capacity. A change of this size will also be difficult to be achieved by our IT system vendors that now struggle to meet the existing mandated changes of present regulations. The IT vendors require access to detailed proposed methodologies many months in advance so that they can modify existing, build new software, and create training programs to address the requested changes. Significant time will be required for training of coding and billing staff to enable them to work in the new environment. These efforts could not be accomplished by October 1 of this year.

In addition, we understand that the government has been considering moving to the International Classification of Diseases, 10th Revision (ICD-10) for billing purposes. This also would present a major shift affecting IPPS and hospitals for some of the same reasons mentioned earlier. In addition, there are a number of quality initiatives required by the Deficit Reduction Act that will also impact on how a hospital manages and bills. We ask CMS to carefully consider the timing of these major changes and their impact on hospitals. In any event, we urge CMS not to revise the IPPS methodology effective in Federal fiscal year 2007 so that, among other things, hospitals such as ours would have sufficient time to evaluate the full impact of this change and plan for such a change unless CMS implements revisions that are in keeping with the current DRG system and structure. It is imperative that we have time so that there is no disruption of any kind in the services we provide to Medicare beneficiaries and all hospital patients.

B. Full Access to the Methodology

As you know, under the current IPPS, we have full access to the methodology underlying IPPS, as CMS makes the necessary software available through the National Technical Information Service. This has proven to be very helpful to us because we are now able to predict and plan for changes to our Revenue Cycle Reimbursement with existing software tools that have been developed. We need to be able to ensure that program, tables, and values are accurately implemented to calculate the estimated reimbursement correctly. Open architecture and detailed methodologies will enable our IT vendors to completely understand the rules for Medicare reimbursement and build and implement software that is complete and will allow us to operate efficiently and effectively. Our advocacy groups, AHA, and others can understand the need for, and the impact of new regulations. They can also help us plan for the needed change. Advocacy groups understand the need for extended period of time for these types of changes that will allow them to be phased in over a few years. These changes will also present a hardship to our fiscal intermediaries that have difficulty making timely required changes for existing regulations. However, as CMS modifies the IPPS, hospitals must retain an equivalent level of access to the underlying methodology, and we have particular concerns about this with respect to APR-DRGs. The APR-DRG system is a proprietary system and we see no assurance in the proposed rule that the same level of detail that is currently available would be available if the agency were to move to APR-DRGs. It

would be difficult to build, verify, and implement a closed architecture solution. Implementing a closed system would present a hardship to the various healthcare IT vendors and the numerous vendors that provide grouping software. While access to some information about the APR-DRGs is made available through a website, the level of detail is limited, so much so that it is difficult to fully respond to the proposed rule. Accordingly, we request that, regardless of the classification system adopted by CMS, the agency provide, in advance, sufficient detail about the system so that hospitals and others can address whether it should be adopted and assess what they will need to do to operate under the new scheme.

We are also concerned that access to the system be available to all vendors and not just those developing the system to be adopted. It is essential that CMS not grant any vendor a monopoly in this area as this can only further drive up the costs of healthcare in this country.

In addition, it is important that hospitals, our vendors, and suppliers of technology all have access to CMS, as currently is the case, to petition for changes in the selected DRG methodology. Historically, there has been an open dialogue between the industry and CMS for updating the DRG methodology. This dialogue needs to continue.

C. Consideration of Alternative Methodologies

In discussing revisions to the IPPS classification system, CMS talks only about the APR-DRGs. We are aware that there are other classification systems that could be used to accomplish the agency's goal. For example, all payer severity DRGs, refined DRGs, and S-DRGs are all built on top of the CMS DRG system, and can achieve similar statistical performance while introducing less disruption to the coding, billing and our Revenue Cycle stream process. Given the importance of any change to the IPPS classification scheme, we believe CMS should consider and discuss other alternatives to the APR-DRGs so that the public can participate more fully in the process of revising the classification system. An additional benefit to not making a classification system change in the upcoming fiscal year is that the agency would be able to address and receive comments on other classification methodologies, and we ask CMS to take this important step.

D. Minimizing the Complexity of a Revised Classification System

As CMS considers different options for a revised classification system, we strongly recommend that the agency consider minimizing the complexity of the new system. Hospitals have been working with a consistent coding framework for over 20 years and our coders work efficiently within this framework. When evaluating revised classification schemes, CMS should consider using a scheme that utilizes the existing coding framework. Schemes such as the one proposed by CMS will require retraining of all of our coders. With coders and billers having to learn a completely new classification system, the training for an already limited resource will be extremely expensive. The present system has been many years in the making and changes such as those

recommended will require time to truly understand the processes and procedures to bill and code under a totally new system. Similarly, greater complexity will decrease coder productivity and extend revenue cycles this change will reduce productivity among coders and cause longer bill hold for claims. This in turn will effect the Revenue Cycle payment turnaround time. While these changes are being designed around CMS date, some commercial payers could be affected since they usually follow the CMS structure. Some of the changes are based on Medicare demographics and will be entirely different from the commercial payers demographics.

CONCLUSION

The Methodist Hospital System fully supports efforts to improve the functioning of the IPPS by more accurately allocating payments for inpatient hospital services. However, we are concerned about CMS' proposed rule because it seems to move too fast to a major system change without adequately considering other possible classification schemes, without providing the public with full access to information necessary to comment on the proposal, and without minimizing the burdens of the proposal on hospitals. Thank you for your attention.

Sincerely,

Bret Curran
Senior Vice President
Financial Operations

Submitter : **Ms. Lynn Abrahamsen** **Date: 06/12/2006**

Organization : **Hennepin County Medical Center**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1488-P-1673-Attach-1.DOC

#1673

June 12, 2006

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

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

Dear Administrator McClellan:

The Methodist Hospital System appreciates the opportunity to comment on the proposed rule regarding Medicare's inpatient hospital payment system. The Methodist Hospital System is a not for profit Healthcare organization based in Houston, Texas. It has extended the world renowned clinical and service excellence of its founding entity, The Methodist Hospital, through a network of community based Hospitals. The system is affiliated with the Texas Annual Conference of the United Methodist Church. The system is also affiliated with the Weill Medical College of Cornell University, New York Presbyterian Hospital, and is ranked as one of *"America's Best Hospitals"*.

We appreciate and support the efforts of the Centers for Medicare and Medicaid Services (CMS) to improve the inpatient hospital prospective payment system (IPPS) so that it will more accurately allocate payment for inpatient operating costs. At the same time, we have a few concerns that we ask CMS to consider as it works toward improvements of IPPS. Specifically, we want to ensure that any changes of this magnitude are done in a measured way so that hospitals such as us have ample opportunity to adapt to the changes at all levels. Moreover, we need to have full and timely access to all aspects of the revised methodology, as we do now, so that we can continue to make knowledgeable decisions about how to operate economically within IPPS. These issues are addressed in more detail below.

DISCUSSION

A. Timeframe for Change

In the proposed rule, CMS says that it is considering revising the IPPS methodology to use All Patient Refined Diagnosis Related Groups (APR-DRGs) as early as the upcoming fiscal year. We do not believe it is realistic to expect hospitals to be prepared for a change of this magnitude effective in less than 5 months. Implementing APR-DRGs and the consolidated severity adjusted system would require significant

changes to existing IT file structures, expansion of database sizes and structure. It would also require changes to interfaces and IT system configurations to accommodate the changes and level of severity. This effort in addition to the already extended requirements for existing IT change requests would create an exceedingly large amount of risk for IT, its staff, and its capacity. A change of this size will also be difficult to be achieved by our IT system vendors that now struggle to meet the existing mandated changes of present regulations. The IT vendors require access to detailed proposed methodologies many months in advance so that they can modify existing, build new software, and create training programs to address the requested changes. Significant time will be required for training of coding and billing staff to enable them to work in the new environment. These efforts could not be accomplished by October 1 of this year.

In addition, we understand that the government has been considering moving to the International Classification of Diseases, 10th Revision (ICD-10) for billing purposes. This also would present a major shift affecting IPPS and hospitals for some of the same reasons mentioned earlier. In addition, there are a number of quality initiatives required by the Deficit Reduction Act that will also impact on how a hospital manages and bills. We ask CMS to carefully consider the timing of these major changes and their impact on hospitals. In any event, we urge CMS not to revise the IPPS methodology effective in Federal fiscal year 2007 so that, among other things, hospitals such as ours would have sufficient time to evaluate the full impact of this change and plan for such a change unless CMS implements revisions that are in keeping with the current DRG system and structure. It is imperative that we have time so that there is no disruption of any kind in the services we provide to Medicare beneficiaries and all hospital patients.

B. Full Access to the Methodology

As you know, under the current IPPS, we have full access to the methodology underlying IPPS, as CMS makes the necessary software available through the National Technical Information Service. This has proven to be very helpful to us because we are now able to predict and plan for changes to our Revenue Cycle Reimbursement with existing software tools that have been developed. We need to be able to ensure that program, tables, and values are accurately implemented to calculate the estimated reimbursement correctly. Open architecture and detailed methodologies will enable our IT vendors to completely understand the rules for Medicare reimbursement and build and implement software that is complete and will allow us to operate efficiently and effectively. Our advocacy groups, AHA, and others can understand the need for, and the impact of new regulations. They can also help us plan for the needed change. Advocacy groups understand the need for extended period of time for these types of changes that will allow them to be phased in over a few years. These changes will also present a hardship to our fiscal intermediaries that have difficulty making timely required changes for existing regulations. However, as CMS modifies the IPPS, hospitals must retain an equivalent level of access to the underlying methodology, and we have particular concerns about this with respect to APR-DRGs. The APR-DRG system is a proprietary system and we see no assurance in the proposed rule that the same level of detail that is currently available would be available if the agency were to move to APR-DRGs. It

would be difficult to build, verify, and implement a closed architecture solution. Implementing a closed system would present a hardship to the various healthcare IT vendors and the numerous vendors that provide grouping software. While access to some information about the APR-DRGs is made available through a website, the level of detail is limited, so much so that it is difficult to fully respond to the proposed rule. Accordingly, we request that, regardless of the classification system adopted by CMS, the agency provide, in advance, sufficient detail about the system so that hospitals and others can address whether it should be adopted and assess what they will need to do to operate under the new scheme.

We are also concerned that access to the system be available to all vendors and not just those developing the system to be adopted. It is essential that CMS not grant any vendor a monopoly in this area as this can only further drive up the costs of healthcare in this country.

In addition, it is important that hospitals, our vendors, and suppliers of technology all have access to CMS, as currently is the case, to petition for changes in the selected DRG methodology. Historically, there has been an open dialogue between the industry and CMS for updating the DRG methodology. This dialogue needs to continue.

C. Consideration of Alternative Methodologies

In discussing revisions to the IPPS classification system, CMS talks only about the APR-DRGs. We are aware that there are other classification systems that could be used to accomplish the agency's goal. For example, all payer severity DRGs, refined DRGs, and S-DRGs are all built on top of the CMS DRG system, and can achieve similar statistical performance while introducing less disruption to the coding, billing and our Revenue Cycle stream process. Given the importance of any change to the IPPS classification scheme, we believe CMS should consider and discuss other alternatives to the APR-DRGs so that the public can participate more fully in the process of revising the classification system. An additional benefit to not making a classification system change in the upcoming fiscal year is that the agency would be able to address and receive comments on other classification methodologies, and we ask CMS to take this important step.

D. Minimizing the Complexity of a Revised Classification System

As CMS considers different options for a revised classification system, we strongly recommend that the agency consider minimizing the complexity of the new system. Hospitals have been working with a consistent coding framework for over 20 years and our coders work efficiently within this framework. When evaluating revised classification schemes, CMS should consider using a scheme that utilizes the existing coding framework. Schemes such as the one proposed by CMS will require retraining of all of our coders. With coders and billers having to learn a completely new classification system, the training for an already limited resource will be extremely expensive. The present system has been many years in the making and changes such as those

recommended will require time to truly understand the processes and procedures to bill and code under a totally new system. Similarly, greater complexity will decrease coder productivity and extend revenue cycles this change will reduce productivity among coders and cause longer bill hold for claims. This in turn will effect the Revenue Cycle payment turnaround time. While these changes are being designed around CMS date, some commercial payers could be affected since they usually follow the CMS structure. Some of the changes are based on Medicare demographics and will be entirely different from the commercial payers demographics.

CONCLUSION

The Methodist Hospital System fully supports efforts to improve the functioning of the IPPS by more accurately allocating payments for inpatient hospital services. However, we are concerned about CMS' proposed rule because it seems to move too fast to a major system change without adequately considering other possible classification schemes, without providing the public with full access to information necessary to comment on the proposal, and without minimizing the burdens of the proposal on hospitals. Thank you for your attention.

Sincerely,

Bret Curran
Senior Vice President
Financial Operations

Submitter : **Mr. Kevin Smith** **Date: 06/12/2006**

Organization : **Winchester Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1674-Attach-1.DOC

#1674

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, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates; Proposed Rule.

Dear Dr. McClellan:

On behalf of Winchester Hospital, 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.

HSRV Weights

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc).

I strongly support the change from the current charge based DRG weighting system to the proposed HSRVcc system in FY07. While I understand that other parties are commenting on imperfections in the cost weighted system proposed by CMS, we should not lose sight of the greater imperfections in the current charge-based system. The proposed DRG weights under the HSRVcc methodology more closely represent the cost of providing services than the current charge-based system. Hospitals that provide more routine medical admissions as opposed to high-end, high-margin (especially cardiac) surgeries and services have been disadvantaged for years under the current charge-based system. The move to a cost-based system should be effective in FY07 regardless of whether perfected. Even as proposed it is more reflective of the costs of providing services which should be the foundation for payment under the Medicare system.

If I can provide you with any additional information regarding our comments, please do not hesitate to contact me at (781) 756-2129.

Sincerely,
Kevin F. Smith
Chief Financial Officer

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

Organization : **Next Wave**

Category : **Health Care Industry**

Issue Areas/Comments

DRGs: Severity of Illness

DRGs: Severity of Illness

See Attached file.

DRGs: Spinal Fusion

DRGs: Spinal Fusion

DRGs: Spinal Fusion:
We note that the requested DRG refinements indexed as Spinal Fusion in the proposed regulations included suggested refinements of non-fusion back and neck surgery as well. In both cases, new Base DRGs were recommended to separate out simple, basic spine surgery patients from other more difficult patients that also have more complex treatments which cost more. These latter cases are more frequently referred to regional centers, while the simpler cases are treated in most hospitals offering spine surgery services.
' Lower Spine Fusion (current DRGs 497 and 498)
o Simple: One level Lumbar without any of the below
o Patients with interbody spine implants
o Patients with multi-level disease and fusion, revisions of prior fusion, fusion of the thoracic section of the spine, and
o Patients with diagnosis of curvature, malignancy, or infection in either principal or secondary positions. (currently some in DRG 546, while others remain in DRGs 497 and 498.)
' Non-Fusion Back and Neck Procedures (current DRGs 499 and 500)
o Simple: Removal or destruction of single displaced disk or single level laminectomy for spinal stenosis
o Patients with multi-level disease and surgery, other diagnoses, other spine procedures
o Patients with artificial disk or other motion preserving implant
One aspect of simple vs.difficult patient referral dynamics is illustrated by the attachment - 'Why Case Mix Refinement is Needed- Example from Minor Back Procedures. In this we show that across broad regions there are similar mixes of simple and difficult cases, while within a region, there is a wide spectrum of some hospitals treating primarily simple cases, and referring difficult cases to the regional centers set up to treat them. Paying the same for simple and difficult cases will create over and underpayments, and set up perverse incentives. We noted the same pattern in the four regions within New York State - each of the regions are similar to each other, but wide referral pattern differences within each of the regions. We expect this same pattern will exist within most self contained geographic areas difficult cases will routinely be
The issues identified are still relevant under either the current DRGs or the APR/CSA DRGs proposed for 2008, since they address complexity and referral pattern issues best addressed by new 'Base DRGs' in either case. A severity DRG structure would allow further differentiation of degree of relative cost differences. (E.g. patients with curvature, malignancy, or infection in secondary diagnosis positions have costs somewhat less than patients with these diagnoses in a principal position, however have costs far greater than patients without these diagnoses.) These diagnoses in any position will likely cause their referral to regional centers. Paying the same DRG rate for simple and difficult cases continues a perverse incentive for adverse selection of patients that could be treated locally, but are referred for fiscal rather than clinical reasons. See Attachment.

HSRV Weights

HSRV Weights

See Attachment

Transparency of Health Care Information

Transparency of Health Care Information

Transparency of Health Care Information:
The current Medicare billing system (UB format) only allows submission of 9 diagnoses and 6 procedures. MEDPAR therefore only has 9 Dx and 6 Pr positions (out of the 25/25 that HIPAA requires that hospitals maintain.) This will cause major coding practice shifting as hospitals seek to make sure that the ever growing number of "important codes" are in the first 9/6 positions (full treatment descriptions which frequently requires several sets of procedure codes, diagnoses explaining reason for admission and extended stay, severity, complications, quality indicator numerators and denominator exclusions, risk adjustments, etc.). MEDPAR should expand to 25/25 (the APR DRG grouper accepts 30/30.) Since MEDPAR drives Medicare payment and is the only "national" data source for administrative data, this is also an issue for measuring or risk adjusting for Quality Indicators and Pay-for-Performance, which use MEDPAR data. Expansion will provide more accurate information for both payment and quality. If kept at the current 9/6 - it will encourage gaming and make both payment and quality measurement wildly inaccurate. The use of this incomplete data will serve to mis-inform stakeholders.

For Complications of prior care, we note that using only 9/6 positions will provide an incentive to doctors not to document and to hospitals not to code complications - since they can only be hurt. With no payment benefit, complications can only make quality measures look worse, and also reduce any pay-for-performance payments.

We also support the CMS proposal to begin to report total costs of "Episodes of Care" and not just component pieces. The latter should include Hospital(s), Post-Acute-Care (Rehabilitation Facility, Skilled Nursing Facility, Home Care), Outpatient Rehabilitation, Drugs, DME, and Medical Care for an entire episode (e.g. Hip replacement) by Hospital, area, region, etc. This is a better measure of true costs, since we have noted wide variation, particularly in the use and type of Post-

Acute-Care across hospitals, areas, and regions. Each component should be provided for each hospital. This will allow comparisons across different mixes of post-acute-services, etc.
See Attached file.

Value-Based Purchasing

Value-Based Purchasing

See attached file

CMS-1488-P-1675-Attach-1.PDF

CMS-1488-P-1675-Attach-2.PDF

CMS-1488-P-1675-Attach-3.PDF

CMS-1488-P-1675-Attach-4.PDF

CMS-1488-P-1675-Attach-5.PDF

#1075

"We Understand Health Care"

June 12, 2006

Mr. Marc Hartstein
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1488–P
P.O. Box 8011 *http://www.cms.hhs.gov/eRulemaking*
Baltimore, MD 21244–1850

Re: File code CMS–1488–P.

Dear Mr. Hartstein:

We are a health services research and consulting group specializing in using data to classify patients into categories for policy, management, financing, and quality improvement. Our staff worked on the design, refinement, and implementation of various Diagnosis Related Group (DRG) payment systems at national and state levels since the 1970's. Our comments update those we made in 1994 (when "Severity" DRGs were last proposed) and intervening years.

We comment on several issue areas for the proposed FFY2007 and FFY2008 Medicare Acute Hospital payment rates. We separate each of these issues, and incorporate this page, specific comments, and appropriate attachments for each:

- DRGs: Hip and Knee Replacements
- DRGs: Spinal Fusion
- HSRV Weights
- DRGs: Severity of Illness
- Transparency of Health Care Information
- Value-Based Purchasing

Our staff has hands-on knowledge of both proposed refinements and alternative approaches. We hope that these insights assist your ongoing efforts to implement a payment system that fairly aligns payments with the costs of providing needed patient care to Medicare Beneficiaries. Please contact us for any additional input you need over the next year to address these issues.

Sincerely,

John D, Shaw
President

Enc.

24 Madison Avenue Ext. ● Albany, NY 12203 ● (518) 452-3351 ● Fax (518) 452-3358 ● www.nextwave.info

DRGs: Spinal Fusion:

We note that the requested DRG refinements indexed as "Spinal Fusion" in the proposed regulations included suggested refinements of non-fusion back and neck surgery as well. In both cases, new "Base DRGs" were recommended to separate out simple, basic spine surgery patients from other more difficult patients that also have more complex treatments which cost more. These latter cases are more frequently referred to regional centers, while the simpler cases are treated in most hospitals offering spine surgery services.

- Lower Spine Fusion (current DRGs 497 and 498)
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One aspect of simple vs.difficult patient referral dynamics is illustrated by the attachment - "Why Case Mix Refinement is Needed- Example from Minor Back Procedures." In this we show that across broad regions there are similar mixes of simple and difficult cases, while within a region, there is a wide spectrum of some hospitals treating primarily simple cases, and referring difficult cases to the regional centers set up to treat them. Paying the same for simple and difficult cases will create over and underpayments, and set up perverse incentives. We noted the same pattern in the four regions within New York State - each of the regions are similar to each other, but wide referral pattern differences within each of the regions. We expect this same pattern will exist within most self contained geographic areas – difficult cases will routinely be

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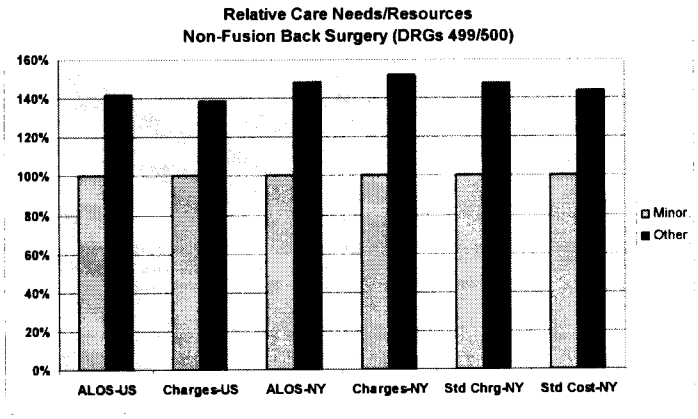
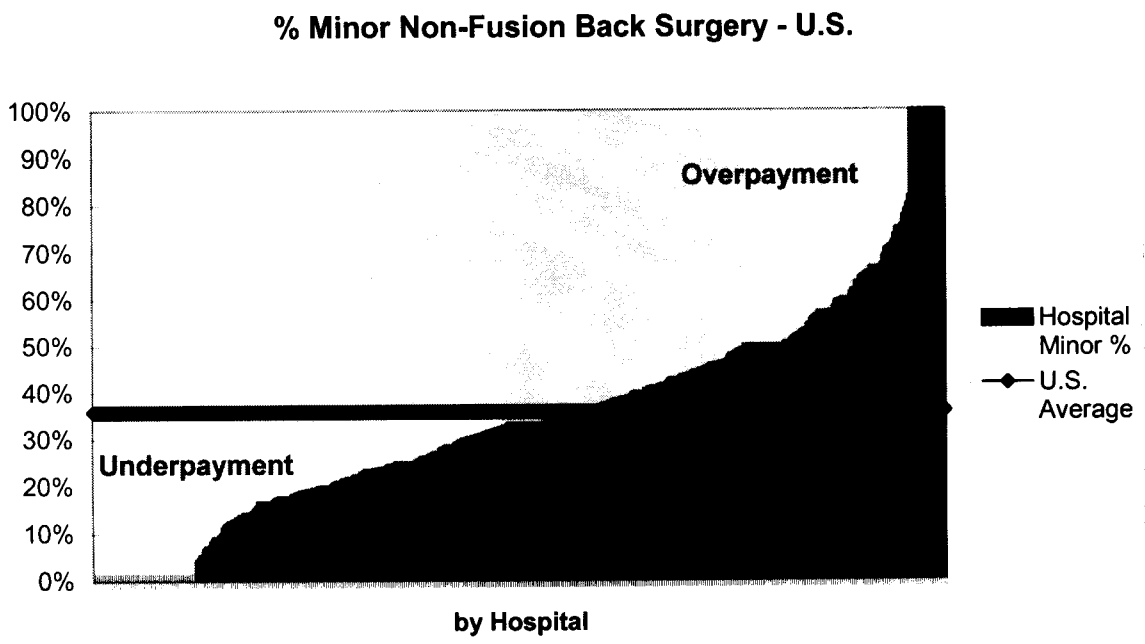
Why Case Mix Refinement is Needed for Non-Fusion Back Surgery (DRGs 499/500)

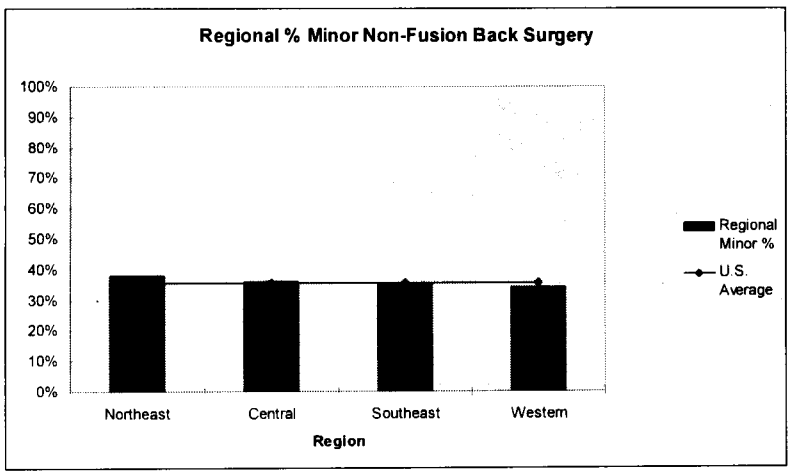
Approximately 35-40% of Medicare cases admitted to a hospital for Non-Fusion Back Surgery (DRGs 499/500) had either a single (herniated) disk removed/destroyed OR a portion of a single vertebrae excised to decompress a narrowed spinal canal (i.e. spinal stenosis). Both relatively minor back procedures relieve pressure on the spinal nerve root and alleviate the pain it causes.

Other cases that group to these DRGs have surgery at multiple levels, vertebral fracture repair, implantation or removal of devices (neural stimulators, artificial disk replacement, etc), repair of degenerative changes in the spinal joints (spondylosis), removal of adhesions or implants from a previous back surgery, etc. These cases have care needs 40-50% higher than the minor back procedures described above. (U.S. and NYS data)



"Averaging" DRG payments for the lower resource minor back procedures with the higher resource needs of the other back surgery patients leads to underpayment of any hospital that does a greater than average number of more difficult cases and to overpayment for hospitals that do more of the minor back procedures. Because difficult cases are routinely referred to regional Centers of Excellence, while at least some hospitals seek out the minor cases that have generous payments (e.g. an accusation leveled at some MD-owned Orthopedic Specialty Hospitals in some states), actual variation in referral and admission patterns drive underpayment/overpayment, e.g.:

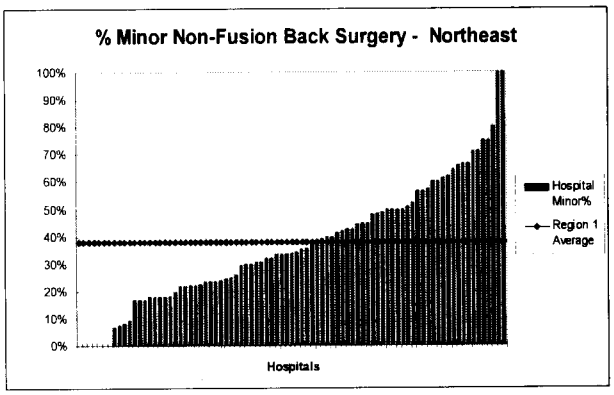


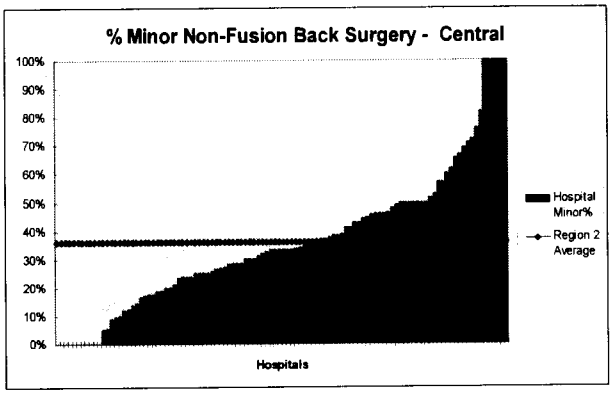


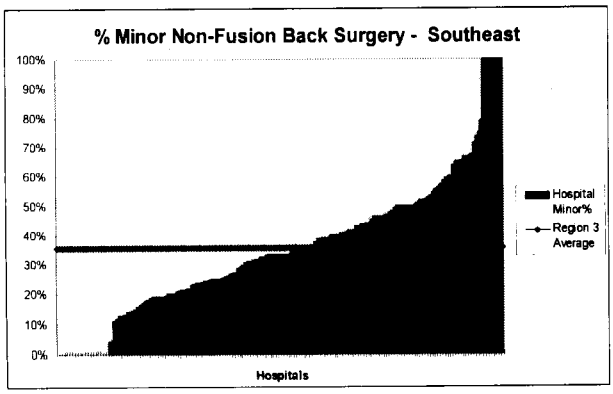
Further analysis shows that the percentage of Non-Fusion Back Surgery cases that are Minor (i.e. Removal/ Destruction of a Single Disk OR a Single Decompression) is consistent ACROSS broad geographic areas, reflecting similar patient care needs overall across regions (Source: 2003 Medicare Cases in National Inpatient Sample- NIS)

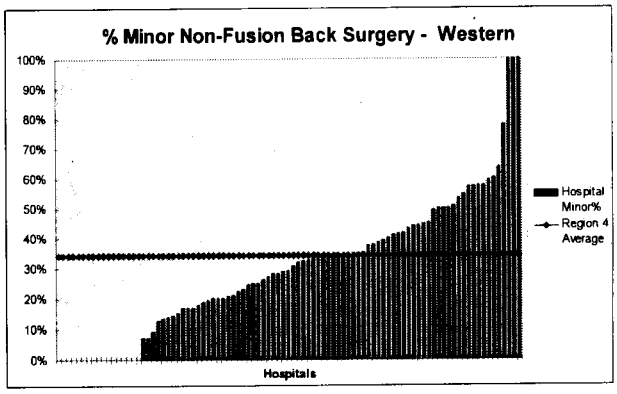
This illustrates that "Averaging" can work - when the mix between high resource and low resource patients are aggregated to a broad level (or when driven solely by random chance.)

Perverse incentives will occur - where conscious referral and/or selection affects admission patterns and the resulting mix of high resource and low resource patients (as it naturally does in each region - see below). Regional Centers of Excellence are penalized by underpayment for admitting the complex "train wreck" patient they were designed and encouraged to care for. Overpayments to other hospitals are at worst removed from patient care as profits, and at best used to "cross-subsidize" other underpaid health care services (thereby confusing everyone and making true system improvements more difficult to design and implement.) Severity adjusting these DRGs to split out minor back procedures will help reduce these perverse incentives.









NEXT WAVE

"We Understand Health Care"

June 12, 2006

Mr. Marc Hartstein
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1488–P
P.O. Box 8011 *http://www.cms.hhs.gov/eRulemaking*
Baltimore, MD 21244–1850

Re: File code CMS–1488–P.

Dear Mr. Hartstein:

We are a health services research and consulting group specializing in using data to classify patients into categories for policy, management, financing, and quality improvement. Our staff worked on the design, refinement, and implementation of various Diagnosis Related Group (DRG) payment systems at national and state levels since the 1970's. Our comments update those we made in 1994 (when "Severity" DRGs were last proposed) and intervening years.

We comment on several issue areas for the proposed FFY2007 and FFY2008 Medicare Acute Hospital payment rates. We separate each of these issues, and incorporate this page, specific comments, and appropriate attachments for each:

- DRGs: Hip and Knee Replacements
- DRGs: Spinal Fusion
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- Transparency of Health Care Information
- Value-Based Purchasing

Our staff has hands-on knowledge of both proposed refinements and alternative approaches. We hope that these insights assist your ongoing efforts to implement a payment system that fairly aligns payments with the costs of providing needed patient care to Medicare Beneficiaries. Please contact us for any additional input you need over the next year to address these issues.

Sincerely,

John D, Shaw
President

Enc.

24 Madison Avenue Ext. ● Albany, NY 12203 ● (518) 452-3351 ● Fax (518) 452-3358 ● www.nextwave.info

HSRV Weights:

As indicated in our comments last year, we strongly support the change from charges to cost when computing weights. This will eliminate much of the bias which currently exists in weights due to different charge mark-ups over cost by state, region, hospital, and cost center.

Different routine nursing costs per day would NOT be addressed by using any of the current or proposed costing methodologies. Current costing methods assign the same the same average amount per day for (non-intensive) routine nursing services to every patient for every day. It does not differentiate patient nursing needs by type of diagnosis or procedure, or the very busy day of surgery versus the day of discharge when the patient sees very little of the nurse. The All-Payor DRGs used for payment in New York utilizes differential nursing weights per day that vary by both DRG and peri-op vs. post-op recovery day. This provides a better cost estimate within routine services.

Data "mapping" issues between cost centers in the MEDPAR billing charge data available at the individual patient level does not always correspond to cost center mapping within hospital cost reports. For example, significant distortions exist for high cost cardiac and orthopedic implants. The cost in many hospitals are reported in routine Central Supply costs, while charges for these implants are frequently reported in ancillary cost centers where they are used (operating room, cath lab, etc.) MEDPAR maps the charges for these same implants to the Cost of Medical Supplies Sold cost center. This causes significant distortion in the Ratio of Cost to Charges (RCC) factors used to determine costs.

The HSRVcc weighting method as proposed has several significant technical flaws. They include using single sets of national average values for the 10 RCC factors used to compute costs and the "scaling factors" used to compute the portion of each of the 10 components to yield the total weight. This introduces new bias into the calculations. Also, it appears that unweighted geometric means of hospital values are used, which in effect gives a hospital with one case in a DRG the same impact on overall weights as another hospital with thousands of cases. It is unclear whether there was a minimum threshold volume level used for each DRG for each hospital like the minimum threshold of 10 cases used elsewhere. Others have commented on these issues, and modeled data from thousands of hospitals which show that the methodology as proposed does far worse in accuracy than even the current biased weights.

Another HSRV weight issue we observed is the "compression in weights" (weights too low for high cost DRGs, weights too high for low cost DRGs) noted by several researchers[1]. We modeled data to evaluate methodology dynamics, with particular attention to what factors cause a bias for weight compression. We tested a scenario where we varied the DRG mix of every hospital and its geographic location, but where <u>every hospital had internal relative DRG weights that were exactly the same</u>. However, when we combined these hospitals using HSRV, weights became compressed. The researchers noted that compression can occur for several reasons, including when there is a "correlation between CMI and the tendency to provide more resources per case.[1]" Since difficult cases are routinely referred to urban teaching referral centers, who have higher wage and teaching costs, this is now a "tendency" and is likely to remain so. The mechanism for this bias is the step in the HSRV method that divides by the hospital CMI.

---

1 Carter, GM and Rogowski, JA "How Recalibration Method, Pricing, and Coding Affect DRG Weights." Health Care Financing Review, Vol. 14, Issue 2. Winter, 1992.

"Difficult" cases are more likely to be treated in referral centers, that are in turn more likely to be located in higher cost urban centers and have a greater commitment to teaching. Therefore, the average CMI divisor for "Difficult" cases is higher than for simple cases treated in every hospital. Unless we begin moving many of our regional referral centers to low cost rural areas, this "tendency," and the corresponding HSRV weight compression bias will remain.

For these reasons, we support weights based on traditional Medicare weighted average methodologies, however, using cost rather than charges. Adjusting for differential routine nursing costs should also be explored. Since it does not appear that this is feasible prior to October, we would support deferring changes in weight methodology until it can be done accurately, and at the same time as DRG Severity adjustments, so that offsetting adjustments can mitigate large swings in payment rates.

NEXT WAVE

"We Understand Health Care"

June 12, 2006

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1488–P
P.O. Box 8011 *http://www.cms.hhs.gov/eRulemaking*
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Sincerely,

John D. Shaw

John D, Shaw
President

Enc.

24 Madison Avenue Ext. ● Albany, NY 12203 ● (518) 452-3351 ● Fax (518) 452-3358 ● www.nextwave.info

DRGs: Severity of Illness:

We support the recognition of "Severity of Illness" *("the extent of physiologic decompensation or organ system loss of function...usually characterized by multiple serious diseases or illnesses" – i.e.* **Co-morbidity Severity***)* into the DRGs. Measuring the degree of impact of co-morbid conditions would enhance DRG accuracy. However, we note that the proposal for using All Payor Refined – Consolidated Severity Adjusted (APR/CSA) DRGs expands recognition of co-morbidity severity, while decreasing or eliminating recognition of:

- **Treatment complexity** *("the relative volume and types of diagnostic, therapeutic, and bed services required for treatment of a particular illness"),* which is the major focus of payment in the current DRG system.
- **Complications** *(996xx-"peculiar to certain specified procedures," 997xx-"affecting body systems not elsewhere classified," 998xx-" of procedures not elsewhere classified," and 999xx-"of medical care not elsewhere classified")* These patients have higher predicted treatment needs, typically due to care at some time prior to admission. These were eliminated because they *"could create the appearance of incentives for less than optimal quality."* However, since most exist upon admission, occurred many years ago, occurred at a different hospital, and may not have been avoidable with standards of practice at the time, this argument does not apply to the vast majority of patients. For example, the examples typically given for complications that should NOT be paid for are wrong site surgery and sponges/instruments left in the patient. These and other "never events" may in total represent ½ of 1% of complications that currently exist. Not paying for the other 99.5% of these complications will simply create new perverse incentives to avoid admitting these patients. It is also less likely these diagnoses will be reported.

These issues and concerns can be seen in more detail in the attached case study ***"Evaluating the Proposed Consolidated Severity Adjusted DRGs for FFY2008 - Examples from Hip and Knee Joint Replacement."*** On balance, while the APR/CSA DRGs have the potential to significantly improve DRG accuracy, in practice, they do not improve upon the Current Medicare DRGs, rather simply change which cases will be overpaid and underpaid, and create new perverse incentives to replace old ones.

We recommend keeping the current "Base DRGs," and expanding them where appropriate (e.g. separate hip and knee joint replacements as proposed in APR/CSA DRGs and Spine surgery refinements discussed in more detail under the topic DRGs: Spinal Fusion.) In addition, the magnitude of the "major resource driver" (type of diagnosis, type of procedure, major specific procedure (e.g. Bi-lateral joint or two incision anterior/posterior fusion), major combination of severe co-morbid conditions-"severity", complication of prior care now being treated, etc.) should determine how to build into a fair payment system to align payments to cost. For example, a payment adjustment that increases a patient's severity by one severity level (about $1,500-2,000) is adequate for a typical revision case that also costs about $1,500-2,000 more, but not for a bi-lateral joint replacement that costs $5,000-6,000 more.

CMS specifically asked for comments regarding alternatives. Attached is a table ***"DRG System Pros & Cons"*** which outlines features that each of the current major DRG systems provides. Our analysis shows that none of these "off the shelf" Version 23 DRGs systems are the best alternative. Rather, we recommend a hybrid system which would combine the best features of each system. From a technical perspective, we would prefer to modify the proposed APR/CSA

DRGs, since the multiple precise adjustments for determining "severity" mirror a number of the recommendations we made in 1994 when the last "Severity" proposal was made. It has calculation steps to explore a variety of patient level differences that affect patient severity adjustments that are age specific, DRG specific, principal diagnosis specific, number and degree of individual severity predictors, etc. Adding back the current Base DRGs and complications to create a new scale ("resource intensity," in addition to the current "severity" and "mortality" scales) could achieve this preferred hybrid. One issue that others have raised is the proprietary nature of the APR DRGs that form the basis of the CSA DRGs. It is unclear how open the proposed system is to these recommendations and future annual changes. If the recommended changes to incorporate complexity by restoring base DRGs and incorporate complications cannot be accommodated, other systems could be modified to capture at least some of the desired precision.

Admission Selection and Referral Patterns

One of the driving policy forces for CMS to make the proposed changes in weights and DRGs is admission selection and referral patterns (particularly attributed to MD owned Specialty Hospitals). This essentially means looking at whether there are different admission patterns of simple and difficult cases within a payment category. Attached is "Why Case Mix Refinement is Needed- Example from Minor Back Procedures." This example shows that there are variable patterns of simple vs. difficult cases within each referral region, but that overall mix between regions is quite similar. This is to be expected due to facility program specialization and regional referral centers for difficult cases. We found the same patterns within New York State, and expect the same within any self contained planning regions.

We recommend that referral patterns for cases with difficult conditions either present or predictable on admission be examined routinely to assess payment equity and assure that regional referral centers are paid appropriately for caring for these difficult cases (and others are not inappropriately rewarded for avoiding treating them.) Referral should occur to best meet the patient's clinical need for care, not to maximize payment - and we believe that the vast majority of referrals are made in the best interest of the patient. Aligning payments with cost will both remove temptation and allay fears for CMS, Congress, etc. about whether admission and referral decisions are appropriately based on the patient's clinical decisions.

Limitations on Numbers of Diagnoses and Procedures Used by CMS

The current Medicare billing system (UB format) only allows submission of 9 diagnoses and 6 procedures. MEDPAR therefore only has 9 Dx and 6 Pr positions (out of the 25/25 that HIPAA requires that hospitals maintain.) This will cause major coding practice shifting as hospitals seek to make sure that the ever growing number of "important codes" are in the first 9/6 positions (full treatment descriptions which frequently requires several sets of procedure codes, diagnoses explaining reason for admission and extended stay, severity, complications, quality indicator numerators and denominator exclusions, risk adjustments, etc.). MEDPAR should expand to 25/25 (the APR DRG grouper accepts 30/30.) Since MEDPAR drives Medicare payment and is the only "national" data source for administrative data, this is also an issue for measuring or risk adjusting for Quality Indicators and Pay-for-Performance, which use MEDPAR data. Expansion will provide more accurate information for both payment and quality. If kept at the current 9/6 - it will encourage gaming and make both payment and quality measurement wildly inaccurate.

D R A F T - Comparison of Current and Potential DRG Classification Systems

Patient Classification System	System Impact Score	Equity, Access, Selection & Referral (Dis)Incentives	Dimension A Severity of Illness		Dimension B Treatment Complexity		Dimension C Complications	
1. Current V23 Medicare DRGs	**0**	Base for Comparison	**0**	Base for Comparison	**0**	Base for Comparison	**0**	Base for Comparison
2. Proposed 2008 APR-CSA DRGs	**0**	Still perverse incentives to avoid treating "difficult" patients –just different definition of "difficult." May be worse, since will know how much used to be paid for these difficult cases.	**+3**	Recognized at the MDC level (Severity level 4), DRG level (Severity levels 1-3), and specific Dx/Pr, with "re-routing" and age-adjustments	**-1**	Ignores significant complexity costs by collapsing several procedure specific DRGs into fewer base DRGs, without adequate adjustment.	**- 2**	Ignores significant complications for payment recognition, including those present on admission. Removed from CC list for levels 2-3-4.
3. V23 AP-DRGs (used in NY non-Medicare payment)	**+3**	Would reduce some perverse incentives to avoid difficult patients by paying for identified MCCs and base DRGs.	**+1**	Recognized at MDC level in MCC DRGs	**+1**	More base DRGs that differentiate patients by type and reason for procedure.	**+1**	Recognized in base DRGs & at MDC level by DRGs for complications & by refined CC list.
4. V23 APS-DRGs (M/C Base DRGs, split by relative CC resource impact)	**+3**	Would reduce some perverse incentives to avoid difficult patients by paying for identified CC severity.	**+2**	Recognized at the DRG level. (using 3 severity levels)	**0**	Same as Current Medicare DRGS	**+1**	Recognized at the DRG level.
5. Refine Current DRGs: CC list, New Base DRGs	**+3**	Would incrementally reduce some perverse incentives to avoid difficult patients.	**+1**	Refine CC list to reflect current practices	**+1**	More Base DRGs to separate simple and difficult cases	**+1**	Refine CC list to reflect current practices
6. Hybrid: Combine "Best " features of above systems	**+6**	Eliminates the most perverse incentives for avoiding treating difficult patients by incorporating ALL known major resource drivers.	**+3**	Use APR-CSA severity logic, but expand base DRGs and incorporate complications.	**+2**	Add Base DRGs to separate simple and difficult cases: clues from AP, APR, DRG refinement requests.	**+1**	Set severity levels for BOTH complications and comorbidities, based on resources (costs)
7. Future Modifications to "Best"	**+9**	Eliminates perverse incentives for avoidable complications. Ongoing updates would eliminate any new ones as clinical practice changes.	**+4**	Continue to refine to match current practice.	**+3**	Continue to refine to match current practice.	**+2**	Eliminate/reduce payment with more data and analysis for "avoidable " complications at facility & region level

Evaluating the Proposed Consolidated Severity Adjusted DRGs for FFY2008
Examples from Hip and Knee Joint Replacement

The Centers for Medicare and Medicaid Services (CMS) has committed to Congress and MEDPAC to modify the hospital payment system to better align costs and payments. This would reduce current incentives for "crème skimming" (seeking out profitable patients) and at the same time, reduce underpayment to hospitals for treating difficult and complex patients (both referred and complicated readmissions). The proposed changes from current Diagnosis Related Group (DRG) definitions in use through FFY2007 to the proposed Consolidated Severity Adjusted DRGs (CSA-DRGs) fix some of the current cost/payment misalignments, but create new ones that must be corrected before they are implemented. Specifically the proposed CSA-DRGs:

a. + Adjust better for patient severity
b. - Adjust less for treatment complexity
c. - Remove current payment differentials for patients with complications

The proposed CSA-DRGs 414-419 for Hip and Knee Joint Replacements <u>are presented below as examples of how the proposed CSA-DRGs will either fix or make current problems worse</u>:

A. The proposed CSA-DRGS adjust better for patient co-morbidity severity

<u>INITIAL JOINT REPLACEMENTS WITHOUT CO-MORBIDITIES</u>

About 40% of these hip and knee patients are straight forward clinically – initial joint replacement with no complicating or co-morbid conditions to make care more difficult. They currently have payment levels set about $ 1,000 over their cost (national average – will differ by locality.) The proposed adjustments would modify payments for these cases so that the margin is less than $200 per case (Table 1.) This will alleviate of the problem of overpaying hospitals that in the past have consciously sought out patients who did <u>not</u> have co-morbid or complicating conditions or require complex treatment.

Table 1 – Initial Joint Replacements without Co-morbidities or Complications

Joint	Est. Cases	% Cases	Est. Cost	FFY07 Est. Pay	FFY07 Est. Margin	FFY08 Est. Pay	FFY08 Est. Margin
Hip	90,677	42%	$ 9,693	$ 10,467	$ 774	$ 9,815	$ 122
Knee	106,870	42%	$ 9,372	$ 10,467	$ 1,096	$ 9,576	$ 204

<u>INITIAL JOINT REPLACEMENTS WITH MINOR (Level 2) CO-MORBIDITIES</u>

Approximately another 34% of the hip and knee patients are initial joint replacements that have minor co-morbid diagnoses that increase treatment costs slightly, but no complicating conditions. Current DRGs pay both hip and knee patients the same amount; however hip patients cost about $ 1,000 more than knee patients. Facilities with a typical 45/55 hip/knee mix will break even. Facilities that treat more hip than knee patients are disadvantaged and vice versa. The proposed adjustments split hip and knee patients into their own DRGs, and adjust the severity level for the minor co-morbidities. This improves payments for both hip and knee patients, and narrows the margin gap between them to about $300 (Table 2.)

Table 2 – Initial Joint Replacements with Only Minor Co-morbidities

Joint	Est. Cases	% Cases	Est. Cost	FFY07 Est. Pay	FFY07 Est. Margin	FFY08 Est. Pay	FFY08 Est. Margin
Hip	66,873	31%	$ 11,004	$ 10,467	$ (537)	$ 11,282	$ 278
Knee	93,359	36%	$ 10,035	$ 10,467	$ 433	$ 10,616	$ 582

<u>INITIAL JOINT REPLACEMENTS WITH MAJOR OR MULTIPLE (Level 3 or 4) CO-MORBIDITIES OR COMPLICATIONS FROM PRIOR SURGERY</u>

About 13% of the hip and knee patients are the more difficult patients (e.g. 711.xx Pyogenic arthritis) who are typically referred to a regional center due to having either major or multiple co-morbid diagnoses or complicating conditions associated with prior surgery. Under the current DRGs, referral centers that

admit these patients lose $ 2,500 – 3,500 on each. The proposal reduces the loss for hip referrals to ($300), and reverses the loss to about a $ 600 gain for knee referrals (Table 3.) A hospital with a typical 60/40 mix of these patients would almost break-even.

Table 3 - Initial Joint Replacements w Major or Multiple Co-Morbid or Complicating Conditions

Joint	Est. Cases	% Cases	Est. Cost	FFY07 Est. Pay	FFY07 Est. Margin	FFY08 Est. Pay	FFY08 Est. Margin
Hip	34,768	16.1%	$ 13,947	$ 10,467	$ (3,480)	$ 13,652	$ (295)
Knee	24,230	9.5%	$ 12,889	$ 10,467	$ (2,422)	$ 13,481	$ 592

B. The proposed CSA-DRGs adjust <u>less</u> for treatment complexity

<u>REVISIONS</u>

About 9% of the hip and knee patients are more complex because they require a revision to a prior joint replacement. A new DRG was implemented in FFY2006 for these cases. In total, payment rates equalized for hospitals with a typical 55/45 hip/knee mix. However, there is a $1,200 difference favoring knees in FFY2007. The proposal <u>decreases overall payments for revision patients</u> (averaging $ 400) by putting the revisions and the initial joint replacements into the same initial hip and knee CSA-DRGs. The severity level of patients undergoing a revision is raised up one level for patients who do not have a significant comorbidity or complicated principal diagnosis – maximum of level 3 for hips but only level 2 for knees. Hip revisions would almost break even, but knee revisions would be underpaid by about $800 average per case (Table 4.) This <u>reverses the direction</u> of the FFY2007 margin difference – an almost $ 2,000 swing.

Table 4 – Revisions to Joint Replacements

Joint	Est. Cases	% Cases	Est. Cost	FFY07 Est. Pay	FFY07 Est. Margin	FFY08 Est. Pay	FFY08 Est. Margin
Hip	21,417	9.9%	$ 13,218	$ 12,677	$ (541)	$ 13,162	$ (56)
Knee	19,419	7.6%	$ 11,998	$ 12,677	$ 679	$ 11,228	$ (770)

<u>BILATERAL OR MULTIPLE JOINT REPLACEMENTS</u>

About 3% of the hip and knee cases undergo bilateral or multiple joint replacements (two hips, two knees, or one of each – during the same patient stay.) Hospital costs are about 50% higher than for a single joint replacement, largely reflecting longer operating room time and the cost of the additional joint implant. When two joints need replacement, physicians and their patients decide clinically whether to replace both joints in a single stay or "stage" them during two separate stays, usually within 6 months. There is a separate DRG through FFY2007 for bilateral cases; however the FFY2008 proposal puts them into the same CSA-DRGs as the initial and single joint replacements. There is only a partial adjustment for a handful of cases (those having BOTH a hip and knee replaced during the same stay), resulting in an <u>average underpayment of ($ 5,100) per case</u>. These difficult cases are typically treated in a few regional referral centers, which will be severely underpaid by the proposal. Added splits for Complications (without or with) are also meaningful for these cases (Table 4.)

Table 4 – Bilateral or Multiple Joint Replacements with and without Complications

Bilat/Mult Jnt. Repl	Est. Cases	% Cases	Est. Cost	FFY07 Est. Pay	FFY07 Est. Margin	FFY08 Est. Pay	FFY08 Est. Margin
*Hip wo	715	0.3%	$15,632	$ 15,934	$ 302	$ 11,356	$ (4,276)
*Hip w	652	0.3%	$ 26,284	$ 15,934	$ (10,350)	$ 12,655	$ (13,629)
Knee wo	10,105	3.9%	14,879	$ 15,934	$ 1,055	$ 10,465	$ (4,414)
Knee w	1,776	0.7%	17,750	$ 15,934	$ (1,816)	$ 11,959	$ (5,791)

**Includes patients with both hip and knee replaced during the same stay.*

C. The proposed CSA-DRGs remove current payment differentials for patients with complications

INFECTED JOINTS WITH DEBRIDEMENT

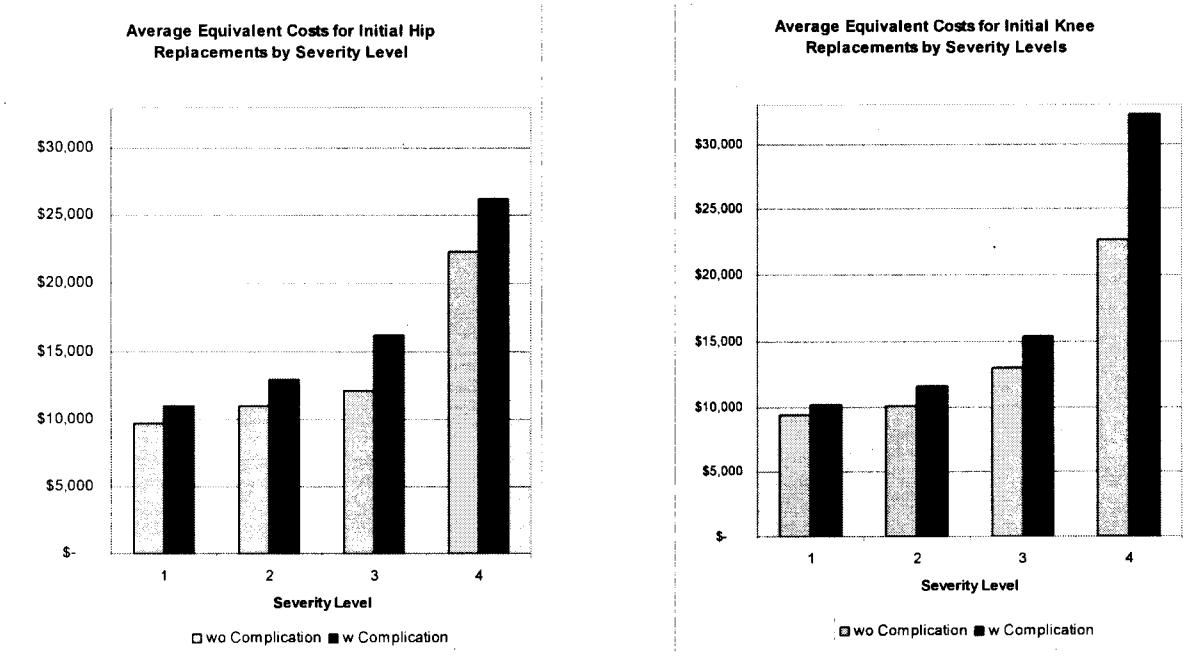
The rest of the cases currently fall into DRG 217 – Debridement. These are some of the most difficult and complex orthopedic patients to treat. Many have deep orthopedic infections not responsive to normal antibiotic treatment. Many have multiple complicating conditions, and on average stay more than twice as long as typical patients. The current DRG 217 is in effect a consolidated "complexity" DRG, consisting of patients who require wound debridement and may or may not have other orthopedic procedures and treatments during the same stay. This is similar conceptually to the level 4 "Severe" CSA-DRGs proposed for co-morbid diagnoses across a Major Diagnostic Category. The proposal eliminates this complexity DRG, and re-assigns patients to other DRGs reflecting their other (not debridement) procedures. The hip and knee patients with wound debridements are underpaid almost ($ 11,000) each (Table 5), which has a serious disproportionate financial impact on the referral hospitals admitting these difficult cases from other hospitals around the region.

Table 5 – Joint Replacements with Wound Debridements

Joint	Est. Cases	% Cases	Est. Cost	FFY07 Est. Pay	FFY07 Est. Margin	FFY08 Est. Pay	FFY08 Est. Margin
Hip	581	0.3%	$ 25,156	$ 24,857	$ (300)	$ 14,327	$ (10,829)
Knee	395	0.2%	$ 24,355	$ 24,857	$ 502	$ 13,527	$ (10,828)

INITIAL JOINTS – WITH AND WITHOUT COMPLICATING CONDITIONS

As can be seen in the following charts, patients with complicating conditions have more resource needs (costs) than patients without these conditions **for every co-morbidity severity level**.



As a consequence, proposed payment rates set at the average at each severity level will introduce a bias to systematically overpay patients without complications and systematically underpay patients with complications. This new systematic bias will result in unnecessary patient referrals to regional centers for complications that could safely be treated locally. This places an unfair burden on these regional referral centers. They must shoulder the costs of this uncompensated care since they cannot deny access. Most of these complications are present on admission, and are therefore "unavoidable" to the admitting hospital.

These charts and (Table 6) below illustrate that facilities can avoid an extra $ 2,000 in non-reimbursed cost per patient by avoiding admission of difficult patients with complicating conditions.

Table 6 – Cost Difference – Admitting a Patient with and without a Complication (Payment=Same)

	Level 1	Level 2	Level 3	Level 4	Weighted Average
Initial Hip – wo vs. w Complication	$ 1,328	$ 2,012	$ 4,063	$ 3,852	$ 2,152
Initial Knee – wo vs. w Complication	$ 791	$ 1,571	$ 2,383	$ 9,589	$ 1,809

Specific Hip/Knee Recommendations

- Implement "Base DRGs" for both Bilateral Hip Replacement and Bilateral Knee Replacement.
- Retain current DRG 217 across orthopedic cases to capture "severe complications".
- Differentiate major complications within initial hips/knees ($2,000/$1,500 higher) and bilateral hips/knees ($8,200/$1,200 higher), either by splitting each by presence of a major complication or incorporate into determination of "resource intensity levels."
- These high resource need patients average out with less intensive cases nationally and across a large region, but specific referral centers admit a disproportionate number of these difficult patients. Initial payment is appropriate to provide equity to the hospitals willing to admit the difficult patient and to avoid perverse "crème skimming" incentives.

Apply Concepts above to other Orthopedic DRGs and other Major Diagnostic Categories

- DRG intensity adjustments should occur along the dimension that is the most significant resource driver: procedure, medical diagnosis, complicating conditions, co-morbidities. For example:
  - Level 4 co-morbidities are 100%+ more than average for the specific procedure
  - Complex patients in DRG 217 are 100% more costly then the average joint replacement
  - Complex Bilateral joint costs are 50% higher than single initial joint replacements
  - Complex Revision joint costs are 20% higher than initial joint replacements
  - Severity levels 1-2 and 2-3 are 11-27% apart from each other in terms of average cost
  - Complication levels are 15-20% higher for initial joints, 10-50% for Bilateral, in addition to co-morbidity severity levels

Figure 1 – Hip Replacements by Severity Level

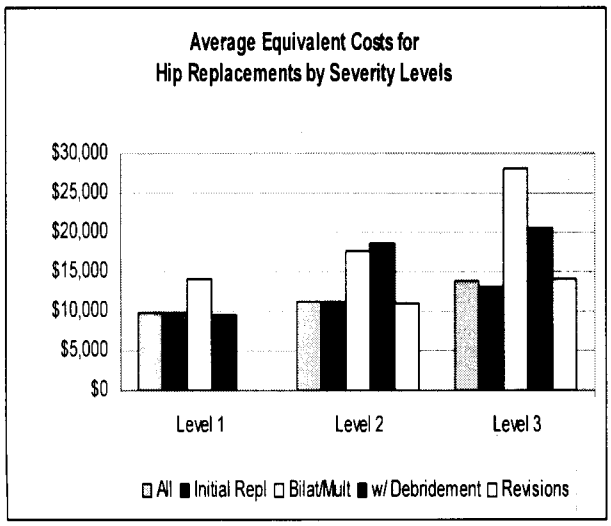
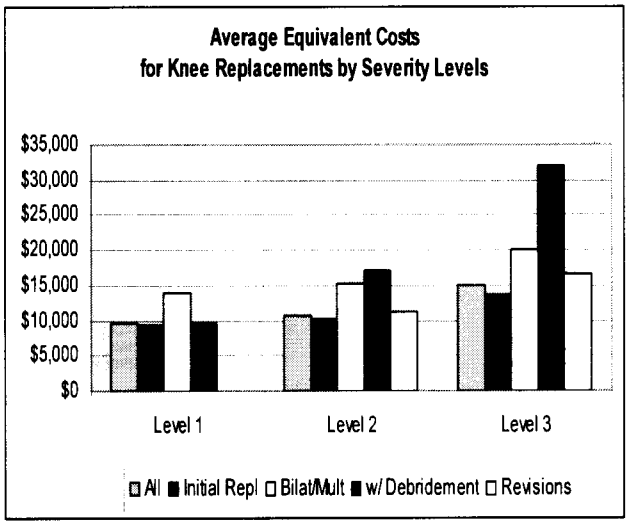


Figure 2 – Knee Replacements by Severity Level



Level 4 cases are not shown here. All level 4 cases collected into a combined CSA-DRG for Level 4 Surgical Orthopedic cases. Levels 1,2.& 3 each have their own CSA-DRGs. The chart above shows how each joint replacement scenario compares in average cost to the total average for each severity level.

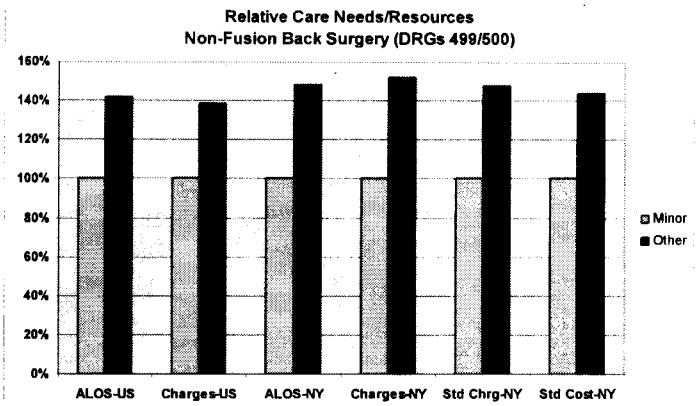
- HOW complexity is integrated into the APR/CSA-DRG structure depends on the degree that the complexity affects relative resources and risk for quality indicators and mortality
    - In the example above and as shown in Figures 1 & 2, revisions increase resources approximately the same amount as each severity level, and also increase relative risk, so incorporating them into the determination of severity level is valid.
    - The impact on relative resources for bilateral or multiple joint replacement patients is significantly higher at all severity levels, and therefore require a new "base DRGs" to accommodate them in the APR-CSA structure
- Current DRGs use **both** complications and co-morbidities to determine resource intensity for payment (cc). **Both** must also be incorporated into any new DRGs for payment equity and to avoid perverse incentives for admission/referral selection.
- Most major complications are present on admission. "Avoidability" of these complications should be reviewed retrospectively as part of Pay for Performance initiatives – both at the hospital level and across a region where many occur.
- "No measure of case mix complexity can be equally effective for all the different aspects of case mix complexity."[1] The current structure for APR-CSA DRGs incorporates co-morbidity severity but not complications and only some complexity, and may be appropriate for severity adjusting quality indicators and mortality – their primary use over the past few years. New weights for relative resources for payment appear necessary to include complications and complexity without adversely impacting risk adjustment use. DRG hierarchy changes would only be necessary if the materiality requires it (like DRG 217 in the example above.) These could be collapsed back when using for risk adjustment for quality and mortality.
- While constructing this case study, we noted several severity adjustments that had been implemented for Hip replacements that the data indicates should also be applied to Knee replacements (TKA). These include:
    - A severity adjustment for obesity (and all diagnosis codes for BMI >= 30), the same as done for Hip replacement (APR-DRG "Step 5")
    - Give knee revisions an add-on severity adjustment up to level 3, the same as is done for hip revisions (APR-DRG "Step 13").
- In review of the complicated principal diagnoses (APR-DRG "Step 10") for Hip and Knee replacements, we noted that several other principal diagnoses are predictive of difficult cases and should be included:
    - Pyogenic Arthritis (71105, 71106, 71107)
    - Acute Osteomyelitis (73005, 73006, 73007)
    - Pathological Fractures (73314, 73315, 73316)

[1] Averill RF, et. al. "All Patient Refined Diagnosis Related Groups (APR DRGs) Methodology Overview," 3M Health Information Systems, Wallingford, CT, March, 2006.

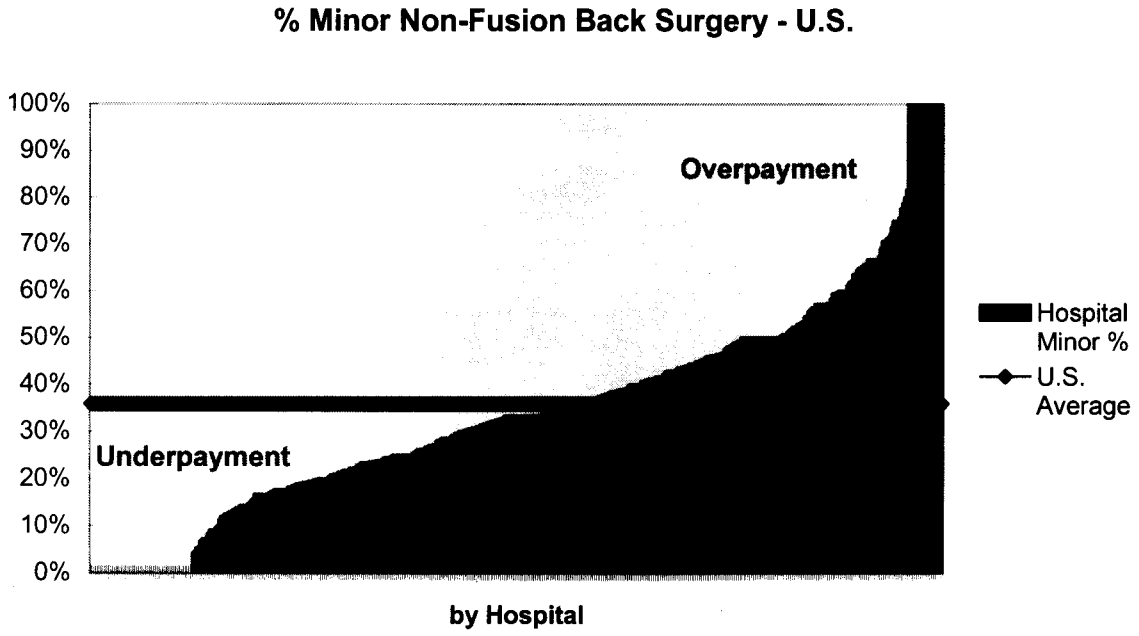
Why Case Mix Refinement is Needed for Non-Fusion Back Surgery (DRGs 499/500)

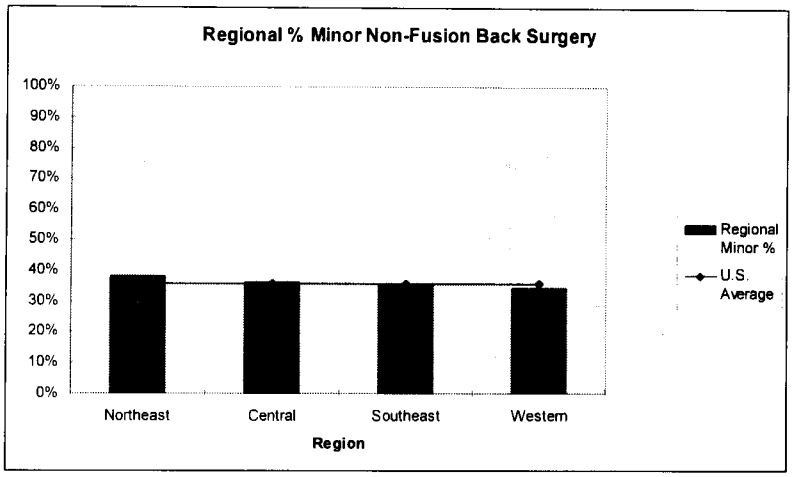
Approximately 35-40% of Medicare cases admitted to a hospital for Non-Fusion Back Surgery (DRGs 499/500) had either a single (herniated) disk removed/destroyed OR a portion of a single vertebrae excised to decompress a narrowed spinal canal (i.e. spinal stenosis). Both relatively minor back procedures relieve pressure on the spinal nerve root and alleviate the pain it causes.

Other cases that group to these DRGs have surgery at multiple levels, vertebral fracture repair, implantation or removal of devices (neural stimulators, artificial disk replacement, etc), repair of degenerative changes in the spinal joints (spondylosis), removal of adhesions or implants from a previous back surgery, etc. These cases have care needs 40-50% higher than the minor back procedures described above. (U.S. and NYS data)



"Averaging" DRG payments for the lower resource minor back procedures with the higher resource needs of the other back surgery patients leads to underpayment of any hospital that does a greater than average number of more difficult cases and to overpayment for hospitals that do more of the minor back procedures. Because difficult cases are routinely referred to regional Centers of Excellence, while at least some hospitals seek out the minor cases that have generous payments (e.g. an accusation leveled at some MD-owned Orthopedic Specialty Hospitals in some states), actual variation in referral and admission patterns drive underpayment/overpayment, e.g.:

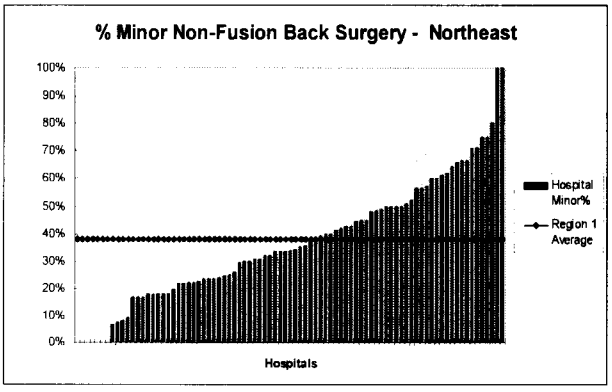


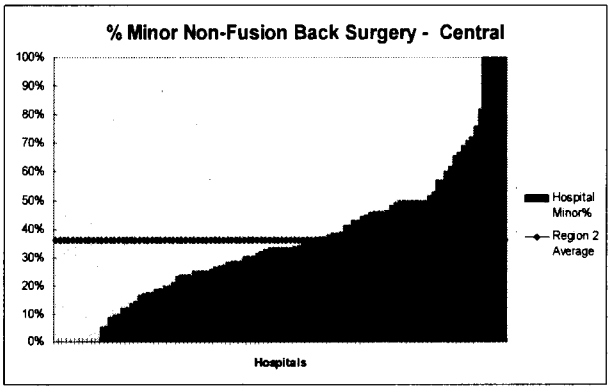


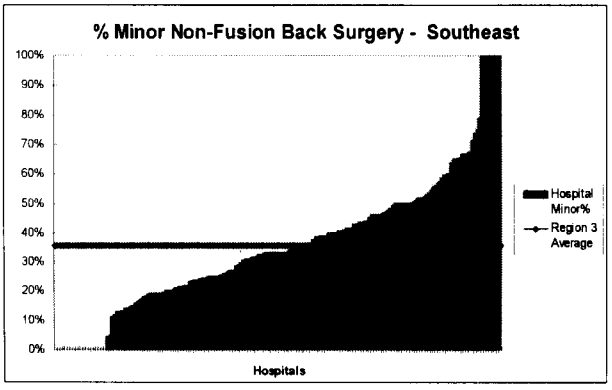
Further analysis shows that the percentage of Non-Fusion Back Surgery cases that are Minor (i.e. Removal/ Destruction of a Single Disk OR a Single Decompression) is consistent ACROSS broad geographic areas, reflecting similar patient care needs overall across regions (Source: 2003 Medicare Cases in National Inpatient Sample- NIS)

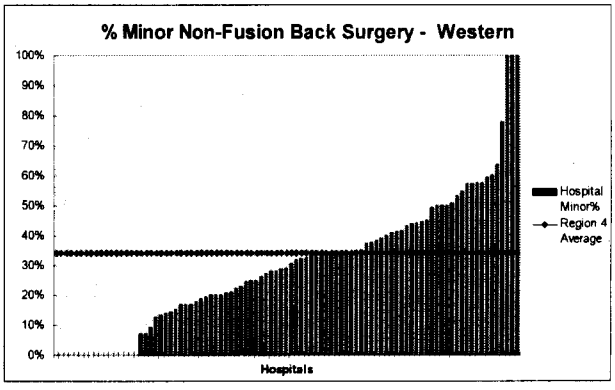
This illustrates that "Averaging" can work - when the mix between high resource and low resource patients are aggregated to a broad level (or when driven solely by random chance.)

Perverse incentives will occur - where conscious referral and/or selection affects admission patterns and the resulting mix of high resource and low resource patients (as it naturally does in each region - see below). Regional Centers of Excellence are penalized by underpayment for admitting the complex "train wreck" patient they were designed and encouraged to care for. Overpayments to other hospitals are at worst removed from patient care as profits, and at best used to "cross-subsidize" other underpaid health care services (thereby confusing everyone and making true system improvements more difficult to design and implement.) Severity adjusting these DRGs to split out minor back procedures will help reduce these perverse incentives.









NEXT WAVE

"We Understand Health Care"

June 12, 2006

Mr. Marc Hartstein
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1488–P
P.O. Box 8011 *http://www.cms.hhs.gov/eRulemaking*
Baltimore, MD 21244–1850

Re: File code CMS–1488–P.

Dear Mr. Hartstein:

We are a health services research and consulting group specializing in using data to classify patients into categories for policy, management, financing, and quality improvement. Our staff worked on the design, refinement, and implementation of various Diagnosis Related Group (DRG) payment systems at national and state levels since the 1970's. Our comments update those we made in 1994 (when "Severity" DRGs were last proposed) and intervening years.

We comment on several issue areas for the proposed FFY2007 and FFY2008 Medicare Acute Hospital payment rates. We separate each of these issues, and incorporate this page, specific comments, and appropriate attachments for each:

- DRGs: Hip and Knee Replacements
- DRGs: Spinal Fusion
- HSRV Weights
- DRGs: Severity of Illness
- Transparency of Health Care Information
- Value-Based Purchasing

Our staff has hands-on knowledge of both proposed refinements and alternative approaches. We hope that these insights assist your ongoing efforts to implement a payment system that fairly aligns payments with the costs of providing needed patient care to Medicare Beneficiaries. Please contact us for any additional input you need over the next year to address these issues.

Sincerely,

John D, Shaw
President

Enc.

24 Madison Avenue Ext. ● Albany, NY 12203 ● (518) 452-3351 ● Fax (518) 452-3358 ● www.nextwave.info

Transparency of Health Care Information:
The current Medicare billing system (UB format) only allows submission of 9 diagnoses and 6 procedures. MEDPAR therefore only has 9 Dx and 6 Pr positions (out of the 25/25 that HIPAA requires that hospitals maintain.) This will cause major coding practice shifting as hospitals seek to make sure that the ever growing number of "important codes" are in the first 9/6 positions (full treatment descriptions which frequently requires several sets of procedure codes, diagnoses explaining reason for admission and extended stay, severity, complications, quality indicator numerators and denominator exclusions, risk adjustments, etc.). MEDPAR should expand to 25/25 (the APR DRG grouper accepts 30/30.) Since MEDPAR drives Medicare payment and is the only "national" data source for administrative data, this is also an issue for measuring or risk adjusting for Quality Indicators and Pay-for-Performance, which use MEDPAR data. Expansion will provide more accurate information for both payment and quality. If kept at the current 9/6 - it will encourage gaming and make both payment and quality measurement wildly inaccurate. The use of this incomplete data will serve to mis-inform stakeholders.

For Complications of prior care, we note that using only 9/6 positions will provide an incentive to doctors not to document and to hospitals not to code complications - since they can only be hurt. With no payment benefit, complications can only make quality measures look worse, and also reduce any pay-for-performance payments.

We also support the CMS proposal to begin to report total costs of "Episodes of Care" and not just component pieces. The latter should include Hospital(s), Post-Acute-Care (Rehabilitation Facility, Skilled Nursing Facility, Home Care), Outpatient Rehabilitation, Drugs, DME, and Medical Care for an entire episode (e.g. Hip replacement) by Hospital, area, region, etc. This is a better measure of true costs, since we have noted wide variation, particularly in the use and type of Post-Acute-Care across hospitals, areas, and regions. Each component should be provided for each hospital. This will allow comparisons across different mixes of post-acute-services, etc.

NEXT WAVE

"We Understand Health Care"

June 12, 2006

Mr. Marc Hartstein
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1488–P
P.O. Box 8011 *http://www.cms.hhs.gov/eRulemaking*
Baltimore, MD 21244–1850

Re: File code CMS–1488–P.

Dear Mr. Hartstein:

We are a health services research and consulting group specializing in using data to classify patients into categories for policy, management, financing, and quality improvement. Our staff worked on the design, refinement, and implementation of various Diagnosis Related Group (DRG) payment systems at national and state levels since the 1970's. Our comments update those we made in 1994 (when "Severity" DRGs were last proposed) and intervening years.

We comment on several issue areas for the proposed FFY2007 and FFY2008 Medicare Acute Hospital payment rates. We separate each of these issues, and incorporate this page, specific comments, and appropriate attachments for each:

- DRGs: Hip and Knee Replacements
- DRGs: Spinal Fusion
- HSRV Weights
- DRGs: Severity of Illness
- Transparency of Health Care Information
- Value-Based Purchasing

Our staff has hands-on knowledge of both proposed refinements and alternative approaches. We hope that these insights assist your ongoing efforts to implement a payment system that fairly aligns payments with the costs of providing needed patient care to Medicare Beneficiaries. Please contact us for any additional input you need over the next year to address these issues.

Sincerely,

John D, Shaw
President

Enc.

24 Madison Avenue Ext. ● Albany, NY 12203 ● (518) 452-3351 ● Fax (518) 452-3358 ● www.nextwave.info

Value-Based Purchasing:
The intended 2008 modifications to reduce payments for Hospital Acquired Infections will require implementation and use of the "present on admission" indicator prior to implementation (national collection begins October 2006.) Potential methodologies to perform this payment modification can be modeled using data from states that already report this information (e.g. New York, California.)

Health Information Technology for Hospitals
CMS must set standards for systems to communicate – this will speed implementation and reduce overall HIT implementation costs.

The proposal noted that "The 2007 Budget states that ''The Administration supports the adoption of health information technology (IT) as a normal cost of doing business to ensure patients receive high quality care.'' This appears to imply that hospitals should be mandated to adopt expensive HIT systems without any payment to do so. What most studies have shown, including the RAND study quoted to support this, is that "A major obstacle to investment in health information technology is that those who pay for it don't necessarily experience the savings," and "We need to find ways to reward health providers who invest in measures that will boost efficiency and promote quality." HIT is an Investment decision, not an operational budgeting decision. Savings accrue to the overall health care system, not just to individual hospitals.

- In other industries that have achieved cost savings due to HIT, most have financed the HIT investment by issuing equity stock (which much of the health care industry cannot do.) Returns due to cost savings go to the company which made the investment (which to a large extent does NOT happen in health care, where most of the savings accrue to the payors and employers.) Many companies that did not make these investments did not see the cost savings, became less competitive, and closed (which in health care would mean denying access to health care services in many rural and inner city areas - the hospitals that cannot make these investments on their own.)
- In other countries that have invested in health care HIT, much of the cost of the infrastructure investment was borne by the government, as are infrastructure investments in transportation and communications.
- The solution is obviously to align the investment with the return. The RAND report indicated that Hospitals might save up to $81 billion annually (primarily through reduced length of stay and better coordination.) The same report indicated that total health care system savings might save up to $ 346 billion annually. The "hospital attributed" portion of the savings is only 23% of the total - if they could keep all of the savings. In reality, many hospitals are paid by non-Medicare payors on a per-diem basis, and would share more than 100% of their cost savings with the payor, since payors generally would not be paying for a portion of a hospital's fixed cost as well as the variable cost savings for the days saved. Based on this evidence, which CMS indicates is the best available at this time, hospitals should only be expected to pick up 10-23% of the investment in implementing HIT. Medicare and other payors should provide the remaining investment in implementing HIT.

Limitations on Numbers of Diagnoses and Procedures Used by CMS
The current Medicare billing system (UB format) only allows submission of 9 diagnoses and 6 procedures. MEDPAR therefore only has 9 Dx and 6 Pr positions (out of the 25/25 that HIPAA requires that hospitals maintain.) This will cause major coding practice shifting as hospitals seek to make sure that the ever growing number of "important codes" are in the first 9/6 positions (full treatment descriptions which frequently requires several sets of procedure codes, diagnoses explaining reason for admission and extended stay, severity, complications, quality indicator numerators and denominator exclusions, risk adjustments, etc.). MEDPAR should expand to 25/25 (the APR DRG grouper accepts 30/30.) Since MEDPAR drives Medicare payment and is the only "national" data source for administrative data, this is also an issue for measuring or risk adjusting for Quality Indicators and Pay-for-Performance, which use MEDPAR data. Expansion will provide more accurate information for both payment and quality. If kept at the current 9/6 - it will encourage gaming and make both payment and quality measurement wildly inaccurate. Performance Payments based on this inaccurate data can be manipulated easily, particularly due to the few cases that typically drive Quality Indicators.

Caution: Composite Measures
We recommend caution in the creation of composite measures for quality scoring, since there are wide variations in documentation and coding currently and in the existing measures themselves. To avoid major "Unintended Consequences", caution is needed to address:

- Variability in documenting and coding "common" conditions that "drive" some quality measures and composites (certain conditions occur much more frequently than others, and can potentially "overwhelm" other measures that occur less frequently in a composite measure.) For example, "dural tears" are coded as complications by some Spine Surgeons (ICD-9-CM code 998.2 - Accidental Puncture or Laceration During a Procedure), since they are unintended and usually require treatment and/or extended stay. Other Spine Surgeons/hospitals do not code these dural tears at all, since they consider them to be "incidental" to the spine surgery. There is also a major difference in the risk of these dural tears - the literature reports that revision spine surgery or lysis of adhesions on the dura from prior surgery has a risk of a dural tear that is 15-30 times greater than for simple laminectomy or disk removal.
    - Similarly, most quality indicators do not differentiate Pulmonary Embolism, Proximal DVT, and Distal DVT. Since the patient risk is widely different for each, and there are major screening and reporting differences between hospitals (some surgeons consider calf DVT to also be "incidental" and not code them at all and some hospitals do not test for PE/DVT in asymptomatic hip and knee replacement patients, and therefore cannot code VTE for many patients that have them, because they are not confirmed.)
- Risk adjustment needs to truly address indicators from the perspective of Risk of **Harm** to the Patient, and fully address major predictors of this harm, including not only the patients age, co-morbid conditions, and type of procedure, but ALL other factors that translate the reported indicator source data to prediction of Harm to the patient as well. None of the existing risk adjustment methodologies do this. Under current methods:
    - A hospital which appropriately reports all dural tears that are clinically meaningful (repair or treatment or extended stay) for their complex patient population, and has rates that are half of those reported in the literature will look "worse" than a hospital that only performs simple laminectomies and

diskectomies with a dural tear rate double that in the literature or a third hospital that has even higher rates, but has a policy that all dural tears are "incidental to the procedure" and reports a rate of 0%.

  - A hospital with 5% PE, 3% Proximal DVT, and 2% Distal DVT (10% VTE rate) would appear "twice as good" as a hospital with 0% PE, 2% Proximal DVT, and 18% Distal DVT (20% VTE rate), even though the true risk of patient harm in the first hospital is much higher than the second.

- Exploration of the measure itself relative to current clinical practices is critical. For example, one quality indicator receiving added attention is "re-admission within 30 days of discharge." The intent is to measure premature hospital discharge and correction of quality problems of the first admission. However, we have observed that there may be many patients that have planned readmissions to address chronic conditions or for sequential surgical procedures where the patient recovers from the first surgery before undergoing the second. Historically, the patient may have been kept in the high cost hospital bed to recover, but now may safely recover in a less intense post-acute-care facility or with home care. Treating both situations as quality problems is inappropriate. Means of distinguishing these two (both frequent) scenarios is needed prior to tying this measure to public reporting or pay-for-performance.

Submitter : **Ms. Jan Niles** **Date: 06/12/2006**

Organization : **Alegent Health**

Category : **Other Health Care Professional**

Issue Areas/Comments

Hospital Quality Data

Hospital Quality Data

I previously tried to send an attachment, but I'm not sure that it worked, so I'll retype my comments here. I would like to comment regarding the proposed requirement for submission of an expanded set of quality measures under the RHQDAPU program

We anticipated the addition of the listed measures for Acute Myocardial Infarction (AMI), Heart Failure (HF), Pneumonia (PNE), and Surgical Infection Prevention (SIP) in the near future. What we are concerned about is the requirement that data be submitted for discharges going back to January 1, 2006. We had not been collecting SIP data yet, and we have been forced to do an extraordinary amount of catch-up work to get it collected for the first quarter of calendar year 2006. (AMI, HF, and PNE have not been a problem, as we had already been collecting and submitting all of this data voluntarily.)

We feel that it was unreasonable to publish a proposed rule on April 25, 2006, that included a requirement to submit data on discharges from nearly four months earlier. By the time this rule becomes final, our vendor's deadline for the submission of January through March 2006 data will have passed.

Thank you for the opportunity to comment.

Jan C. Niles, RHIA
Data Management Specialist, Quality Management Services
Alegent Health
Omaha, NE

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

Organization : **New York Presbyterian Hospital**

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 : **Dr. Raymond Blair** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

CMS-1488-P-1678-Attach-1.DOC

#1678

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

Someone at CMS will need to explain to me, how the teaching, curriculum development and evaluation process for the six required ACGME physician skill competencies is not related to patient care. Isn't this exactly what the IOM has criticized our training professions for? In fact, our program currently evaluates us in all these competencies as a continuing quality improvement process DURING patient care. Without time to discuss and reflect our experiences and outcomes we will not be serving the needs of our current and future patients.

Should indeed this come to pass, we will have faculty who will be caught in the productivity race with no time for us. We may get pop-up feed back from an Electronic Health Record in sites that have them that we have made an error or we are not following a guideline. No discussion there. What is being proposed is dangerous for our current patients and our future patients. Our patients deserve for us to have a better education than you are proposing.

Why does the American taxpayer support medical students at over $200,000 per student per year and offers the faculty of residencies less than $15,000 for teaching per resident per year? I am getting a lot more from my residency training to protect and serve my patients of the future than all of medical school combined. Please do not cut us any more – rescind the clarification of this dangerous and capricious rule.

Medical Resident

Submitter : **Ms. Susan Hollander** **Date: 06/12/2006**

Organization : **Catholic Healthcare West**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1488-P-1680-Attach-1.DOC

CMS-1488-P-1680-Attach-2.DOC

CMS-1488-P-1680-Attach-3.DOC

#1680

Catholic Healthcare West
CHW

185 Berry Street
Suite 300
San Francisco, CA 94107-1739
(415) 438-5500 *Telephone*
(415) 438-5724 *Facsimile*

June 12, 2006

SUBMITTED ELECTRONICALLY

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

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

Dear Dr. McClellan:

Catholic Healthcare West (CHW), on behalf of our 41 hospitals in Arizona, California and Nevada, is pleased to submit the following comments on the notice of proposed rulemaking (NPRM) for the Medicare Hospital Inpatient Prospective Payment System for Fiscal Year 2007, as published in the April 25, 2006 *Federal Register* (Vol. 71, No. 79) and 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.".

The rule, if adopted as proposed, would make the most sweeping changes to the hospital inpatient prospective payment system (IPPS) since its implementation in 1983. Some of these proposed changes would have a tremendous affect on the care our hospitals provide to Medicare beneficiaries. The major elements 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 determined Medicare's payments for hospital inpatient services. The proposed changes include a move, beginning in FY 2007, to a system of payment weights based on costs, rather than the charge-based system that has been in use since 1983, for determining the payment weights for each patient category.
2. Significant changes to refine the method for identifying the variation in patients' severity of illness within DRGs. CMS said that this 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.

4. In addition, the rule would update the payment rates, outlier threshold, quality reporting requirements and payments for medical education, among other policy changes.

Catholic Healthcare West is supportive of many of the provisions in the proposed rule, but we have significant concerns about others. The DRG changes, due to their re-distributional impact, will certainly bring potentially major destabilizing factors to bear on the financial situation of many hospitals. With 41 hospitals in our health system, CHW naturally has hospitals that stand to potentially both gain and lose significant Medicare funds as a result of the DRG changes. Regardless of those impacts, however, there are still questions with regard to the concepts and methodology CMS plans to use to create the changes, and whether the changes will ultimately create an improved payment system.

We will provide comments and recommendations on the following issues:

1. DRG Relative Value Cost Weights - HSRVcc
2. Consolidated Severity-Adjusted DRGs
3. Proposed Changes to Specific DRG Classifications – MDC 1: Intracranial Neurostimulator System for Deep Brain Stimulation, Carotid Artery Stents and Changes to the ICD-9-CM Coding System
4. FY 07 Applications for New Technology Add-On Payments – X STOP Interspinous Process Decompression System
5. Inpatient Prospective Payment System Updates
6. Increase in the Medicare Fixed-Loss Cost Outlier Payment Threshold
7. Reporting of Hospital Quality Data for Annual Hospital Payment Update
8. Value-based purchasing
9. Changes to the Area Wage Index – Occupational Mix Adjustment
10. Payment for Direct and Indirect Medical Education
11. Hospital Emergency Services Under EMTALA

In addition to our comments, we also support the comments and recommendations of the American Hospital Association, the Catholic Health Association, Premier, Inc. and the California Hospital Association.

DRG RECLASSIFICATIONS

In response to payment recommendations from the Medicare Payment Advisory Commission (MedPAC) to address the proliferation of physician-owned, limited service hospitals, the Centers for Medicare & Medicaid Services (CMS) proposed the biggest changes to the calculation of DRG relative weights since the creation of the prospective payment system (PPS). These changes would significantly redistribute payments among the DRGs and among hospitals. Specifically, CMS proposes the use of hospital-specific relative values (HSRVs) and a modified version of cost-based weights rather than charge-based weights in fiscal year 2007. CMS also proposes an alternative patient classification system called consolidated severity adjusted DRGs (CS-DRGs), with implementation likely by FY 2008.

CHW supports meaningful improvements to Medicare's inpatient PPS, and applauds CMS for its efforts to craft changes to the PPS system in an attempt to limit the incentives that spur the proliferation of physician-owned specialty hospitals. However, we are concerned that the proposed DRG changes will also harm full-service, acute care hospitals with emergency departments that serve Medicaid and uninsured patients, and that also have significant cardiac and/or orthopedic surgery services. These full-service hospitals with large heart or orthopedic programs are doing the right things by providing emergency and inpatient services for all of the people in their communities, including low income and uninsured patients. Yet they will see their reimbursement for their surgical services decline significantly under the proposed rule, thereby limiting these hospitals' ability to offset some of the losses they incur in caring for Medicaid and uninsured patients. CHW has several hospitals that would fall into this category, each of which would be essentially punished under the proposed rule for doing the right thing, even though the intention of rule is to target limited-service specialty hospitals that cherry-pick only the profitable, insured patients.

We believe that hospitals and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs that will provide an equal incentive to treat all types of patients and conditions. We also believe the system should be simple, predictable, and stable over time. One of the fundamental values of a *prospective* payment system is the ability of providers to reasonably estimate payments in advance to inform their budgeting, marketing, staffing and other key management decisions. Another core feature of the PPS is clinically cohesive and meaningful DRGs that are 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. CHW believes that these are essential characteristics of a well-functioning PPS and it is within these policy goals that we evaluate CMS' proposal.

We would like to emphasize here that payment changes alone will not remove the inappropriate incentives created by physician self-referral to limited-service hospitals. Physicians will still have the ability and incentive to steer financially attractive patients to facilities they own, avoid serving low-income patients, practice similar forms of selection for outpatient services and drive up utilization for services. We strongly urge CMS to rigorously

examine the investment structures of physician-owned, limited-service hospitals. It is imperative that CMS continue the suspension of issuing new provider numbers to physician-owned, limited-service hospitals until the strategic plan developed has been fully implemented and Congress has had an opportunity to consider CMS' final report.

1. DRG CHANGES: HSRV WEIGHTS

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 to develop and maintain, we are concerned that the alternative methodology being proposed by CMS hasn't 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 methodology would allow very small hospitals to have equal impact on the national cost-to-charges ratios as larger hospitals. These and other methodological issues seem reason enough to invest addition time and energies in the assessment and, as appropriate further refinement of this proposed change.

2. DRG CHANGES: SEVERITY OF ILLNESS

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. 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 Consolidated Severity-Adjusted DRGs (CSA DRGs).

CHW appreciates CMS' attempts to modify DRG payments to address the proliferation of physician-owned, limited service specialty hospitals, and we support the concept of a severity-based system. However, we are concerned about the potential unintended consequences and implications of the as-yet unproven and essentially untested payment changes of the new HSRV and CSA DRG system on hospitals. **Given the obvious potential impact on hospitals' payments, we respectfully urge CMS to delay implementing either of these DRG proposals for one year, pending more thorough**

analysis to ensure that the changes truly help to create a better payment system. 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.

Being that the DRG IPPS is dependent upon accurate ICD-9-CM codes and that moving to a severity system would again utilize ICD-9-CM codes, **we believe that having a more robust coding system, like that of ICD-10 would enhance the coding and data for any severity based system.** It should also be noted here that improvement in clinical documentation on a national level is imperative and directly linked to coded data. We encourage CMS to work with the AMA and in general communicate with the physicians in the United States to collaborate with hospitals on documentation improvement skills, as this can only aid in the improvement of clinical codes and data

Another point of concern regarding the CSA-DRGs is the implication associated with the suggestion of adjusting for case-mix "creep." While not specifically saying that it would imposed 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 to prevent all hospitals from being arbitrarily penalized for the practices of a relative few.**

Therefore, consistent with the recommendations of our hospital associations, Catholic Healthcare West believes that immediate implementation of the proposed DRG changes would be premature, and we recommend the following:

- **CHW supports a one-year delay, until at least FY 2008, in implementing the proposed DRG changes, given the concerns with the HSRVcc and CSA DRG methodology. This recommendation for delay also reflects our concerns regarding the need for an appropriate lead time to modify hospital coding systems. Further, recognizing that the court mandate limits CMS' implementation flexibility with regard to the FY 2007 occupational mix adjusted wage index, requesting a one-year delay also reflects our desire to have a year to first assess the impact of the occupational mix changes to minimize the combined impact of these other potentially disruptive major policy changes on our hospitals.**

- **CHW supports moving to a DRG-weighting methodology based on hospital costs rather than charges, but believes that during the one-year delay, CMS should complete a more thorough analysis that would include a parallel pilot test of the proposed changes in order to identify any unintended consequences.**

- **If the need for a new, more effective classification system is demonstrated and developed, CHW recommends that it be implemented simultaneously with the new DRG weighting system, but not earlier than FY 2008. This change in implementation would provide better predictability and would smooth the volatility created by these two, generally offsetting DRG changes, and also should help to ensure that redistribution of hospital payments is not unduly disruptive to selected individual hospitals.**

- **Finally, CHW recommends that CMS provide a three-year transition period to implement the proposed HSRVcc policy change, given the magnitude of payment redistribution across DRGs and hospitals. Such a transition would protect hospitals from major payment disruptions.**

CHW is committed to working with CMS, in collaboration with our associations, over the next year to address these concerns and to potentially help to develop and evaluate alternatives for new DRG weights and classifications. Given our large number of hospitals and mix of hospital sizes and types across three states, CHW represents almost a microcosm of hospitals across the country. We would, therefore, be pleased to work with CMS staff to model the impact of any potential refinements to the proposed DRG changes.

3. PROPOSED CHANGES TO SPECIFIC DRG CLASSIFICATIONS

DRGs: Neurostimulators:

The Kinetra implantable dual array neurostimulator pulse generator that delivers deep brain stimulation for treatment of Parkinson's disease and essential tremor is approved for new technology add-on payment through FY 2006 only. Without this add-on payment, CHW opposes CMS' recommendation to keep the implantation of dual array implantable neurostimulators for deep brain stimulation in DRG 1 (Craniotomy Age >17 with CC) and DRG 2 (Craniotomy Age >17 without CC), as we believe that these devices will be inadequately paid in these DRGs. **CMS should recognize the higher resources associated with this technology, and reassign the full system Kinetra implants to DRG 543 (Craniotomy with Implant of Chemo Agent or Acute Complex CNS Principal Diagnosis) under MDC 1.**

DRGs: Carotid Artery Stents:

CHW opposes 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.**

Changes to the ICD-9-CM Coding System:

CHW is in support of the recommended additions and revisions to ICD-9-CM for October 2006. However, we would also once again bring to the attention of CMS that ICD-9-CM has reached limitations, which restrict the collection of valuable clinical data. We support – as does AHA and AHIMA – the adoption of ICD-10 for clinical data collection in the United States. **We recommend that CMS move expeditiously to ICD-10 in order to adapt to the significant changes to IPPS, and thus reflect accurate clinical data for severity, acuity and risk or mortality, as well as quality measures.**

4. FY 07 APPLICATIONS FOR NEW TECHNOLOGY ADD-ON PAYMENTS

X STOP Interspinous Process Decompression System:

St. Francis Medical Technologies, a medical group affiliated with CHW's St. Mary Medical Center in San Francisco, submitted an application for new technology add-on payments for the X STOP Interspinous Process Decompression System for FY 2007. The X STOP device, which was developed by two spine surgeons at St. Mary Medical Center, is inserted between the spinous processes of adjacent vertebrae in order to provide a minimally-invasive alternative to conservative treatment (exercise and physical therapy) and invasive surgery (spinal fusion). It received premarket approval from the FDA on November 21, 2005. CMS believes that the device satisfies the newness and cost threshold criteria for new technology add-on payments, but invite comments as to whether the device provides substantial clinical improvement. **CHW recommends that CMS approve the X STOP system for new technology add-on payments, as physicians have reported that it achieves symptomatic relief of pain for patients with advanced spinal stenosis with minimally-invasive surgery.**

5. INPATIENT PROSPECTIVE PAYMENT SYSTEM UPDATES

CHW fully supports the proposed rule's full market basket increase of 3.4 percent if the respective hospital voluntarily reports the additional required quality measures. (See below regarding additional comments on the voluntary quality reporting option.)

6. MEDICARE FIXED-LOSS COST OUTLIER PAYMENTS

For FY 2007, the proposed rule establishes an 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 increase is not a particularly sizable increase from the FY 2006 payment threshold of $23,600, we remain very concerned that the threshold is too high.

CMS projects that the threshold for FY 2007 will result in outlier payments equal to 5.1% of operating DRG payments. Statute requires that outlier payments for any year be projected to be no less than 5% or more than 6% of total operating inpatient PPS payments. However, in

recent years, CMS has not reached that level of payment to hospitals. According to an analysis by the American Hospital Association (AHA), 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.

CHW appreciates 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.

The AHA estimates that the fixed-loss threshold necessary to achieve 5.1 percent in FY 2006 should have been set at $21,275 as compared to the $23,600 actually utilized. They further estimate that CMS underspent the funds set aside for outliers by approximately $3 billion over FYs 2004, 2005 and 2006. This amount represents a real cut in payments to hospitals that cannot be recouped. If CMS leaves the threshold at $25,530 as proposed for FY 2007, we believe that CMS will again significantly underspend by over $300 million.

CHW has analyzed the impact of the proposed $25,530 outlier threshold on payments for our hospitals. If this threshold had been in place in the 12-month period from April 2005 – March 2006, <u>CHW hospitals would have lost approximately $3.5 million</u>.

Therefore, CHW respectfully recommends the following with regard to the Medicare Inpatient PPS outlier payment threshold:

CHW opposes using CMS' proposed methodology to estimate the outlier threshold. Instead, CHW urges CMS to adopt the methodology proposed by the AHA for establishing the outlier threshold in its comment letter to CMS on this proposed rule. The AHA's methodology is applicable regardless of what DRG changes are made or not made in FY 2007, and incorporates both cost <u>and</u> charge inflation, which we agree will make the threshold calculation more accurate and reliable. The estimated fixed-loss threshold that would result in 5.1 percent outlier payments under this methodology would be $24,000. Therefore, we urge CMS to adopt the AHA's outlier methodology and lower the outlier threshold.

7. HOSPITAL QUALITY DATA

The Deficit Reduction Act of 2005 (DRA) expands quality reporting requirements for hospitals to be eligible to receive a full market basket update. The proposed rule states that

to qualify for a full market basket update, hospitals would have to pledge to submit data on all 21 measures currently part of the Hospital Quality Alliance's (HQA) public reporting for patients discharged on or after January 1. Hospitals failing to submit data for the first calendar quarter of 2006 by August 15 would receive an inpatient update equal to the market basket minus two percentage points. Hospitals that fail data validation tests for data submitted for the first three calendar quarters of 2005 would also lose the two percentage points from the market basket update.

CHW fully supports the HQA's effort to make more information on hospital quality available to the public, and we join with CMS in wanting to make it happen quickly and accurately. However, as written, the proposed rule 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. **CHW recommends that CMS make the data collection prospective. This change 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.**

The DRA gave the Secretary of the Department of Health and Human Services (HHS) the authority to further expand the measures that must be reported to qualify for full market basket update in future years. **We strongly urge CMS to select measures only from those used by the HQA for public reporting.** To choose different measures would thwart efforts to streamline quality reporting, add to the confusion regarding quality measurement that currently exists in health care and dilute efforts to create a single source to share solid reliable information with the public. In addition, whenever the Secretary intends to expand the set of measures linked to payment, **CMS should consider publishing the proposal at least one full year prior to the start of the fiscal year.** This lead time will enable hospitals and their vendors to put the needed data collection processes in place to be able to provide the requested data.

Further, we agree with CMS that it is critical that the collected data be validated. The process used to validate the HQA data was reviewed by the Government Accountability Office, which concluded that there was "a high overall baseline of accuracy," but recommended several changes to improve the validation process. CMS proposes to look at the validation results for data submitted on patients who were discharged during the first three calendar quarters of 2005. CMS has hired a contractor to randomly select five patient records per quarter. That contractor selects the patients, asks the hospital to send a copy of the medical record for the hospitalization of the patients that occurred during that period, and then reabstracts the same data that the hospital abstracted from the medical record. A comparison is made between the data the hospital submitted and the data the contractor abstracted, and if there is at least an 80 percent agreement, the hospital is said to have passed validation. In the proposed rule, the hospital would have to have at least 80 percent agreement across the 15 medical records that the contractor reabstracted. This methodology assumes that the contractor has correctly reabstracted the data and that discrepancies must

mean erroneous data submission on the part of the hospital. However, that is not always the case. This validation process is still in its infancy and seems to be working to correctly validate the information submitted by many, but unfortunately not all, hospitals.

Some data validation problems have actually begun with the data submission process. Hospitals and their data collection vendors submit data to the Quality Improvement Organization (QIO) data warehouse in a good-faith effort to get the information submitted in the right format, with all of the right labels and coding. An "error report" is generated that is supposed to alert the hospital if it appears data were received in a way that is inconsistent with the requirements. The hospital is supposed to receive this report in time to make any necessary corrections. However, the report can be hundreds of pages long with a multitude of meaningless notations. A significant problem in data transmission might have occurred, but the indications of it are buried in this voluminous report and may not be discovered until it is too late for the hospital to make a correction. In addition, the data collection vendors on whom the hospitals rely to format and submit the data correctly do not have access to these error reports, nor do they have any other mechanisms for checking to make sure that the data they sent was received correctly. This has inevitably led to errors not being caught in time. When these errors are then left in the database, the CMS contractors' reabstraction of the data does not match up with what is recorded for the hospital in the database, leading to the hospital failing validation.

Another common problem results when the contractor has asked for the medical record pertaining to a particular patient, but has not specified which admission it wanted. Since it is not uncommon for heart failure patients to be readmitted for care, the omission of the specifics on which admission was being reabstracted has inevitably led to the hospital copying and submitting data on one admission, and the contractor trying to make that match up with the data for a different admission – and the data simply will not match up.

There also have been many reported instances in which the contractor conducting the reabstraction of the data failed to find information that was clearly in the medical record – a simple human error, but one that should not be used to penalize the hospital.

CMS was made aware of these problems with the validation process and it has begun to work to improve the process reliability so it can be used to support payment decisions. However, in the first three calendar quarters of 2005, the validation process did not have sufficient integrity to warrant hospital payments being withheld based on the validation results. At this juncture, we firmly believe that the problems with the validation process itself need to be resolved before any payment decisions are made solely on the basis of the contractor's work. **We strongly urge CMS to review, on a case-by-case basis, any incidence where a hospital's payment would be put in jeopardy as a result of the validation process. It should allow the hospital to submit information showing that it made a good-faith effort to supply the data warehouse with accurate information so that the public could be informed about the quality of its care. If the hospital has made a good-faith effort, it should receive full payment regardless of whether the data are deemed accurate enough for public display. In addition, CMS should instruct its QIO data warehouse to accept**

any significant corrections so that the public can have a full and accurate picture of hospital quality.

8. VALUE-BASED PURCHASING

The DRA required CMS to develop a plan to implement hospital value-based purchasing (pay-for-performance) beginning in FY 2009. The plan must consider a number of issues, including measure development, data infrastructure and refinement, public reporting and incentives.

Before addressing these issues and the questions posed by CMS, 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 believe that 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. This perspective is what guides our responses to the incentive methodology questions that follow.

CHW believes that payment rewards should be based on evidence-based measures of adherence to quality improving "processes." By using evidence-based process measures (e.g., aspirin provided at arrival to patients with acute myocardial infarction; antibiotics provided one hour prior to surgery), every provider has the opportunity to succeed, thereby improving the overall quality of the system. Incentive approaches should incorporate rewards for both attainment of a certain threshold of performance and improvement in performance.

We are concerned about premature efforts to tie payments to issues that could change incentives, such as efficiency. We believe that, for now, pay-for-performance initiatives should focus solely on quality improvement. There is no common definition of efficiency of care for hospitals. Efficient over what period of time: the course of a hospitalization or a stated period? Also, efficient for whom: the hospital ... the patient ... the government ... other payers? Each answer would lead to the development of different measures of efficiency and very different conclusions about whether care was efficient. Much more work needs to be done to define what should be encouraged in terms of efficient care before it is incorporated into payment policy.

Our recommendations follow each 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 a particular 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.** Incentive approaches to payment should use a system of rewards to increase payments or reduce regulatory burden for successful providers. Because the Medicare inpatient PPS already pays less than the cost of care for more than one-third of hospitals, incentives involving penalties should not be used. Additionally, rewards should be sizeable enough to cover the costs of implementing process changes and allow for reinvestment in quality improvement efforts. However, if such penalties are adopted, they should not 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 for 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 these 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 report; and composite measures may easily accommodate the addition of individual measures being represented in a public.

Also, to be effective, incentive approaches must align hospital and physician incentives, encouraging all to work toward the same goal of improving quality and providing effective, appropriate care. Incentive approaches rewarding improvement can only be successful if

physician and hospital performance can be successfully aligned, in terms of both performance and finances.

9. OCCUPATIONAL MIX ADJUSTMENT TO THE AREA WAGE INDEX

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.

CHW is very concerned about the implications of this court-mandated application of the occupational mix adjustment to 100 percent of the wage index. **While we cannot precisely model the impact of this adjustment on our hospitals, CHW is extremely concerned that our California hospitals will be disproportionately harmed by this change, because we are the only state in the country with state-mandated nurse-to-patient staffing ratios.** We believe that this system is designed to benefit parts of the country that make greater use of lesser-skilled nurses and allied health professionals, and to reduce payments in areas that make greater use of registered nurses in nursing positions. Because of California's nurse staffing laws, which specifically mandate Registered Nurse (R.N.) staff-to-patient ratios, this adjustment is likely to be especially damaging to California hospitals by reducing the payments they receive for the care they provide to Medicare beneficiaries.

While we understand that CMS was – and is – under extreme time pressure due to the timing of the court's decision, we do not believe that the 30-day comment period was sufficient for hospitals to allow for a thorough review and impact analysis. CHW expects, given the deadline change for FY 2007 survey data, that the survey results will again contain many errors and will thus be unrepresentative of true labor mix. While CMS might not have time to make changes that would improve accuracy of results for FY 2007, **we would request that CMS entertain comments with regard to the implementation for FYs 2008 and 2009. Further, we strongly urge CMS to use its discretionary authority to smooth out the impact of this change on adversely affected hospitals. Such attention could take the form of a multi-year transition or the use of corridors, as CMS has used in the past. Finally, we urge CMS to publish the occupational mix adjustment changes as an interim-final rule in August with an associated comment period.**

10. IME ADJUSTMENT AND GME PAYMENTS

Exclusion of Didactic Training - The proposed rule states that resident training that occurs at non-hospital sites must be related to patient care if a hospital wishes to count that time for direct medical education (DGME) and indirect medical education (IME) payment purposes. Resident time spent in didactic activities that often occur in associated medical schools – such as educational conferences, journal clubs and seminars – would specifically be excluded. CMS noted that its statement in a previous letter on this topic "implying that didactic time spent in non-hospital settings could be counted for direct GME and IME ... was inaccurate." CMS also noted that time spent in these activities could be counted for DGME purposes if they occur in a hospital; however, the counting prohibition applies for IME payments regardless of where the educational activity occurs.

We strongly urge CMS to rescind the purported "clarification" in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare DGME and IME payments. The stated rationale for the exclusion of this time is that it not "related to patient care." This position is in stark contrast to CMS' 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."[1]

We strongly agree with CMS' 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. 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. **CHW urges CMS to withdraw this change in the proposed rule relating to the counting of didactic time for purposes of DGME and IME payments, and to recognize the integral nature of these activities to the patient care experiences of resident physicians during their residency programs.**

11. EMTALA

Definition of "Labor" – **CHW supports CMS' proposal to modify the definition of "labor" at 489.24(b) to allow, in addition to a physician, a certified nurse-midwife or other qualified medical personnel operating under their scope of practice, as defined in hospital medical staff bylaws and in state law, to certify that a woman is in false labor.** This change recognizes that licensure and scope of practice should remain under the purview of state law and regulation. Further, this change provides hospitals with the staffing flexibility needed to maintain access to and the efficiency of vital obstetrical services,

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[1] September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins.

particularly in hospitals located in areas of the country that may find it difficult to attract and retain physicians, such as rural areas.

Hospitals without Dedicated Emergency Departments (ED) – Under the proposed rule, a hospital with "specialized capability" is required to accept appropriate transfers under EMTALA regardless of whether it has a dedicated ED. Guidance is still needed on the definition of specialized capability. In addition to questions related to the availability of on-call physicians and inpatient psychiatric resources, this proposed regulation calls into question application to inpatient rehabilitation facilities and long-term acute care hospitals.

CHW agrees that a physician-owned, limited-service hospital should be treated as a hospital "with specialized capability or facilities" under EMTALA, without regard to whether it has an ED. However, we believe it is unlikely this requirement will result in improved access for patients to the specialty care they need.

It is important to separate the capabilities of the practicing physicians from the capabilities of the facility in which they are practicing. While the physician expertise housed in the physician-owned, limited-service facility could be capable of meeting the needs of community hospital patients, the facility is seldom designed or operated in a manner to support this level of practice. Although physician-owned, limited-service hospitals hold themselves out as "hospitals," many of these facilities actually have a range of capabilities more similar to a hospital department or ambulatory surgical center. These hospitals often do not have emergency capabilities, as they are geared toward elective cases of minor severity. For these reasons, it generally would not be in the best interests of community hospital patients to be transferred to these facilities.

At the same time, many physician-owned, limited-service hospitals have withdrawn specialist services from the community at-large. As their physicians maintain an increasing amount of their practice at these hospitals or other sites outside the community hospital (e.g., ambulatory surgical centers), they are much less willing to accept on-call responsibility for the broader community's emergency needs. While withdrawing specialist services from on-call coverage, these same physician-owned, limited-service hospitals presume to rely on the community hospital for back-up in the event of complications requiring around-the-clock access to emergency care and inpatient admission to the community hospital. **Every physician-owned, limited-service hospital that relies on the community's emergency services capacity should be obligated to support it.**

In addition, this policy does not address the problem of patients at physician-owned, limited service hospitals who suffer from complications appearing in a hospital ED with no warning call, no medical history, no operative report, no information on the anesthesia used and, often, no ability to reach the treating surgeon for consultation. **Physician-owned, limited-service hospitals should be required to have agreements with the community hospitals they plan to rely on in the event that they do not have the capacity to treat a particular patient.**

Specifically, CHW recommends the following:

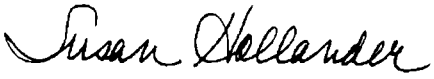
- **A physician-owned, limited-service hospital should be required to have a pre-existing agreement with the community hospital(s) it intends to rely on for emergency back-up services.**

- **The Secretary should establish the terms that must be addressed by an agreement, including:**

  - **Procedures for an appropriate transfer for patients not covered under EMTALA** (e.g., inpatient or outpatient whose condition develops into an emergency beyond the capability of the limited-service hospital and consequently needs to be transferred to a full-service hospital);
  - **Continuity of care** (e.g., telephone consultation with the receiving hospital and physician, sending the patient's medical records along when transferred, etc.); and
  - **Support for maintaining full-time emergency capacity at the community hospital, including on-call coverage** (e.g., physician-owned, limited-service hospital physicians serve in on-call panels at the community hospital, or the physician-owned, limited-service hospital provides financial support to the community hospital to maintain on-call coverage).

In closing, thank you for your review and consideration of these comments. Catholic Healthcare West would welcome the opportunity to discuss our comments with you or your staff, as well as to provide additional input as you make further refinements to the proposed rule. If you or your staff have any questions regarding these comments, please contact me at (626) 744-2268 or **shollander@chw.edu**.

Sincerely,



Susan D. Hollander
Vice President, Public Policy and Advocacy

Submitter : amy gruber

Date: 06/12/2006

Organization : amy gruber

Category : Individual

Issue Areas/Comments

GME Payments

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.

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,

Amy D. Gruber MD

Submitter : **Mr. Robert Cross**

Date: 06/12/2006

Organization : **Piedmont Healthcare**

Category : **Hospital**

Issue Areas/Comments

Hospital Quality Data

Hospital Quality Data

See attachment

CMS-1488-P-1682-Attach-1.DOC

#1682

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: Reporting of Hospital Quality Data for Annual Hospital Payment Update (§ 412.64(d)(2))

Dear Dr. McClellan:

On behalf Piedmont Hospital, Piedmont Fayette Hospital and Piedmont Mountainside Hospital, Piedmont Healthcare (PH) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) requirements regarding Hospital Quality Data found in the Deficit Reduction Act (DRA) of 2005.

In accordance with the requirements in the DRA of 2005, CMS has proposed expansion of the 10 Quality measure starter set to a total of 21 quality measures and linked the reporting of these measures to the hospital annual payment update (APU) for fiscal year (FY) 2007. The focus areas of the 11 additional measures are acute myocardial infarction, heart failure, pneumonia, and surgical infection prevention (SIP).

The rule also proposes that the data collection for the expanded set of quality measures begin with discharges occurring in the first calendar quarter of 2006 – January – March discharges. This data must be submitted to the QIO Clinical Warehouse no later than August 15, 2006 for hospitals paid under the CMS prospective payment system (PPS) to receive their full market basket update. Failure to submit the data on these additional measures in the time frame proposed will result in those hospitals receiving the full market basket update minus 2 percentage points.

A. **Hospital Quality Data**

• Timing: The final ruling for this proposal will not be announced until August 1, 2006. At this time, hospitals will have only 15 days to comply and submit data for the first 3 months of calendar year (CY) 2006. Although data is not required to be in the data warehouse until August 15, 2006, hospitals must have their data submitted to their performance measurement vendors sometime between June 15 and June 30 depending on the performance measurement vendor, well before the final announcement. Performance measurement vendors have had to move back their cutoff dates to allow hospitals sufficient time to abstract medical records. In essence, a large number of hospitals have only been given about six weeks to meet the new abstraction requirements in this proposed rule.

Government Reimbursement Department
2727 Paces Ferry Road; Suite 1-1000; Atlanta, Georgia 30339

• Vendor Issues: In preparing to meet the deadlines proposed in this rule, hospitals have to enter into agreements with their performance measurement vendors in order institute a process that allows them to abstract medical records for the additional measures; Hospitals that may have been collecting the data have not authorized their performance measurement vendors to transmit that data to the QIO Clinical Warehouse. In addition, some vendors will need to implement and test new programming quickly to for hospitals to comply.

• Hospital Costs: Hospitals will incur the additional expenses associated with the work required by their respective performance measurement vendors. In addition, overtime costs are required for staff needed to perform this work under an expedited time frame. Hospitals have not been given sufficient time to ensure appropriate training of their medical records staff to ensure a high degree of accuracy in the data abstraction, particularly with respect to the SIP measures. The SIP measures are particularly problematic since few hospitals are presently collecting and reporting these measures to the QIO Clinical Warehouse. Hospitals are concerned about validation scores on these new measures and how it will impact their market basket update.

Recommendations – PH strongly urges that CMS require the submission of the additional measures, specifically the SIP measures, to begin with 3rd quarter 2006 discharges and that the annual payment update be tied to successful transmission of the measures. Also recommended is that the SIP measures **not** be included in the formal validation process for the annual payment update until after one full year of reporting of the additional measures. PH does support a review of the records by the Clinical Data Abstraction Center (CDAC) for these measures, especially the SIP measures, to permit hospitals to obtain feedback about the data abstraction for learning purposes during the course of the year.

PH further recommends that CMS develop a process that affords organizations sufficient time prospectively to begin collection and reporting of any additional measures that will be considered in an annual payment update or part of a value-based purchasing program for hospitals in the future.

Future Measures
The DRA requires the expansion to other quality measures. The types of measures that may be added include: the HCAHPS® patient perception of care survey findings; structure measures as detailed in the recent Institute of Medicine report *Performance Measurement:Accelerating Improvement;* and other measures that reflect consensus among affected parties as required.

Recommendations - CMS has clearly indicated that HCAHPS® results will be considered as part of a future measure expansion. Therefore, hospital payment update may be tied to having HCAHPS® results in the QIO Clinical Warehouse before next fiscal year. Hospitals are required to participate in a dry run before their data is shared publicly but some hospitals have not yet participated. PH recommends that CMS identify when hospitals will need to have HCAHPS® data reported to the QIO Clinical Warehouse to meet possible time lines for the next fiscal year's

APU and to offer another dry run period that will assist hospitals to meet those time frames. Further, PH recommends that CMS work with the Hospital Quality Alliance (HQA) partners to identify other measures that reflect the quality of hospital care.

Sincerely,

Robert C. Cross
Director of Government Reimbursement
Piedmont Healthcare

Submitter : **Dr. Don Callens**

Date: **06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

CMS-1488-P-1683-Attach-1.DOC

#1083

Dear CMS Policy Maker:

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being unrelated to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. The hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty. Rescind the interpretation of the IME and DME support rule.

Sincerely,

Submitter : **Mr. J Gordon Stofer** **Date: 06/12/2006**

Organization : **Pratt Regional Medical Center**

Category : **Other Health Care Professional**

Issue Areas/Comments

DRG Weights

DRG Weights

I fully support the American Hospital Association recommendation of a one year delay in implementing the Diagnosis Related Group (DRG) changes as indicated in the inpatient prospective payment system proposed rule. The redistribution of $ 1.4 to $1.7 billion within the inpatient system will have a significant impact on many hospitals. If the proposed system indeed contains flaws this additional time could be invaluable.

Submitter : **Mr. Michael Hill**

Date: 06/12/2006

Organization : **New Hampshire Hospital Association**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1488-P-1685-Attach-1.DOC

#1685

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 New Hampshire Hospital Association (NHHA), with its 26 acute care hospital members,, we 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.

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc). It also proposes refining the DRGs to account for patient severity, with implementation likely in FY 2008. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education, among other policies.

While the NHHA supports many of the proposed rule's provisions, we have serious concerns about the proposed changes to the DRG weights and classifications.

125 Airport Road Concord, NH 03301-7300 Tel: 603.225.0900 Fax: 603.225-4346 http://www.nhha.org

New Hampshire hospitals supports meaningful improvements to Medicare's inpatient PPS. We believe the NHHA and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. 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. Moving forward requires thoughtful change.

Specifically, the NHHA supports the following:

- **One-year Delay:** The NHHA supports a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. The NHHA and the hospital field are committed to working with CMS over the next year to address these concerns.

- **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:** The NHHA does not support a new classification system at this time, 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.

HOSPITAL QUALITY DATA

The Deficit Reduction Act of 2005 (DRA) expands quality reporting requirements for hospitals to be eligible to receive a full market basket update. The proposed rule states that to qualify for their full market basket update, hospitals would have to pledge to submit data on all 21 measures currently part of the Hospital Quality Alliance's (HQA) public reporting on www.HospitalCompare.hhs.gov for patients discharged on or after January 1. Hospitals failing to submit data for the first calendar quarter of 2006 by August 15 would receive an inpatient update equal to the market basket minus two percentage points. Hospitals that fail data validation tests for data submitted for the first three calendar quarters of 2005 would also lose the two percentage points from the market basket update.

The NHHA fully support the HQA's effort to make more information on hospital quality available to the public, and we agree with CMS in wanting to make it happen quickly and accurately. However, as written, the proposed rule 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.**

The DRA gave the Secretary of the Department of Health and Human Services (HHS) the authority to further expand the measures that must be reported to qualify for full market basket update in future years. **We strongly urge CMS to select measures only from those used by the HQA for public reporting.** To choose different measures would thwart efforts to streamline quality reporting, add to the "babble" of quality measurement that currently exists in health care and dilute efforts to create a single source to share solid reliable information with the public. In addition, whenever the Secretary intends to expand the set of measures linked to payment, **CMS should consider publishing the proposal at least one full year prior to the start of the fiscal year.** This will enable hospitals and their vendors to put the needed data collection processes in place to be able to provide the requested data.

Further, we agree with CMS that it is critical that the collected data be validated. The process used to validate the HQA data was reviewed by the Government Accountability Office, which concluded that there was "a high overall baseline of accuracy," but recommended several changes to improve the validation process. CMS proposes to look at the validation results for data submitted on patients who were discharged during the first three calendar quarters of 2005. CMS has hired a contractor to randomly select five patient records per quarter. That contractor selects the patients, asks the hospital to send a copy of the medical record for the hospitalization of the patients that occurred during

that period, and then reabstracts the same data that the hospital abstracted from the medical record. A comparison is made between the data the hospital submitted and the data the contractor abstracted, and if there is at least an 80 percent agreement, the hospital is said to have passed validation. In the proposed rule, the hospital would have to have at least 80 percent agreement across the 15 medical records that the contractor reabstracted. This methodology assumes that the contractor has correctly reabstracted the data and that discrepancies must mean erroneous data submission on the part of the hospital. However, that is not always the case. This validation process is still in its infancy and seems to be working to correctly validate the information submitted by many, but unfortunately not all, hospitals.

We strongly urge CMS to review, on a case-by-case basis, any incidence where a hospital's payment would be put in jeopardy as a result of the validation process. It should allow the hospital to submit information showing that it made a good-faith effort to supply the data warehouse with accurate information so that the public could be informed about the quality of its care. If the hospital has made a good-faith effort, it should receive full payment regardless of whether the data are deemed accurate enough for public display. In addition, CMS should instruct its QIO data warehouse to accept any significant corrections so that the public can have a full and accurate picture of hospital quality.

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.

Definitions and Covered Employees. In filling out the interim-survey, our members found that the placement of certain employees caused confusion. Examples include surgical technicians, paramedics who are employed by the hospital and usually work in the emergency department, and unit secretaries who are also known as ward clerks. CMS clarified after the proposed rule was released that these employees should be placed in the "all other" category for the interim-collection. Moving forward, CMS should re-evaluate where these employees belong. **However, such changes should not be made to the ongoing collection, as it would necessitate the resubmission of the first calendar quarter's data to ensure that both quarters could be used for FYs 2008 and 2009.** If CMS believes that such changes are warranted, then the hospitals will need notification prior to the release of the final inpatient PPS rule in order to meet the August 31 deadline for submissions.

Cost Centers. We agree with CMS' "bright line" clarification for this collection that only nursing personnel within the cost centers listed should be included in that category for the purposes of consistency. It is significantly less work for hospitals to focus on certain cost centers, and we continue to support this methodology. **We believe that the vast majority of nursing personnel within a hospital fall within these cost centers and do not believe that CMS should include every cost center that may have a few nursing personnel included in it.**

However, CMS should consider refining the list for future collections. Every hospital has a different method for attributing costs to the cost centers, thus there are probably a few cost centers that contain a significant number of nursing personnel for certain hospitals that were not captured for this collection. Given the shortened comment period in combination with the magnitude of the other changes proposed by CMS in the inpatient PPS rule this year, we were unable to extensively research which cost centers CMS should add. We suggest that CMS accept comments on any potential changes to the cost center list before making such changes. **In addition, we believe that additional cost centers should *not* be added to the ongoing collection as it would necessitate the resubmission on the first calendar quarter's data to ensure that both quarters could be used for FYs 2008 and 2009.** If CMS believes that such changes are necessary for the current collection, then hospitals would need notification prior to the release of the final inpatient PPS rule in order to meet the August 31 deadline for submissions.

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.**

However, hospitals will 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 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, 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. **The NHHA 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. 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.**

The NHHA appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me or Paula Minnehan, VP, Finance and Rural Hospitals, at (603) 225-0900 or pminnehan@nhha.org.

Sincerely,

Michael Hill, President

Submitter : **Mr. Bryan Jones**

Date: 06/12/2006

Organization : **KPMG, LLP**

Category : **Health Care Industry**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1686-Attach-1.PDF

#1686

KPMG LLP
Suite 3100
717 North Harwood Street
Dallas, TX 75201-6585

Telephone 214 840 2000
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Internet www.us.kpmg.com

June 12, 2006

Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS- 1488- P
P.O. Box 8011
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 CMS:

KPMG LLP ("KPMG") appreciates the opportunity to submit comments on the proposed rule to refine the diagnosis-related group (DRG) system under the Inpatient Prospective Payment System (IPPS) to better recognize severity of illness among patients. Specifically we wish to comment on Section II. Proposed Changes to DRG Classifications and Relative Weights, Issue Identifier, "DRGs: Severity of Illness".

KPMG is an audit, tax, and advisory firm that is committed to providing services to our clients that will assist them with their organizational leadership, integrity and quality initiatives. Furthermore, KPMG's Healthcare practice includes approximately 1,000 professionals nationwide who deliver audit, tax, regulatory compliance, investigative, information and business risk management, transaction advisory, operations improvement, financial performance measurement, and other audit and advisory services to healthcare organizations. These organizations include acute care hospitals, as well as payers, and pharmaceutical, biotech, and medical device companies.

We appreciate and welcome CMS' commitment to making improvements to the current system. We view the proposed changes to the current DRG system as an opportunity to improve the entire healthcare industry.

In this capacity, we have a few suggestions regarding the proposed rule changes, particularly those related to the DRG classification system. At the center of our suggestions is the need for transparency with regard to any changes to the DRG classification system. Without transparency that is equivalent to or better than today's system, the potential exists to limit the ability of hospitals to choose tools that best help them to respond to the proposed changes. The industry should also have ample time to plan for and implement the changes once the rules have been finalized. Without quality planning and education regarding the changes the industry risks a

significant reduction in documentation, coding and billing accuracy. These suggestions are discussed in more detail below.

A. On the Issue of Transparency

Currently, hospitals are able to access the complete DRG classification methodology, which CMS makes available equally to all members of the public. Complete and timely access to this methodology is crucial to the healthcare industry because so many providers rely on advice and tools that they have developed internally, or that they have acquired from advisory firms to help manage the complexity of the system. The DRG classification and weighting methodology is one of the core inputs to compliance training and monitoring for hospitals.

It is important that as CMS changes the DRG system, hospitals and their advisors retain at least as much access as they have today to the underlying methodology. There seems to be no guarantee that this would remain the case under the proposed move to All Patient Refined Diagnosis Related Group (APR-DRG) classification system. Our concern is that the vendor whose proprietary system CMS ultimately might use would be in a position to limit the choices of tools and methodologies that hospitals might use to comply with the IPPS rules. This would not be a concern if CMS insures that all hospitals and their advisors receive access to the complete system methodology including source code, system and user documentation and support from the owner of the methodology.

B. Roll-out of DRG Changes

According to the proposed rule, CMS could move to APR-DRGs as early as October 1, 2006. Based on our experience in working with hospitals and on the complexity of the proposed changes, we believe this time frame would make it very difficult for hospitals to comply on time without sacrificing quality and/or efficiency. Therefore, we recommend that CMS consider making the effective date for the changes no earlier than one fiscal year post final rule publication.

C. Other Methodologies

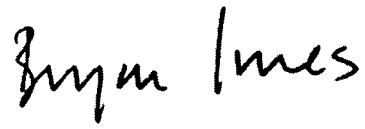
While the proposed rule discusses only APR-DRGs, we feel there are other classification systems that could be considered by CMS. For example, we suggest considering the All-Payer Severity-Adjusted DRG (APS-DRG) system. This system is built on top of the CMS DRG system and achieves similar statistical performance and could introduce less disruption to the coding and billing processes. Our experience with the APS-DRG system has been positive. Our experience with APS-DRGs, supported by the feedback of our hospital clients, is that the methodology is straight-forward and relatively easy to understand. Other more complex methodologies we have worked with have created compliance and inefficiency concerns for

some of our clients. We anticipate that the implementation of a more complex DRG system will lead to a reduction in coding efficiency and accuracy, which in turn will drive lengthened revenue cycles. Our suggestions are simply intended to help mitigate losses associated with those changes.

Again, KPMG appreciates the opportunity to comment on the proposed rule. Thank you for your consideration.

Sincerely yours,

KPMG LLP



By: Bryan H. Jones
Partner

Submitter : **Dr. Paula Braveman** **Date: 06/12/2006**

Organization : **UC San Francisco**

Category : **Physician**

Issue Areas/Comments

GME Payments

GME Payments

As a faculty member of the Department of Family and Community Medicine, I appreciate 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).

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.

In addition, 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,

Paula A. Braveman, MD, MPH
Department of Family and Community Medicine
Univerity of California, San Francisco

Submitter : Dr. Norma Jo Waxman MD

Organization : University of California San Francisco

Date: 06/12/2006

Category : Physician

Issue Areas/Comments

GME Payments

GME Payments

As a faculty member of the UCSF department of family medicine, 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
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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, 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.

Submitter : **Mr. Kurt Meyer**

Date: 06/12/2006

Organization : **Rebsamen Medical Center**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1689-Attach-1.DOC

#1689

Caring for You Like Family

1400 Braden, Jacksonville, AR 72076 (501) 985.7035

June 12, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-14880-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:

We would like to comment on the proposed charges in the Inpatient Prospective Payment Systems. The proposal includes two of the most consequential changes in the Medicare payment methodology since the implementation of the IPPS in 1983.

First, the rule would significantly alter the way in which CMS weights DRGs. Currently, the weights are charge-based. Under CMS' proposed rule, that would change in FY2007 to a methodology which bases the weights on a newly developed hospital-specific relative value cost center (HSRVcc). We agree that basing DRGs on costs rather than charges may result in more appropriate payments; however, CMS offers no compelling evidence that its approach to converting charges to costs using the national cost center cost-to-charge ratios (CCRs) rather than hospital specific data is anything more than the most expedient pathway.

CMS also proposes moving to an entirely new patient classification system beginning in FY2008. Currently, CMS uses 526 DRGs to classify all Medicare patients. Your agency considered use of 3M's all-patient refined DRGs (APR-DRGs) as an alternative to its current set of DRGs, which would increase the number of categories to 1,258. But, instead it chose to refine the APR-DRG system by consolidating those DRGs into a new DRG universe with 861 consolidated severity-adjusted DRGs, or CS-DRGs.

It is our opinion, that there needs to be more careful analysis of this reclassification, along with greater access to the specifics of CMS's methodology and the new GROUPER. The current DRG GROUPER logic has been in the public domain since the inception of the IPPS. Without access to the new GROUPER, we have no understanding of how and why patients fall into certain CS-DRGs and cannot evaluate whether it represents policy improvement.

While the changes being proposed yield small shifts in the percentages of losses or gains by individual facilities, they lead to broad swings in total payments and absolute dollars due to the large sums involved.

It has been conveyed to CMS by various groups and we support...CMS should work in cooperation with these hospital groups in refining the system to create an equal opportunity for return across DRGs.

Specifically, we support the initiative which will provide an equal incentive to treat all patients and conditions, which include the following:

- **One-year Delay:** We support a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. The AHA and the hospital field are committed to working with CMS over the next year to address these concerns.
- **Valid Cost-based Weights:** We support moving to a DRG-weighting methodology based on hospital costs rather than charges, but CMS' proposed HSRVcc method flawed.
- **A New Classification System Only if the Need Can Be Demonstrated:** The AHA does not support a new classification system at this time, 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:** The AHA commits to working with CMS to develop and evaluate alternatives for new weights and classifications.

Thank you for the opportunity to submit these comments. Please feel free to contact me at kmeyer@rebsamenmedicalcenter.com or (501) 985.7031.

Sincerely,

Kurt Meyer
Chief Executive Officer

Submitter : **Ms. Toni Lawson** **Date: 06/12/2006**

Organization : **Idaho Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1690-Attach-1.PDF

CMS-1488-P-1690-Attach-2.PDF

#1690

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

Dear Dr. McClellan,

On behalf of the Idaho Hospital Association's thirty-nine member hospitals, we 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.

While the IHA supports many of the proposed rule's provisions, we have serious concerns about the proposed changes to the DRG weights and classifications.

Idaho hospitals support meaningful improvements to Medicare's inpatient PPS. We share a common goal with CMS in refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. 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.

Idaho hospitals can ill afford to act as test cases for a new classification system that has not yet been proven necessary. As one of our members commented, "Some hospitals may win and some may lose, but we won't know for years." We should have a clearer understanding of the impact of such dramatic changes before new system is put in place.

Like many of the organizations in our field, we support the following:

- **One-year Delay:** The IHA supports a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. The IHA, as well as our national partners, the American Hospital Association are committed to working with CMS over the next year to address these concerns.

- **Valid Cost-based Weights:** We support moving to a DRG-weighting methodology based on hospital costs rather than charges, but we are concerned by the many reports that CMS' proposed HSRVcc method is flawed.

- **A New Classification System Only if the Need Can Be Demonstrated:** The IHA does not support a new classification system at this time, 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.

P.O. BOX 1278
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FAX: 208.338.7800

IDAHO HOSPITAL
ASSOCIATION

- **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.

While Idaho hospitals support meaningful improvements to Medicare's inpatient PPS, we also believe the system should be simple, predictable, and stable over time. One of the key components of a *prospective* payment system is the ability of providers to reasonably estimate payments in advance to inform their budgeting, marketing, staffing and other key management decisions. Our community hospitals should not have to ride a financial roller coaster while CMS works through the unknown elements of a new system.

As we understand it, this proposed system change is designed, in part, to address the inappropriate incentives created by physician self-referral to specialty hospitals. Physicians will still have the ability and incentive to steer financially attractive patients to facilities they own, avoid serving low-income patients, practice similar forms of selection for outpatient services and drive up utilization for services. We strongly urge CMS to rigorously examine the investment structures of physician-owned, limited-service hospitals. We urge CMS to continue the suspension of issuing new provider numbers to physician-owned, specialty hospitals until the strategic plan developed has been fully implemented and Congress has had an opportunity to consider CMS' final report.

The Idaho Hospital Association appreciates CMS and its efforts to improve Medicare's inpatient PPS. We ask that you take the appropriate time to assure that proposed changes truly result in an enhanced system rather than worsen what we currently have.

Sincerely,

Steven A. Millard
President
Idaho Hospital Association

P.O. BOX 1278
BOISE, ID 83701-1278
PHONE: 208.338.5100
FAX: 208.338.7800

Submitter : **Dr. Daniel Giang** **Date: 06/12/2006**

Organization : **Loma Linda University Medical Center**

Category : **Hospital**

Issue Areas/Comments

GME Payments

GME Payments

Loma Linda University Medical Center welcomes the opportunity to comment on this proposed rule change. We strongly urge the agency to rescinde the purported clarification in the proposed rule that excludes resident time spent in didactic activities in the caculation of Medicare DGME and IME payments.

CONFERENCES ARE ESSENTIAL TO CARE OF PATIENT: Conferences, journal clubs, etc. are required to integrate advances in medical knowledge and related scientific discoveries to specific patients. Either we are asking, "What can we learn from one specific patient that helps us care for other patients," or "What can we apply from medical knowledge to this patient."

CONFERENCES MEET SOCIETAL EXPECTATIONS. In response to public comments, the ACGME requires all residency programs to teach and evaluate residents in professionalism, patient centered-learning, communication and interpersonal skills, and systems-based learning. Journal Club, for example, addresses patient-centered learning. Systems-based learning includes instructions on governmental regulations that should improve compliance.

AUDITING NIGHTMARE: The proposed changes will cause fiscal intermediaries complex auditing problems. As an example, we have manually analyzed hours spent by our preventive medicine residents to not claim any of the two-hour blocks of time they spend in classroom work toward their MPH. This is a small program using two-hour blocks of time. The documentation and auditing requirements to enforce similar rules on vast numbers of residents in one-hour blocks will require a tremendous amount of time both on the part of hospitals, but also on the part of fiscal intermediaries.

NEW AMBIGUITIES WILL NEED FURTHER CLARIFICATION: Consider the following scenarieos: (1) A resident is called out of conference to care for a sick patient. Can her time spent caring for the patient be counted for IME? If so, how should it be documented? (2) A conference in the adjacent medical school is scheduled from 5 PM to 6 PM. Should one hour be removed from the DGME and IME for that day even though the residents worked 10 hours? If the conference is cancelled, can the entire day be counted? (3) If residents eat lunch in the cafeteria, that appears to be allowed for both DGME and IME. If they listen to a lecture during lunch, would that not be allowed for IME? (4) Prior to participating in a pediatric oncology rotation where all patients are treated using research protocols, residents must complete a course on human subjects research. If this is done on line while the resident is at home, would these hours need to be deducted from DGME and IME? If they are completed as part of a lecture in the hospital, would DGME (but not IME) be allowed? (5) Ten hours after going off call, a resident attends a journal club held at a faculty member's home. Should those two hours be deducted from the DGME and IME? If instead of attending journal club, the resident sleeps at home, would no deductions from DGME and IME be required? If the resident attends journal club, but falls asleep during it, can his DGME and IME be counted?

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 graduate medical education.

Sincerely yours,
Daniel Giang, MD
Director, Graduate Medical Education

Submitter : **Dr. Carena Chai**

Date: 06/12/2006

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

CMS-1488-P-1692-Attach-1.DOC

#1692

Dear CMS policy maker

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being un related to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. That hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty . Rescind the interpretation of the IME and DME support rule

Sincerely,

Submitter : **Dr. Gwennaye Coath** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

CMS-1488-P-1693-Attach-1.DOC

#1693

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

Someone at CMS will need to explain to me, how the teaching, curriculum development and evaluation process for the six required ACGME physician skill competencies is not related to patient care. Isn't this exactly what the IOM has criticized our training professions for? In fact, our program currently evaluates us in all these competencies as a continuing quality improvement process DURING patient care. Without time to discuss and reflect our experiences and outcomes we will not be serving the needs of our current and future patients.

Should indeed this come to pass, we will have faculty who will be caught in the productivity race with no time for us. We may get pop-up feed back from an Electronic Health Record in sites that have them that we have made an error or we are not following a guideline. No discussion there. What is being proposed is dangerous for our current patients and our future patients. Our patients deserve for us to have a better education than you are proposing.

Why does the American taxpayer support medical students at over $200,000 per student per year and offers the faculty of residencies less than $15,000 for teaching per resident per year? I am getting a lot more from my residency training to protect and serve my patients of the future than all of medical school combined. Please do not cut us any more – rescind the clarification of this dangerous and capricious rule.

Medical Resident

Submitter : **Ms. Olivia Wong Kubasik** **Date: 06/12/2006**

Organization : **District of Columbia Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1694-Attach-1.DOC

#1694

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Tel: (Office) 202/289-4925 • (Cell) 202/528-2721 • Fax: 202/371-8151 • E-mail: okubasik@dcha.org • Web: www.dcha.org

June 12, 2006

Centers for Medicare & Medicaid Services
Attention: CMS-4105-P
P.O.Box 8010
Baltimore, MD 21244-1850

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

Dear Sir/Madam:

On behalf of the hospital membership of the District of Columbia Hospital Association (DCHA), we would like to submit the following comments to the Centers for Medicare & Medicaid Services (CMS) on the fiscal year (FY) 2007 inpatient prospective payment system (PPS) proposed rule.

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc). It also proposes refining the DRGs to account for patient severity, with implementation likely in FY 2008. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education, among other policies.

While the DCHA supports many of the proposed rule's provisions, we have serious concerns about the proposed changes to the DRG weights and classifications.

Children's National Medical Center • George Washington University Hospital • Georgetown University Hospital
Greater Southeast Community Hospital • Hadley Memorial Hospital • Howard University Hospital • Malcolm Grow Medical Center, Andrews AFB, MD
National Naval Medical Center, Bethesda, MD • National Rehabilitation Hospital • Providence Hospital • Psychiatric Institute of Washington, D.C.
Riverside Hospital • Saint Elizabeths Hospital, D.C. Department of Mental Health • Sibley Memorial Hospital
Specialty Hospital of Washington • Veterans Affairs Medical Center • Walter Reed Army Medical Center • Washington Hospital Center

The hospital field supports meaningful improvements to Medicare's inpatient PPS. We believe our hospitals share a common goal in refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. 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. Moving forward requires thoughtful change.

Specifically, the DCHA supports the following:

- **One-year Delay:** The AHA supports a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. The AHA and the hospital field are committed to working with CMS over the next year to address these concerns.

- **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:** The AHA does not support a new classification system at this time, 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**: The AHA commits to working with CMS to develop and evaluate alternatives for new weights and classifications.

The DCHA appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me by phone at (202) 289-4925 or by email at okubasik@aha.org.

Sincerely,

Olivia Wong Kubasik
Vice President for Policy Development
District of Columbia Hospital Association

Submitter : **Ms. Lyndean Brick** **Date: 06/12/2006**

Organization : **Murer Consultants on behalf of USC Norris Cancer**

Category : **Hospital**

Issue Areas/Comments

Hospitals-Within-Hospitals

Hospitals-Within-Hospitals

Attached please find comments relative to the hospital-within-hospital proposed regulations as prepared by Murer Consultants on behalf of USC Norris Cancer Hospital.

Lyndean Lenhoff Brick, J.D.
Senior Vice President
Murer Consultants

CMS-1488-P-1695-Attach-1.RTF

#1695

These comments are being submitted on behalf of USC Norris Cancer Hospital in regard to the Hospital within Hospital ("HWH") proposed regulations. USC Norris Cancer Hospital ("Norris") is a 60-bed PPS-excluded cancer hospital located within 250 yards of USC University Hospital.

CMS' HWH rules developed in response to the rapid growth of long term care hospitals. In fact, during the first several years after the HWH rules were codified, they were only applicable to long term care hospitals. In 1997, CMS expanded the application of the HWH rules to other types of PPS-excluded hospitals including cancer hospitals. At that time, CMS stated that "We believe that the same principle should apply to cancer and children's facilities, which the statute provides for excluding only as hospitals, not as units." Thus, the HWH criteria regarding separate governing body, separate chief executive officer, separate chief medical officer, separate medical staff and either the basic services rule, 15 percent rule or 75 percent rule were now applicable to cancer hospitals and other excluded facilities.

The grandfathering provision at 42 C.F.R. §412.22(f) served to exempt excluded hospitals from the HWH rules if such a hospital was in place as of September 30, 1995 and continued operation under the same terms and conditions, including number of beds and square footage, in existence on September 30, 2003. While this exception allowed HWHs to continue their excluded status, maintaining operation under the same terms and conditions has resulted in inequitable treatment of cancer hospitals and confusion concerning the application of the limitation. The proposed revision to the grandfathering criteria does not significantly reduce the inequitable and ambiguous nature of the policy.

1. The HWH Regulations Should Not Be Applied to Cancer Hospitals

Both the current and proposed revisions to the grandfathering provisions should exempt cancer hospitals from the HWH requirements and pose no restrictions on changes in terms and conditions, bed increases or square footage increases. Development of cancer HWHs that are nominal hospitals is not a threat to the Medicare system. Based on information available from CMS, there are currently 10 PPS-excluded cancer hospitals and 42 C.F.R. 412.23(f), which details the criteria for cancer hospitals, ensures that additional excluded cancer hospitals will not be developed in the future. Therefore, Medicare is under no threat from the proliferation of nominal cancer HWHs that operationally resemble hospital units.

To our knowledge, Norris is the only cancer hospital in the country to which the HWH / grandfathering regulations apply. Ground was broken for the construction of a freestanding Norris hospital on May 10, 1979; long before PPS, long term care HWHs, and TEFRA target rate ceilings. As an integral component of a leading research university, the Norris facility was placed on campus with other USC-affiliated health facilities. Because, Norris' freestanding building had been constructed within 250 yards of another hospital, Norris is now subject to restrictions regarding growth and governance with which no other cancer hospital in the county must comply. Norris became subject to the requirement that it may never increase size about 24 years after it began construction of its freestanding hospital facility.

We understand CMS's concern with nominal hospitals that resemble units. However, we do not believe that the existing 10 cancer hospitals in the country pose a risk in this regard. The lack of risk is evident in the fact that only Norris must comply with the HWH / grandfathering provisions. We believe it is inequitable and punitive to subject a single provider within a specific provider class to very restrictive regulatory requirement. CMS has advised some grandfathered HWHs that they may simply come into compliance with the HWH regulations if they want to expand their facilities. However, an owner's choices of (1) forfeiture of control, or (2) never expanding often are not feasible choices to make. They are also not choices which should be applied to a single provider within a class without a significantly compelling reason. CMS' regulatory authority should not be exercised so broadly that such an inequitable situation results in the absence of a clear policy rationale.

2. The Expanded Grandfathering Provision Is Ambiguous

The proposed revision to the grandfathering regulation would allow for grandfathered HWHs to decrease beds or square footage and not jeopardize their grandfathered status. However, there is still a high degree of uncertainty as to what constitutes a change in terms or condition under the revised grandfathering provision. For example, it is not clear whether a grandfathered HWH may add or delete specific services or if such a change would constitute a change in a term or condition.

Another ambiguity relates to permitted square footage additions. Under the proposed regulations, a provider may:

Increase the square footage... considered to be part of the hospital at any time, if these changes are made necessary by relocation of the hospital—

> *(A) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility; or*
> *(B) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.*

The difficulty in applying the proposed square footage increase exceptions is illustrated by several scenarios:

Scenario 1. A grandfathered HWH undergoes a change of ownership which is approved by the State Attorney General. The Attorney General's approval of the change of ownership is conditioned upon providing specific core services and relocating to a new physical plant. Therefore, the hospital must relocate and is required to adhere to new construction standards. In addition, the provision of core services and updated licensure requirements make an increase in total square footage necessary. Is this scenario permissible under the exception for "changes in Federal, State, or local law affecting the physical facility?"

Scenario 2. A grandfathered HWH leases space adjacent to an acute care hospital. The owner of the property will only renew the lease with the HWH in a new area within 250 yards of the acute hospital and there is not another suitable location for the HWH to use. Because the HWH is assuming new space, the State applies new construction standards which require each patient room to be 35 square feet larger, convert 2 patient rooms to isolation rooms with anterooms and to provide a larger lobby. Could the HWH maintain its grandfathered status even if a net increase in square footage occurs?

Scenario 3. A grandfathered HWH must make renovations and updates to its inpatient space. Even reducing the number of licensed and Medicare-certified inpatient beds, the application of and compliance with new construction standards will result in a net square footage increase. Could the HWH maintain its grandfathered status through this renovation (and bed decrease) even if a net increase in square footage occurs?

Scenario 4. Changes in practice patterns have resulted in a grandfathered HWH providing more services on an outpatient rather than an inpatient basis. The grandfathered HWH would like to allocate existing square footage to providing outpatient services and would have fewer inpatient beds and inpatient square footage as a result. May the grandfathered HWH reallocate square footage in this manner without jeopardizing its grandfathered status?

We are not aware of any situations in which a Federal, State or local authority changes a law which then requires the relocation of a HWH to a new facility. On the other hand, cancellations of leases, CON requirements, the general need to renovate where new codes, ADA and AIA requirements arise are very common. At this point, the proposed regulation is ambiguous and does not provide guidance as to how CMS would address these more common scenarios.

Because of the inequitable and ambiguous nature of the current and revised grandfathering provisions as applied to cancer hospitals, we respectfully request that cancer hospitals be exempt from the bed and square footage limitations at 42 C.F.R. 412.22(f). Thank you for your attention to this matter.

Sincerely,

Lyndean Lenhoff Brick, J.D.
Senior Vice President
Murer Consultants, Inc.

Submitter : **Mr. Jay Stracke** **Date: 06/12/2006**

Organization : **Zimmer, Inc.**

Category : **Device Industry**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1696-Attach-1.DOC

CMS-1488-P-1696-Attach-2.DOC

#1696

Zimmer, Inc.
P.O. Box 708
Warsaw, IN 46581-0708
574.267.6131
www.zimmer.com

June 12, 2006

Mr. Marc Hartstein
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-1488-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: COMMENTS ON CMS-1488-P: MEDICARE PROGRAM; PROPOSED CHANGES TO THE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM AND FISCAL YEAR 2007 RATES

Dear Mr. Hartstein:

Zimmer, Inc. appreciates the opportunity to provide comments on the proposed Medicare rule (CMS-1488-P) regarding Changes to the Hospital Inpatient Prospective Payment System (IPPS) and Fiscal Year 2007 Rates. Founded in 1927 and headquartered in Warsaw, Indiana, Zimmer is the worldwide #1 pure-play orthopaedic leader in the design, development, manufacture and marketing of reconstructive and spinal implants, trauma and related orthopaedic surgical products. As the leader, we are continually achieving technological advancements that make a difference in patient's lives for each of the medical markets we serve. Our primary interest is ensuring that Medicare patients continue to receive appropriate access to high quality, effective healthcare solutions, including new and innovative orthopaedic technologies that each and every day, improve quality of life.

In the April 12, 2006 notice of proposed rulemaking, CMS proposed a number of very complex regulatory changes that would significantly impact hospital inpatient payment. Ultimately the delivery of care to Medicare beneficiaries and to patients enrolled in private, non-Medicare health plans that choose to follow similar payment policies would be affected by the proposed changes. Collectively, these changes represent the most significant revision of the Medicare diagnosis-related group (DRG) payment methodology since its introduction over 20 years ago.

CMS' primary interest in implementing fairly untested, comprehensive reforms is in response to the Medicare Payment Advisory Commission's (MedPAC's) 2005 Report to Congress on Physician-Owned Specialty Hospitals. The proposed adjustments to the DRG payment system include significant changes in the methods for calculating DRG weights, relying on a complex, multi-step and multi-source calculation of estimated hospital costs rather than on traditional

claims-based hospital charges. The fundamental changes to the DRG system were proposed to improve payment accuracy and eliminate incentives to specialty hospitals, which are presumed to "cherry pick" or treat only the most profitable patients. According to CMS data, only about 2% (74 of 3,647) of all hospitals representing 0.05% (44,200 of 11,085,511) of all Medicare admissions paid under the IPPS in 2005 were identified as specialty in nature (cardiac, orthopaedic, or surgery).

Zimmer fully supports CMS' efforts to improve the overall accuracy of payments to hospitals, and we believe it is imperative that CMS first ensure that any payment and policy changes are well researched, rigorously analyzed, thoroughly debated and flawlessly implemented. Changes to the impatient payment system should avoid the disruption of acute care services and allow continued access to important new medical technologies. As CMS has acknowledged, the economics of healthcare services can and will change medical practice patterns, ultimately impacting patient care.

Summary of Recommendations

The following is a brief summary of our recommendations related to several of the items outlined in the April 12 notice of proposed rulemaking. More detailed comments follow this summary.

- ✓ Hospital Specific Relative Value Weights – The proposed methods for calculating estimated costs are technically inaccurate and inconsistent with traditional methods used by CMS for other payment computations. Important modifications to the sample of data used and the methods for national averaging of costs are essential prior to implementation of this method in FY 2007. In addition, CMS should give more consideration to alternative methods that may further enhance payment accuracy.

- ✓ Severity of Illness - The proposed consolidated severity-adjusted DRG system lacks necessary clarity. A severity of illness payment system should account for severity of illness <u>and</u> procedural complexity including costs of medical technology. Furthermore, the proposed consolidated severity-adjusted DRG system and APR-DRG system do not adequately reflect the necessary base set of DRGs, including DRGs that CMS has recently created in its current system based on significant differences in case complexity and cost. In addition, it is unclear how the current CMS criteria and process for integrating new medical procedures and technology into the DRG payment system must be modified. Therefore, we recommend that CMS delay implementation until at least FY 2008 and address concerns as part of its FY 2008 proposed rulemaking.

- ✓ Cost-Based Weights: Outlier Threshold - The current uniform system that doubly rewards DRGs with a high prevalence of outliers should be modified to create DRG-specific outlier thresholds to ensure that relatively costly cases assigned to each DRG grouping have relatively equal opportunities for payment increases. MedPAC recognized this important step toward achieving payment accuracy, and CMS should seek legislative authority to implement it.

- ✓ DRGs: Hip and Knee Replacements – CMS should reconsider its proposal to eliminate a large number of cases from DRG 471 (Bilateral or Multiple Major Joint Procedures of Lower Extremity) based on a change in the GROUPER ICD-9 coding logic. Based on an extensive review of 2005 MedPAR data, including evaluation of clinical coherence and resource utilization, these cases appear to be appropriately assigned to DRG 471. Procedure codes should not be removed from DRG 471 without additional review of both the clinical and resource complexity of cases linked to these codes.

HSRV Weights

CMS is proposing immediate implementation of a modified version of the Hospital Specific Relative Value (HSRV) methodology recommended by MedPAC that, in CMS' opinion, is more administratively feasible. This approach relies on a particularly complicated formula using data from both hospital claims and cost reports of different years to estimate the average total costs for each DRG. The mathematical pathway to a DRG relative weight involves a series of steps that include substantial data trimming, calculation of hospital specific cost-to-charge ratios (CCR) and average hospital charges for 10 selected cost centers, and national average CCR computations.

Although we believe that using estimated hospital costs instead of traditional charges to compute DRG relative weights represents an important step forward in Medicare's payment policy, we do not believe that the proposed methods for calculating estimated costs are technically accurate. Specifically, we believe that the method used by CMS to "cleanse" data sets prior to computing payment factors eliminates important records from over 230 large hospitals, representing over 25% of Medicare routine hospital charges. This extensive and rather arbitrary exclusion of data from particularly consequential calculations has a large impact on DRG weights resulting in considerably less accurate payments relative to estimated hospital costs. Moreover, we understand that CMS has failed to account for hospital-specific volumes of charges in the calculation of national average cost estimates, distorting relative weights. We believe that the use of a simple average method versus a weighted average method to compute a national CCR contradicts basic algebraic principles and grossly misrepresents the intended outcome of this key mathematical step. Therefore, at a minimum, CMS should correct these errors as early as

possible, no later than October 1, 2006, so that estimated national CCR ratios are weighted by hospital volume of care and additional data from the excluded large hospitals are included in DRG relative weight calculations.

It is unclear whether this new and more complicated approach truly yields more accurate payments, relative to costs, across all DRGs. We encourage CMS to continue to evaluate other, alternative options for improving cost estimates and subsequent payment accuracy. In light of the enormous impact of methodology changes on hospital payments, CMS should thoroughly consider adopting alternative approaches to estimating costs, including the adjusted method outlined in June 9, 2006 comments from the Advanced Medical Technology Association (AdvaMed). We believe this revised approach is more consistent with the 2005 MedPAC recommendations, better reflects actual hospital costs and is similar to methods used to compute payments in the Medicare Hospital Outpatient Prospective Payment System. We understand that this revised methodology would enable CMS to best reach its objectives of improving payment accuracy and addressing specialty hospital skimming without imposing significant payment cuts to surgical procedures.

We also encourage CMS to take actions to ensure that all data sources used in new payment calculations are up to date, fully reliable and accurate. The current hospital cost report data, proposed for the first time to become an integral part of DRG weight calculations, was developed for historical cost-based reimbursement systems primarily used prior to 1984. Hospital cost reports are not subject to rigorous, timely and comprehensive audits and the reliability of data extracted from these reports is questionable. Relying on data in cost reports older than the charge data included on hospital claims fails to adequately reflect the actual costs (and charge practices) of newer medical solutions and would effectively increase the current two year lag of new technology recognition. This would represent a step backward from the recent progress that CMS has made toward using more current data to reflect the costs of medical innovation. We encourage CMS to commission a panel of experts to study ways to improve the accuracy and timeliness of information included in these records because data from hospital cost reports are integral to improved payment accuracy under the HSRV method.

DRGs: Severity of Illness

CMS is also proposing to adopt no later than October 1, 2008 a new DRG structure, such as the proposed consolidated severity-adjusted DRGs, to align payment with patient severity of illness. We understand that CMS has carefully analyzed other severity of illness based systems including the All Patient Refined Diagnosis Related Group (APR DRG) system designed by 3M Health Information Systems. Based on this analysis CMS proposed a unique system for the Medicare population; we agree that the Medicare population is unique and therefore requires a more tailored DRG payment system.

We appreciate that CMS has expressed broad interest in public comments on this issue and has explicitly recognized that this proposed system would require additional changes before it is ready for implementation. For example, CMS has acknowledged that the APR DRG system which is now used by the state of Maryland and some private payer systems, do not adequately recognize effective new medical technologies and procedures that are clearly more costly and complex, but are not consistently used for patients with a greater severity of illness. We fully agree with CMS' recommendation that a method for recognizing complexity be included in any new severity-based DRG system.

While Zimmer in principle supports efforts to ensure that Medicare payments better reflect the severity of illness of patients within a particular DRG, we share the concerns of AdvaMed and other medical technology stakeholders that CMS' severity-adjusted payment proposals require major modifications, further review and discussion before implementation.

We are very concerned, for example, about the implementation of a new DRG severity-based structure that fails to recognize the extreme variations in procedural complexity and medical technology that the current CMS DRG system recognizes. For example, many Medicare beneficiaries today receive essential primary, revision and bilateral hip and knee replacement procedures. These procedures are recognized within the current DRG system as requiring significantly different clinical applications and resource needs, but do not necessarily relate to different patient diagnoses as defined by current ICD-9 diagnosis codes. In FY 2006, CMS split DRG 209 into DRG 544 and 545 based on important differences in complexity and resources in order to make these payments more accurate. Unfortunately, neither the consolidated severity-adjusted DRG proposed by CMS nor the APR DRG system includes similar base DRGs.

Rather, as noted in Table 1, the consolidated severity-adjusted DRG system does not include base DRGs that account for the nearly 60,000[1] annual Medicare cases for hip and knee revisions and bilateral and multi-joint procedures. Cases currently assigned to revision and bilateral joint replacement DRGs currently have relative weights that are 22% and 44% higher than the DRG assigned to standard hip and knee replacement cases, respectively. Other orthopaedic procedures, such as DRG 496 (Combined Anterior/Posterior Spinal Fusion), are also not recognized in either severity of illness system, despite having a current DRG weight of approximately 38% more than the DRG reserved for less complicated cases. Because these more complex and costly cases are not accounted for by severity of illness factors, this change could adversely impact reimbursement for these cases and ultimately patient access to this essential care. Over the last decade, CMS has made important advances in tailoring the Medicare DRG

[1] 2005 Medicare Provider Analyses and Review (MedPAR)

system to reflect meaningful differences in procedural complexity. Adopting a new severity-based system that does not reflect these improvements would be a serious mistake.

Table 1: Major Hip and Knee Surgical Procedures

Current DRGs		Consolidated Severity-Adjusted DRGs	
544	Major Joint Replacement or Reattachment of Lower Extremity	414	Hip Joint Replacement - SOI 1
		415	Hip Joint Replacement - SOI 2
		416	Hip Joint Replacement - SOI 3
		417	Knee Joint Replacement - SOI 1
		418	Knee Joint Replacement - SOI 2
		419	Knee Joint Replacement - SOI 3
545	Revision of Knee or Hip Replacement	NONE	
471	Bilateral or Multiple Major Joint Procedures of Lower Extremity	NONE	

CMS has neither defined the specific severity of illness (SOI) criteria for each new DRG nor provided a detailed crosswalk from current CMS DRGs to the proposed consolidated severity-adjusted DRGs. In the absence of this information, determining the percentage of cases for each current base DRG that would likely be assigned to each SOI category within the corresponding base DRG is impossible. Furthermore, CMS has not provided sufficient information on how to determine the new consolidated severity-adjusted DRG assignment for those current base DRGs without corresponding consolidated severity-adjusted DRGs.

We are also especially concerned that CMS would adopt a new DRG structure without first clearly defining and seeking stakeholder comment on a refined process and criteria for integrating new and more costly technologies and associated procedures that offer improved clinical outcomes – but don't necessarily involve greater severity of patient illness. It is unclear, for example, if and when CMS would consider creating new base DRG payments or amending SOI criteria. It is also not clear if the current CMS criteria for providing new technology DRG add-on payments would adequately ensure timely access to medical technology for Medicare beneficiaries. For example, the current new technology DRG criteria require that new procedures be significantly more costly on average than the predicted DRG payment. Given that the distribution of cases under a revised system would be spread more broadly based on severity of illness differences, it is uncertain how this criteria will be implemented. The new technology DRG payment is temporary and provides only limited payment relief when the individual case is poorly paid. We do not think this system adequately addresses the needs of new technologies, particularly given the lack of recognition for medical complexity in the proposed DRG system.

We believe it is important that CMS consider necessary revisions to the process for providing timely and adequate payment for more new and more complex medical innovation when implementing a severity-adjusted DRG system.

Finally, we do not agree with MedPAC recommendations that call for the Secretary to "project the likely effect of reporting improvements on total payments and make an offsetting adjustment to the national average base payment amounts." Rather, we think it is inappropriate to prospectively or retrospectively adjust all hospital payments downward based on the perceived impact of hospital coding improvements. Certainly a shift to severity of illness based DRGs will require that hospitals further focus on the proper coding of all patient diagnoses. Penalizing hospitals, however, for a predicted improvement in coding would imply that appropriate coding is wrong.

For these reasons, we do not believe the proposed consolidated severity-adjusted DRG system is ready for national implementation. Rather, several important modifications to the proposed system are needed, and more clarity on the process for integrating new technologies is essential. Therefore, we recommend that CMS delay implementation until at least FY 2008 and address concerns as part of its FY 2008 proposed rulemaking.

Cost-Based Weights: Outlier Threshold

We encourage CMS to continue to evaluate options, and seek legislative authority as necessary, to refine the current payment outlier system as recommended by MedPAC. We believe the current uniform system that doubly rewards DRGs with a high prevalence of outliers should be modified to create DRG-specific outlier thresholds to ensure that relatively costly cases assigned to each DRG grouping have relatively equal opportunity for payment increases. We believe this should be an important component of DRG restructuring to improve overall payment accuracy and equity.

DRGs: Hip and Knee Replacements

We understand that CMS is proposing to eliminate all cases that include certain ICD-9 procedure codes (either principal or secondary procedures) as outlined by CMS from potential assignment to DRG 471 (Bilateral or Multiple Major Joint Procedures of Lower Extremity). This change in coding logic is apparently in response to questions from hospital coders regarding the clinical coherence of certain procedures. Based on our understanding of the proposed change to the GROUPER logic and a review of both the clinical complexity and average resource requirements of these cases, we strongly disagree.

We analyzed the 2005 Medicare Provider Analyses and Review (MedPAR) file and determined that this change in GROUPER logic would remove nearly 1,100 cases (7% of cases) from DRG 471. In most instances, these cases involve multiple procedures, including some that CMS suggests should rightfully be assigned to DRG 471. For example, it appears that the changes that CMS is proposing would exclude from DRG 471 all cases that contain procedure code 81.53 – Revision of Hip Replacement, Not Otherwise Specified, including those cases where this is listed as a secondary procedure. A large number of cases that CMS proposes to assign to the lower paying DRG for hip and knee revisions include both revision of hip (81.53) and partial hip replacement (81.52), presumably representing bilateral or multiple joints.

In addition to further analyzing the clinical complexity of these cases, we believe that CMS should consider the average standardized charges for these cases relative to the average charge for DRG 471 before making any changes. Table 2 summarizes the average standardized charges for three distinct groups of cases: those which contain only a procedure code proposed to be removed by CMS, those with at least one additional ICD-9 procedure code that should track to DRG 471, and those with at least two additional ICD-9 procedures codes that track to DRG 471.

Table 2: FY 2005 MedPAR Analysis of DRG 471 Discharges

	Number of Discharges	**Average Length of Patient Stay (days)**	**Standardized Charge**	**Standardized Charges Relative to all DRG 471**
All DRG 471	16,496	4.9	$50,397	XXXX
Proposed Cases to be Excluded	1,089	9.2	$67,328	125%
- Single procedure	391	10.4	$72,676	144%
- Two procedures	692	8.6	$64,375	128%
- Three + procedures	6	5.3	$59,555	118%

In the proposed rule, CMS states that it considers whether the resource consumption and clinical characteristics of patients with a given set of conditions are significantly different than the remaining patients in the existing DRG. Based on our analyses, we believe that CMS should further consider the clinical complexity and resource utilization of these cases (and not simply the presence of a single ICD-9 code that appears inconsistent with the DRG nomenclature)

before deciding to change the DRG coding logic and associated GROUPER system. CMS should avoid coding reassignment at this time unless actual claims can validate important differences in both clinical coherence and resource requirements.

It is very apparent that CMS has spent considerable time and energy in developing its proposed, wholesale changes to the DRG system beginning in October 2006. We fully appreciate efforts aimed at improving payment accuracy, to make certain that all episodes of care are appropriately reimbursed, and to ensure that hospitals and providers provide the best possible care and not simply the most profitable care. As a worldwide leader in medical innovation, we take very seriously our work to improve the lives of patients, including those insured by Medicare.

Again, we appreciate the chance to provide comment on this proposal and respectfully request that CMS consider our comments. We look forward to additional opportunities to work with CMS staff and leadership on these and other important issues.

Sincerely,

Jay R. Stracke
Director
Health Economics and Reimbursement

cc: Jonathan Brenner, Manager Health Economics and Reimbursement
Russ Miller, Manager Health Economics and Reimbursement
Chris Cerone, Vice President, Government Affairs

Submitter : **Dr. Joanna Crawford** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

CMS-1488-P-1697-Attach-1.DOC

#1697

Dear CMS policy maker

I am a family medicine resident in a very busy HPSA. I really need my faculty to teach. Why would you interpret a rule designed to do just that as being un related to patient care time? Whether we are having a discussion after a patient encounter, a small group discussion regarding a difficult clinical situation, reviewing our evaluation for our care and didactic tests in a certain disease domain, or participating in lectures – we are learning about, caring for current and protecting our future patients.

My concern is that the faculty are already stretched to produce more patient visits with poor compensation and must cover four of us at a time for supervision in clinic. That hour they spend before and after clinic to discuss a specific topic that is not related to a specific individual patient will disappear with the implementation of the rule you suggest. They will not have time to sit down with us to discuss our overall performance – we will get an email.

The faculty, without support for their own development, will be likely to lose their academic edge as they work to see patients, see more patients and supervise patient care without any incentive to reflect, discuss and research our and their work.

Please help us be better physicians to our patients by supporting a competent and refreshed faculty . Rescind the interpretation of the IME and DME support rule

Sincerely,

Submitter : **Dr. Marionj Leff** **Date: 06/12/2006**

Organization : **Sutter Health Family Medicine Residency Program**

Category : **Individual**

Issue Areas/Comments

GME Payments

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 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 may be excluded when determining the full-time equivalent 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 positionj. 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 into 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,

Marion Leff, M.D.

Submitter : **Mr. Roger Sarao** **Date: 06/12/2006**

Organization : **New Jersey Hospital Association**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1488-P-1699-Attach-1.DOC

#1699

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 New Jersey Hospital Association's (NJHA) 114 member hospitals, health care systems and other health care organizations, we 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.

The rule proposes the most significant changes in the calculation of diagnosis-related group (DRG) relative weights since 1983 by creating a version of cost-based weights using the newly developed hospital-specific relative values cost center methodology (HSRVcc). It also proposes refining the DRGs to account for patient severity, with implementation likely in FY 2008. In addition, the rule would update the payment rates, outlier threshold, hospital wage index, quality reporting requirements, and payments for rural hospitals and medical education, among other policies.

While the NJHA supports many of the proposed rule's provisions, we have serious concerns about the proposed changes to the DRG weights and classifications.

The hospital field supports meaningful improvements to Medicare's inpatient PPS. We believe the NJHA and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs, which will provide an equal incentive to treat all types of patients and conditions. 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. Moving forward requires thoughtful change.

Specifically, the NJHA supports the following:

- **One-year Delay:** The NJHA joins the American Hospital Association (AHA) in supporting a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and

CS-DRG methodology. The NJHA, AHA and the hospital field are committed to working with CMS over the next year to address these concerns.

- **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 Need Can Be Demonstrated:** The NJHA does not support a new classification system at this time, 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.

We have enclosed detailed comments that further explain our concerns and recommendations on the proposed DRG weight and classification system changes, as well as our position on many other issues in the proposed rule. **For the most part, the comments from the NJHA mirror those submitted by the AHA. However, we have strengthened the language for those sections of the proposed rule that are of particular concern for the NJHA and our members, and omitted language on those sections not applicable to New Jersey (e.g., rural issues).**

The NJHA appreciates the opportunity to submit these comments. If you have any questions about our remarks, please feel free to contact me at 609-275-4022 or shopkins@njha.com.

Sincerely,

Sean J. Hopkins
Senior Vice President

New Jersey Hospital Association
Detailed Comments on the
FY 2007 Inpatient Prospective Payment System Proposed Rule

PROPOSED CHANGES

DRG CHANGES

In response to payment recommendations from the Medicare Payment Advisory Commission (MedPAC) to address the proliferation of physician-owned, limited service hospitals, the Centers for Medicare & Medicaid Services (CMS) proposed the biggest changes to the calculation of diagnosis-related group (DRG) relative weights since the creation of the prospective payment system (PPS). These changes would significantly redistribute payments among the DRGs and among hospitals. Specifically, CMS proposes 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. CMS also proposes an alternative patient classification system called consolidated severity adjusted DRGs (CS-DRGs), with implementation likely in FY 2008.

The hospital field supports meaningful improvements to Medicare's inpatient PPS. We believe the hospital industry and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs which will provide an equal incentive to treat all types of patients and conditions. We also believe the system should be simple, predictable, and stable over time. One of the fundamental values of a *prospective* payment system is the ability of providers to reasonably estimate payments in advance to inform their budgeting, marketing, staffing and other key management decisions. Another core feature of the PPS is clinically cohesive and meaningful DRGs that are 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 NJHA believes that these are essential characteristics of a well-functioning PPS and it is within these policy goals that we evaluate CMS' proposal.

NEW DRG WEIGHTS: HSRVCC

CMS proposes an alternative to MedPAC's approach to HSRVs and cost-based weights that could be characterized as a short cut. CMS asserts that this combined methodology, known as the HSRV cost center methodology (HSRVcc), achieves similar results in a more administratively feasible manner. But that is not the case. Specifically, the CMS proposal involves two major steps.

1. Develop, on a charge-basis, hospital-specific relative weights for each DRG. CMS established 10 cost center categories based on broad hospital accounting definitions: routine day costs, intensive care day costs, and eight ancillary cost centers. CMS calculated DRG relative weights for each of the 10 cost centers by DRG for each hospital and then used those hospital-specific weights for calculating national DRG weights. CMS' current process aggregates charges for all hospitals at the DRG level to calculate weights. CMS believes the new approach removes the variation introduced by hospital characteristics such as teaching, disproportionate share, location and size, among others.

2. "Scale" the charge-based DRG weights to "costs" using the national cost center cost-to-charge ratios (CCRs) developed from the cost report data (as opposed to using hospital-specific CCRs at the claim level). CMS believes this approach will remove the effect of different CCRs across

departments within hospitals. CMS chose this methodology because the use of national average rather than hospital-specific departmental CCRs is administratively easier.

The NJHA supports the move to cost-based weights but believes CMS' proposed method is flawed. More work is needed to determine the best way to create cost-based weights. Hospitals are willing to work with CMS in a process to develop consensus around the right way to make this change. Below we discuss our detailed concerns and questions regarding the proposed HSRVcc methodology.

HSRVcc METHOD CONCERNS

The NJHA agrees with the American Hospital Association (AHA) in that more time is needed to develop a sound methodological approach to create cost-based weights and to understand their potential impact.

1. **Errors:** While analyzing CMS' proposed rule, the AHA uncovered a series of data errors, inconsistencies across databases and questionable methodological choices. Further analyses commissioned by the AHA, the Association of American Medical Colleges and the Federation of American Hospitals and conducted by The Moran Company, Inc. to investigate these questions showed that small changes in method lead to large changes in DRG weights, signaling that the proposed changes are highly unstable.

   For instance, the following, more minor, inconsistencies were identified in the analyses conducted by The Moran Company:

   - CMS inadvertently included organ acquisition costs in the data used to set weights for DRGs. These costs should be excluded. This error has a material effect on the resulting weight calculation for transplants. For example, CMS publishes a weight of 5.5466 for DRG 302 (Kidney Transplant), but with this correction The Moran Company calculates a weight of 3.0102.

   - CMS was inconsistent in its treatment of certain categories of hospitals between their calculation of the FY 2007 HSRVcc weights and the proposed CS-DRG weights, making it hard to directly compare the results. For example, hospitals in Maryland were included in the FY 2007 MedPAR data used for the HSRVcc weight calculation and excluded from the CS-DRG calculation.

   - The Moran Company used transfer-adjusted charges prior to calculating weights. It was CMS' policy to do this. However, it is unclear whether the weights published for CS-DRGs included this step.

   - Data cleaning steps used were not always consistent with standard CMS practices (e.g., removal of cases with 0 charges, low volume DRGs, etc.).

   - The cleaning steps applied to the cost report data were not consistent with the cleaning steps applied to the MedPAR claims data, which resulted in different hospitals being included in data sets used for the calculation of the weights and the calculation of the scalers to the weights. For example, hospitals in Maryland and hospitals without cost reports for FY 2003 were excluded from the cost report data used to calculate the scalers and included in the MedPAR file used to calculate the weights.

2. **Trimming:** CMS trimmed the cost center CCRs at 1.96 standard deviations from the geometric mean. We believe that this skews the CCRs, as the hospitals with high routine charge mark-ups are

systematically removed from the calculation. This results in the exclusion of 198 hospitals' routine CCRs, accounting for over 26 percent of total routine charges. It also creates a mismatch between the CCRs used and the charges they are applied to, as the hospitals that are trimmed out of the CCRs are still included in the charges that are then reduced to costs and determine the cost shares.

3. **Weighting:** CMS also hospital-weighted rather than charge-weighted the calculation of the CCRs which in turn are used to calculate the scaling factors used to convert the charge-based relative weights to "cost." There are several issues with this approach:

    - This approach gives an equal weight to each hospital in the national cost-to-charge ratio calculation even though hospitals can range in size from fewer than 25 to more than 1,000 beds.

    - This method is inconsistent with the method of averaging used to develop the cost center-specific DRG weights to which the scaling factors are applied. For this part of the analysis, CMS calculated hospital-specific DRG relative weights, but then used a case-weighted average to develop the national value.

    - The hospital-weighted approach results in a 1 percent to 54 percent difference versus a charge-weighted approach in the resulting scaling factors used for the conversion to cost.

    The above errors in the calculations over-weight CMS' routine cost shares and under-weight the ancillary cost shares, creating erroneously large swings in DRG weights. These methodological problems have a large impact on the relative weight calculations at the DRG level.

    These changes have a material impact on hospital payment. CMS' method for weighting and trimming redistributes $1.4 billion dollars among hospitals. Charge-weighting the CCRs and trimming them at three standard deviations would reduce the shift in dollars to $900 million – a reduction of ***half a billion dollars***, or 33 percent. This highlights the need for more work to validate each methodological step to understand how it affects payment and ensure it adds to "accuracy."

4. **Failure to Calculate Costs at the Claim Level:** CMS chose to use *charges* to initially calculate the relative weights at the DRG level and then a national scaler to make the conversion to "cost-based" weights. The national scaler converts the 10 cost center charge-based weights to one national weight using the actual share of costs across departments. CMS maintains that this adjusts for differential mark-ups across hospital departments. In contrast, MedPAC estimated *costs* at the claim level to calculate relative weights. CMS provided no validation of the methodological shortcut they propose.

5. **Cost Centers:** CMS aggregates charges into 10 cost centers for each DRG, then applies a cost-center level CCR (derived from the cost reports) to charge figures (from claims data). But because hospitals often report charges on the cost reports differently than charges on the claims, the cost-center level CCRs are calculated based on a different set of charges than the charges to which the CCRs are later applied. We believe this may materially distort the DRG weights and needs to be thoughtfully considered and accounted for in any methodology. If CMS is going to move to cost-based weights, regardless of the methodology, hospitals will need time to align their mapping of cost centers into departments or cost categories for purposes of cost reporting with that of claims reporting.

6. **Validation:** As mentioned above, CMS provided no analysis to validate that the proposed changes result in better payment policy. While measuring improved payment accuracy is difficult, the large degree to which the weights fluctuate given methodological changes alone indicates the need for

further analysis and study. CMS should construct a process to test the sensitivity of weights to various methodological assumptions and publicly share the result, including:

- Compare CMS weights to MedPAC's HSRV-cost approach;
- Compare CMS weights to an approach using standardized costs (as opposed to HSRV);
- Compare CMS weights to weights calculated by estimating costs at the claims level using the 10 cost center approach;
- Evaluate alternative methodologies for estimating costs;
- Compare stability of weights over time; and
- Determine whether payment policy is improved.

Assessment of "payment accuracy" conducted by The Moran Company as well as The Health Economics and Outcomes Research Institute (THEORI), a division of the Greater New York Hospital Association, finds the CMS HSRVcc approach to be not at all to marginally better than the current system. Fixing the major methodological flaws yields minimal improvement, according to THEORI. CMS' HSRVcc approach actually creates new areas of care where systematic incentives for specialization could occur. This analysis raises significant questions about CMS' approach and further analysis should be conducted before any changes to the current charge-based methodology are made. These analyses will help determine the most effective and administratively feasible approach for a shift to cost-based weights in FY 2008.

NEW PATIENT CLASSIFICATION: SEVERITY OF ILLNESS

CMS also proposes moving to an entirely new patient classification system beginning in FY 2008 *or earlier*. Currently, Medicare uses 526 DRGs to classify all Medicare patients. CMS considered use of 3M's all-patient refined DRGs (APR-DRGs) as an alternative to its current DRGs, which would increase the number of categories to 1,258. However, CMS ultimately proposed refining the APR-DRG system by consolidating APR-DRGs into fewer categories. This would result in a new DRG system with 861 consolidated severity-adjusted DRGs, or CS-DRGs.

The NJHA believes that the need for and best approach to changing the patient classification system has not been concretely and objectively demonstrated. More careful analysis is needed, along with greater access to the specifics of CMS's methodology and the new GROUPER. Below we discuss our detailed concerns and questions about this proposal.

CS-DRG METHOD CONCERNS

1. **Validation:** It is unclear whether there is a need for a new patient classification system. More work is needed to assess the proposed system and others that might be considered. As with the HSRVcc proposal, CMS provided no analysis that shows that the proposed changes result in an improved hospital payment system compared to the existing DRG system or APR-DRGs.

   CMS must test the degree to which the variation in costs within cases at the DRG level is reduced under both CS-DRGs and APR-DRGs. Payment classifications that still exhibit a high degree of cost variation should be identified and potentially revised. We suggest comparing the distribution of the coefficient of variation at the DRG level for various grouping approaches.

For instance, CMS chooses to collapse the tier-four cases within major diagnostic categories (MDCs). It is unclear whether all of the tier-four cases are clinically cohesive enough to be combined and whether consolidation adequately considers variations in resource requirements. CMS also aggressively collapses the DRGs with low Medicare volume such as obstetrics, psychiatric and substance use services without any discussion of the potential ramifications for other payment systems, such as other Medicare PPSs, Medicaid and the private sector that often bases payment off the Medicare inpatient DRG system. CMS believes that a new patient classification system that distinguishes more-sick from less-sick patients will reduce the "cherry picking" of healthy patients, but there may be other, easier ways to accomplish this. For example, CMS embarked on a new way to differentiate patients last year based on the absence or existence of a major cardiovascular diagnosis but did not discuss the possibility of other similar, less disruptive changes to the system as an option in this year's rule.

Even more fundamentally, today's DRG system was created to distinguish the resource use required among patients. It has been modified over time to reflect changes in clinical practice and technology. The APR-DRG system is based on severity of illness, not necessarily the resource use required. The impact of a move to CS-DRGs – an APR-DRG hybrid – is unclear. But the implications of moving from a resource-based system to a severity-based payment system must be more fully explored and understood.

2. **Budget Neutrality Adjustment:** CMS suggests in the proposed rule that it would reduce payments to hospitals by instituting a budget neutrality adjustment to offset the fact that case mix may increase because of improved coding rather than actual changes in acuity. However, CMS did not propose an adjustment or even a methodology for determining an adjustment. CMS often institutes such adjustments that are based on assumptions but never checked or later corrected. We recommend that CMS hold off on such an adjustment until there is evidence that one is needed.

3. **Availability of the GROUPER:** The proprietary nature of the proposed CS-DRG GROUPER is of concern. The current DRG GROUPER logic has been in the public domain since the inception of the PPS. Without the new GROUPER logic, it is virtually impossible for NJHA or anyone else to analyze thoroughly the system and comment – without access to the new GROUPER, we have no understanding of how and why patients fall into certain CS-DRGs and cannot evaluate whether it represents policy improvement. If CS-DRGs are adopted and the GROUPER remains proprietary, the NJHA would be limited in our ability to educate and assist our member hospitals. Moreover, a single company's monopoly would be both more expensive and more difficult to integrate into our hospitals' existing systems. Maryland hospitals report a GROUPER price of $20,000 per hospital with the ultimate price varying based on criteria such as whether it is used on a mainframe or PC. We urge CMS to make any new classification system widely available to the public.

4. **Too Few Diagnoses and Procedures Considered:** We are concerned that CMS' GROUPER does not use all diagnoses and procedures that affect a patient's severity of illness and/or the resources utilized. The current DRG GROUPER only considers nine diagnoses and up to six procedures. Hospitals submit claims to CMS in an electronic format. The HIPAA compliant electronic transaction 837i standard allows up to 25 diagnoses and 25 procedures. Many fiscal intermediaries are ignoring or omitting the additional codes submitted by hospital providers since these additional diagnoses and procedures are not needed by the GROUPER to assign a DRG.

   Capturing all diagnoses and procedures meeting the definitions of reportable secondary diagnoses and procedures will provide a more complete picture of patient complexity. As CMS considers methodologies for refining the patient classification system, the number of secondary diagnoses may

be an important factor in determining differences in patient characteristics. This is particularly true of patients with many chronic illnesses that add to the complexity of treating them.

NJHA RECOMMENDATIONS

The hospital field supports meaningful improvements to Medicare's inpatient PPS. We believe the NJHA and CMS share a common goal in refining the system to create an equal opportunity for return across DRGs which will provide an equal incentive to treat all types of patients and conditions. 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. Moving forward requires thoughtful change. Specifically, the NJHA supports the following:

- **One-year Delay:** The NJHA joins the AHA in supporting a one-year delay in the proposed DRG changes given the serious concerns with the HSRVcc and CS-DRG methodology. The NJHA, AHA and the hospital field are committed to working with CMS over the next year to address these concerns.

- **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 Need Can Be Demonstrated:** The NJHA does not support a new classification system at this time, 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. For example, of the 2,566 hospitals that would experience an increase in payment using the HSRVcc[1] methodology alone, 48 percent would experience a net loss when CS-DRGs and HSRVcc are done together. Of the 859 hospitals that have a decrease in payment under the HSRVcc methodology alone, 33.9 percent would become overall winners when CS-DRGs and HSRVcc are done together.

- **Three-year Transition:** Any changes should be implemented with a three-year transition, given the magnitude of payment redistribution across DRGs and hospitals. We recommend that CMS provide a three-year transition with a blend of the old DRG weights and the new DRG weights. In the first year, hospitals would be paid based on an average of DRG weights: 75 percent of the old weights; 25 percent of the new weights. The second year would be 50 percent of each, and the third year would be 25 percent of the old weights and 75 percent of the new weights. Another method of transition is dampening the reduction for DRGs with significant decrease in relative weights similar to the dampening of APC weights in the outpatient PPS. Dampening could be more feasible – especially if a significant change to the classification system is made – because it does not require CMS to calculate payments using two different systems.

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[1] Source: Moran Company analysis of 2004 MedPAR under FY 2007 payment policies using weighted CCRs and trimming CCRs at 3.0 standard deviations. See comments and technical appendix submitted by the American Hospital Association for more detail.

We further believe that a stop loss should be instituted as part of this transition. This would be similar to the approach currently used under the inpatient psychiatric PPS whereby no hospital can receive less than 70 percent of what they would otherwise have been paid under the old system. In combination with the DRG blend or dampening, this would result in less significant losses in the first year than in the last year of the transition. To avoid having to run all claims under both DRG weights, CMS could establish a payment-to-cost ratio for each hospital in FY 2006 and use that as a base against which to compare payments under the new system.

Implementing a Modern Clinical Classification System. We continue to agree with CMS' assessment in the May 9, 2002 hospital inpatient PPS notice of proposed rulemaking that ICD-10 is an improvement over ICD-9-CM and will provide greater specificity and detail. We believe that CMS should continue with plans to implement ICD-10. Implementing the significant DRG changes is a temporary fix, and a more refined DRG system can only be accomplished with more specific clinical classification systems, capable of painting a more complete picture of a patient's condition and the services provided to treat that condition – namely ICD-10-CM and ICD-10-PCS.

LONG-TERM CARE HOSPITAL (LTCH) DRGS

The NJHA is very concerned about the proposed reweighting of the long-term care hospital (LTCH) DRGs for FY 2007. The projected payment cut resulting from the reweighting – 1.4 percent – in combination with the payment cut resulting from the recent LTCH PPS final rule for 2007 – 7.1 percent – will cause substantial volatility for LTCH providers, and ultimately restrict access for patients needing long-term acute care services. It would be extremely difficult for any provider group to withstand an 8.5 percent cut in one year. By pursuing these changes, CMS is misinterpreting MedPAC's estimate of 2006 Medicare margins for LTCHs and creating an extremely unstable regulatory environment for LTCHs. MedPAC projected a 7.8 percent Medicare margin for LTCHs in 2006 and recommended no market basket update for FY 2007. However, this MedPAC projection does not include two major policy changes that also decrease Medicare margins for LTCHs: the projection excludes the impact of the "25% Rule" limiting payments to co-located LTCHs and the new reductions associated with the LTCH short-stay outlier policy. Therefore, CMS goes too far with this proposal to reduce Medicare payments even further.

Given these considerations, we urge the agency to forgo the proposed 1.4 percent cut and instead implement the reweighting in a budget-neutral manner.

This would appropriately redistribute allocated funds among the payment categories to reflect current costs and omit the inappropriate modification of total payments due to unrelated considerations. **It is irrational to treat the LTCH PPS differently than other Medicare payment systems by failing to reweight the LTCH PPS in a budget-neutral manner.**

At this time, CMS should focus on developing further patient and facility criteria for LTCHs to ensure that patients who are clinically suitable continue to have access to the LTCH setting. We strongly support CMS' pursuit of a scientific foundation for these expanded criteria and are eager to review the recommendations currently under development by CMS' contractor the Research Triangle Institute.

HOSPITAL QUALITY DATA

The Deficit Reduction Act of 2005 (DRA) expands quality reporting requirements for hospitals to be eligible to receive a full market basket update. The proposed rule states that to qualify for their full market basket update, hospitals would have to pledge to submit data on all 21 measures currently part of

the Hospital Quality Alliance's (HQA) public reporting on www.HospitalCompare.hhs.gov for patients discharged on or after January 1. Hospitals failing to submit data for the first calendar quarter of 2006 by August 15 would receive an inpatient update equal to the market basket minus two percentage points. Hospitals that fail data validation tests for data submitted for the first three calendar quarters of 2005 would also lose the two percentage points from the market basket update.

The NJHA and its member hospitals support the HQA's effort to make more information on hospital quality available to the public, and we join with CMS in wanting to make it happen quickly and accurately. However, as written, the proposed rule 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.**

The DRA gave the Secretary of the Department of Health and Human Services (HHS) the authority to expand further the measures that must be reported to qualify for full market basket update in future years. **We strongly urge CMS to select measures only from those used by the HQA for public reporting.** To choose different measures would thwart efforts to streamline quality reporting, add to the "babble" of quality measurement that currently exists in health care and dilute efforts to create a single source to share solid reliable information with the public. In addition, whenever the Secretary intends to expand the set of measures linked to payment, **CMS should consider publishing the proposal at least one full year prior to the start of the fiscal year.** This will enable hospitals and their vendors to put the needed data collection processes in place to be able to provide the requested data.

Further, we agree with CMS that it is critical that the collected data be validated. The process used to validate the HQA data was reviewed by the Government Accountability Office, which concluded that there was "a high overall baseline of accuracy," but recommended several changes to improve the validation process. CMS proposes to look at the validation results for data submitted on patients who were discharged during the first three calendar quarters of 2005. CMS has hired a contractor to select, at random, five patient records per quarter. That contractor selects the patients, asks the hospital to send a copy of the medical record for the hospitalization of the patients that occurred during that period, and then reabstracts the same data that the hospital abstracted from the medical record. A comparison is made between the data the hospital submitted and the data the contractor abstracted, and if there is at least an 80 percent agreement, the hospital is said to have passed validation. In the proposed rule, the hospital would have to have at least 80 percent agreement across the 15 medical records that the contractor reabstracted. This methodology assumes that the contractor has correctly reabstracted the data and that discrepancies must mean erroneous data submission on the part of the hospital. However, that is not always the case. This validation process is still in its infancy and seems to be working to validate correctly the information submitted by many, but unfortunately not all, hospitals. Significant problems have occurred for some hospitals of which we are aware.

Some data validation problems have actually begun with the data submission process. Hospitals and their data collection vendors submit data to the Quality Improvement Organization (QIO) data warehouse in a good-faith effort to get the information submitted in the right format, with all of the right labels and coding. An "error report" is generated that is supposed to alert the hospital if it appears data were received in a way that is not consistent with the requirements. The hospital is supposed to receive this report in time to make any necessary corrections. However, the report can be hundreds of pages long with a multitude of meaningless notations. A significant problem in data transmission might have

occurred, but the indications of it are buried in this voluminous report and may not be discovered until it is too late for the hospital to make a correction. In addition, the data collection vendors on whom the hospitals rely to format and submit the data correctly do not have access to these error reports, nor do they have any other mechanisms for checking to make sure that the data they sent was received correctly. This has inevitably led to errors not being caught in time. When these errors are then left in the database, the CMS contractors' reabstraction of the data does not match up with what is recorded for the hospital in the database, leading to the hospital failing validation.

Another common problem results when the contractor has asked for the medical record pertaining to a particular patient, but has not specified which admission it wanted. Since it is not uncommon for heart failure patients to be readmitted for care, the omission of the specifics on which admission was being reabstracted has inevitably led to the hospital copying and submitting data on one admission, and the contractor trying to make that match up with the data for a different admission – and the data simply will not match up.

There also have been many reported instances in which the contractor conducting the reabstraction of the data failed to find information that was clearly in the medical record – a simple human error, but one that should not be used to penalize the hospital.

CMS was made aware of these problems with the validation process and it has begun to work to improve the process reliability so it can be used to support payment decisions. However, in the first three calendar quarters of 2005, the validation process did not have sufficient integrity to warrant hospital payments being withheld based on the validation results. At this juncture, we firmly believe that the problems with the validation process itself need to be resolved before any payment decisions are made solely on the basis of the contractor's work. **We strongly urge CMS to review, on a case-by-case basis, any incidence where a hospital's payment would be put in jeopardy as a result of the validation process. It should allow the hospital to submit information showing that it made a good-faith effort to supply the data warehouse with accurate information so that the public could be informed about the quality of its care. If the hospital has made a good-faith effort, it should receive full payment regardless of whether the data are deemed accurate enough for public display.** In addition, CMS should instruct its QIO data warehouse to accept any significant corrections so that the public can have a full and accurate picture of hospital quality.

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 remain very concerned that the threshold is too high. According to analyses by the AHA, 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.

The NJHA appreciates 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. The NJHA strongly opposes using this methodology to estimate the outlier threshold. The AHA conducted a series of analyses to identify a more appropriate methodology. Below we put forth for CMS' consideration a methodology from the AHA that incorporates both *cost* inflation and *charge* inflation. We believe the use of more than one indicator will make the threshold calculation more accurate and reliable.

First, the AHA inflated 2005 charges by 15.71 percent (the inflation factor used by CMS in the proposed rule) and then reduced the charges to costs. Instead of using the cost-to-charge ratios (CCRs) from the CMS Impact File, they used the CCRs from the March 31, 2006 HCRIS release. In addition, the AHA accounted for the nine-month lag from the end of a cost-reporting period until the FI is able to update the CCR. They accomplished this by projecting forward from the most recent fiscal period in the March 31 HCRIS update to the fiscal period(s) expected to be used for the calculation of the CCR(s) determining federal FY 2007 outlier payments.

The cost inflation factor for projecting CCRs was determined from the cost reports of a cohort of 3,253 matched hospitals for periods beginning in federal FYs 2002, 2003 and 2004. All three cost reports were available for each hospital from the recent update of HCRIS. The 2002-2004 aggregate annual rate of increase in the cost per discharge for these hospitals was 5.69 percent[2]. This cost inflation factor and the CMS charge inflation factor of 7.57 percent were used to project CCRs over the time periods described above. The projected CCRs were applied to projected federal FY 2006 charges to simulate the determination of costs for FY 2007 outlier payments. **The estimated fixed-loss amount that would result in 5.1 percent outlier payments under this methodology is $24,000.**

The NJHA strongly urges CMS to adopt the AHA's methodology, which is applicable regardless of what DRG changes are made or not made in FY 2007. The fixed-loss threshold necessary to achieve 5.1 percent in FY 2006 should have been set at $21,275 as compared to the $23,600 actually utilized. We believe CMS underspent the funds set aside for outliers by an estimated $3 billion over FYs 2004, 2005 and 2006. **This is a real cut in payments to hospitals that cannot be recouped. If CMS leaves the threshold at $25,530, rather than dropping it to $24,000, we believe that CMS will again significantly underspend by over $300 million.** We urge CMS to adopt the AHA's recommended methodology to lower the outlier threshold.

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.

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[2] An audit adjustment was applied to costs from "as submitted" cost reports. The audit adjustment was determined by comparing 2,729 "as submitted" cost reports from the December 31, 2003 HCRIS database with the settled reports of the same hospitals in the March 31, 2006 HCRIS update.

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.

Definitions and Covered Employees. In filling out the interim-survey, some of our members found that the placement of certain employees caused confusion. Examples include surgical technicians, paramedics who are employed by the hospital and usually work in the emergency department, and unit secretaries who are also known as ward clerks. CMS clarified after the proposed rule was released that these employees should be placed in the "all other" category for the interim-collection. Moving forward, CMS should re-evaluate where these employees belong. **However, such changes should not be made to the ongoing collection, as it would necessitate the resubmission of the first calendar quarter's data to ensure that both quarters could be used for FYs 2008 and 2009.** If CMS believes that such changes are warranted, then the hospitals will need notification prior to the release of the final inpatient PPS rule in order to meet the August 31 deadline for submissions.

Cost Centers. We agree with CMS' "bright line" clarification for this collection that only nursing personnel within the cost centers listed should be included in that category for the purposes of consistency. It is significantly less work for hospitals to focus on certain cost centers, and we continue to support this methodology. **We believe that the vast majority of nursing personnel within a hospital fall within these cost centers and do not believe that CMS should include every cost center that may have a few nursing personnel included in it.**

However, CMS should consider refining the list for future collections. Every hospital has a different method for attributing costs to the cost centers, thus there are probably a few cost centers that contain a significant number of nursing personnel for certain hospitals that were not captured for this collection. Given the shortened comment period in combination with the magnitude of the other changes proposed by CMS in the inpatient PPS rule this year, we were unable to research extensively which cost centers CMS should add. We suggest that CMS accept comments on any potential changes to the cost center list before making such changes. **In addition, we believe that additional cost centers should *not* be added to the ongoing collection as it would necessitate the resubmission on the first calendar quarter's data to ensure that both quarters could be used for FYs 2008 and 2009.** If CMS believes that such changes are necessary for the current collection, then hospitals would need notification prior to the release of the final inpatient PPS rule in order to meet the August 31 deadline for submissions.

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.**

However, hospitals will 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 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, 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. **The NJHA 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. 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.**

HOSPITAL REDESIGNATIONS AND CLASSIFICATIONS

Section 508 Reclassifications. Section 508 of the *Medicare Modernization Act* (MMA) provided $900 million over three years for a one-time geographic reclassification opportunity, which expires March 31, 2007. Because the 508 reclassifications expire mid-year and hospitals may not receive Section 508 funding at the same time as any other form of reclassification, CMS has proposed special provisions for accepting or denying partial-year reclassifications for FY 2007.

In FY 2006, CMS stated that individual hospitals reclassified under Section 508 would be allowed to request regular reclassification for the portion of the three-year period that the hospital is not receiving Section 508 funding, or to turn down the Section 508 reclassification for the first half of FY 2007 and receive regular individual reclassification for the full three years.

CMS also stated that Section 508 hospitals that would like to be part of a group reclassification could turn down their 508 reclassification for the first half of FY 2007 and join a group for the full three-year period. Or the hospitals could maintain Section 508 reclassification while the rest of the group gets their "home wage index" for the first half of the year. The entire group then could reclassify together for the rest of the three-year period.

In the proposed rule, CMS clarifies that "home wage index" means that hospitals could receive the wage index they otherwise would have, absent the group reclassification. For some hospitals, this might literally be the wage index for the area in which they are located. For others, this may mean an individual reclassification to another area.

Section 508 hospitals, and those involved in a group reclassification with a Section 508 hospital, would normally have been required to accept or reject reclassification within 45 days of the publication of the proposed rule; however, the complications with the occupational mix adjustment will prevent this. **We appreciate and support CMS' flexibility around the expiration of Section 508 and the reclassification deadlines given the unusual circumstances this year.**

GEOGRAPHIC RECLASSIFICATIONS

Multi-campus Hospitals. Payment is determined using the wage index value for the MSA in which a campus is located, even though the organization may have other campuses located in different labor market areas. Because multi-campus hospitals submit a single cost report that does not break down wage data by campus, an individual campus historically has been unable to seek reclassification. For FYs 2006-2008, CMS authorized individual campuses to use the average hourly wage data of the entire multi-campus hospital system to seek geographic reclassification to the labor market area in which the other campus(es) are located. CMS also stated in the FY 2006 rule that, in the future, it would continue to consider mechanisms to collect the data necessary for geographic reclassifications that are not unduly burdensome for providers. However, CMS now proposes rescinding this option, as there was only one hospital in the country that was affected by this situation and, after the change in labor market areas in FY 2005, it has subsequently joined an urban county group that is reclassified to the area in which it was previously reclassified using the multi-campus hospital rule.

The NJHA opposes CMS' proposal to remove this option. While CMS may know of only one hospital at this point, there may be others, and additional hospitals may be affected after the next census collection and subsequent changes in labor market definitions. In addition, the need for this provision has not subsided as CMS suggests. The one affected hospital will need to use either campus-specific or hospital-wide data for its next reclassification, whether group or individual, and lack a method to do so.

CMS suggests that each campus should disaggregate and receive its own provider number. A multi-campus hospital with a single provider number provides certain health and treatment benefits to patients, such as the ability to move among campuses for various aspects of treatment. Each campus may specialize in a particular service (oncology, cardiology, etc.) and patients can move among the campuses with one medical records system, one billing system and a unified medical staff. Economies of scale reduce costs for the whole system. **Thus, we do not believe it is a realistic or appropriate option to force these campuses to apply for individual provider numbers.**

We recommend that CMS continue to allow multi-campus hospital systems to use the data from all campuses as a proxy for individual campuses to reclassify to an area where another one of the campuses is located given how few hospitals are expected to use this option. This is a reasonable request as most multi-campus hospital systems likely pay equal or similar wages at each campus. If CMS finds that the situation becomes more prevalent, it could require the manual completion of the campus-specific Schedule S-3 for those hospitals that do not have the appropriate individual campus data. However, if CMS moves to a campus-specific S-3, CMS still needs to extend the current special rule for five years until the new campus-specific data is useable for an application.

Urban Group Reclassifications. The NJHA supports CMS' proposal to allow hospitals located in counties that are in the same CBSA as the county in which they seek redesignation to be considered to have met the proximity requirement. **Given that CBSAs are actually more refined classifications than Combined-statistical Areas, we believe that the inclusion of CBSAs in the proximity criteria would be consistent with CMS' policy goals and protect hospitals from unintended consequences.**

WAGE INDEX BUDGET NEUTRALITY

CMS eliminates the CAH data from the wage index file it uses to compute the national average hourly wage (NAHW). For FY 2007, 1,191 CAHs representing approximately 24 percent of all inpatient PPS hospitals (as of FY 2000) – 55 percent of all rural hospitals in FY 2000 – have been eliminated from the file. Because CAHs have lower average hourly wages (AHWs) than the average PPS hospital, the elimination of this data results in an overstated NAHW. While the NAHW has been increasing, the

systematic withdrawal of low-wage hospitals has artificially inflated the NAHW to some extent. This artificial increase is included in the negative budget neutrality adjustment that consequently reduces payment, resulting in the national inpatient PPS operating payments being understated by an estimated $1.52 billion over five years (2003-2007). **Thus, we believe that CMS should apply a positive budget neutrality adjustment in FY 2007 to compensate for the underpayments.** The understatement increases each year as more hospitals become CAHs and more data are eliminated from the wage index data. However, we believe that this could be a one-time adjustment as we expect very few hospitals to convert to CAH status now that the necessary provider designation is no longer an option.

GRADUATE MEDICAL EDUCATION (GME) PAYMENTS

Exclusion of Didactic Training. The proposed rule states that resident training that occurs at non-hospital sites must be related to patient care if a hospital wishes to count that time for direct medical education (DGME) and indirect medical education (IME) payment purposes. Resident time spent in didactic activities that often occur in associated medical schools – such as educational conferences, journal clubs and seminars – would specifically be excluded. CMS noted that its statement in a previous letter on this topic "implying that didactic time spent in non-hospital settings could be counted for direct GME and IME ... was inaccurate." CMS also noted that time spent in these activities could be counted for DGME purposes if they occur in a hospital; however, the counting prohibition applies for IME payments regardless of where the educational activity occurs.

We strongly urge CMS to rescind the purported "clarification" in the proposed rule that excludes medical resident time spent in didactic activities in the calculation of Medicare DGME and IME payments. The stated rationale for the exclusion of this time is that it not "related to patient care." This position is in stark contrast to CMS' 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."[3]

We strongly agree with CMS' 1999 position. The activities cited are an integral component of the patient care activities engaged in by residents during their residency programs. In addition, it would be very difficult to separate out time spent at these activities. **We urge CMS to withdraw this change 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.**

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

Hospitals without Dedicated Emergency Departments (ED). Under the proposed rule, a hospital with "specialized capability" is required to accept appropriate transfers under EMTALA regardless of whether it has a dedicated ED. **Guidance is still needed on the definition of specialized capability.** The EMTALA technical advisory group (TAG) has the ability to make recommendations for clarifying guidance, and we look forward to working with its members on this topic. In addition to questions related to the availability of on-call physicians and inpatient psychiatric resources, this proposed regulation calls into question application to inpatient rehabilitation facilities and long-term acute care hospitals.

The NJHA agrees that a physician-owned, limited-service hospital should be treated as a hospital "with specialized capability or facilities" under EMTALA without regard to whether it has an ED. However, in the DRA-mandated HHS interim report to Congress on its development of a strategic plan

[3] September 24, 1999 Letter from Tzvi Hefter, Director, Division of Acute Care to Scott McBride, Vinson & Elkins.

regarding physician investment in specialty hospitals, the Secretary suggested that this interpretation of EMTALA "may result in an increase in the number of specialty hospitals accepting transfers of emergency patients on nights and weekends." (CMS uses "specialty" to mean the hospitals covered under Congress's moratorium, i.e., physician-owned, limited-service hospitals providing primarily cardiac, surgical or orthopedic services.) **We believe it is unlikely this will result in improved access for patients to the specialty care they need.**

It is important to separate the capabilities of the practicing physicians from the capabilities of the facility in which they are practicing. While the physician expertise housed in the physician-owned, limited-service facility could be capable of meeting the needs of community hospital patients, the facility is seldom designed or operated in a manner to support this level of practice. Although physician-owned, limited-service hospitals hold themselves out as "hospitals," many of these facilities actually have a range of capabilities more similar to a hospital department or ambulatory surgical center. These hospitals often do not have emergency capabilities, as they are geared toward elective cases of minor severity. Their capabilities are typically limited to a single major diagnostic category, and they staff for minimal inpatient capacity. Many of these facilities minimize resource consumption by being almost a Monday through Friday operation. For these reasons, it generally would not be in the best interests of community hospital patients to be transferred to these facilities.

At the same time, many physician-owned, limited-service hospitals have withdrawn specialist services from the community at-large. As their physicians maintain an increasing amount of their practice at these hospitals or other sites outside the community hospital (e.g., ambulatory surgical centers), they are much less willing to accept on-call responsibility for the broader community's emergency needs. While withdrawing specialist services from on-call coverage, these same physician-owned, limited-service hospitals presume to rely on the community hospital for back-up in the event of complications requiring around-the-clock access to emergency care and inpatient admission to the community hospital. With the change in physician practice patterns and the increased number of physicians requesting only courtesy admitting privileges at community hospitals, relying only on the professional obligations attached to admitting privileges is not sufficient to assure appropriate transfer arrangements and the availability of physicians to provide emergency specialty capacity. **Every physician-owned, limited-service hospital that relies on the community's emergency services capacity should be obligated to support it.**

In addition, this policy does not address the problem of patients at physician-owned, limited service hospitals who suffer from complications appearing in a hospital ED with no warning call, no medical history, no operative report, no information on the anesthesia used and, often, no ability to reach the treating surgeon for consultation. **Physician-owned, limited-service hospitals should be required to have agreements with the community hospitals they plan to rely on in the event that they do not have the capacity to treat a particular patient.**

Specifically, the NJHA recommends the following:

- **A physician-owned, limited-service hospital should be required to have a pre-existing agreement with the community hospital(s) it intends to rely on for emergency back-up services.**
- **The Secretary should establish the terms that must be addressed by an agreement, including:**
  - **Procedures for an appropriate transfer for patients not covered under EMTALA** (e.g., inpatient or outpatient whose condition develops into an emergency beyond the capability of the limited-service hospital and consequently needs to be transferred to a full-service hospital);
  - **Continuity of care** (e.g., telephone consultation with the receiving hospital and physician, sending the patient's medical records along when transferred, etc.); and

- **Support for maintaining full-time emergency capacity at the community hospital, including on-call coverage** (e.g., physician-owned, limited-service hospital physicians serve in on-call panels at the community hospital, or the physician-owned, limited-service hospital provides financial support to the community hospital to maintain on-call coverage).

NEW TECHNOLOGY

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

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

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

The National Committee on Vital and Health Statistics (NCVHS) and Congress, in committee language for the MMA, recommended that the Secretary undertake the regulatory process to upgrade ICD-9-CM to ICD-10-CM and ICD-10-PCS. Congress' call for action recognized that procedure classification codes serve to identify and support research and potential reimbursement policies for inpatient services, including new health technology, as required under the *Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.*

To date, despite these recommendations, as well as the recommendations of several federal health care agencies and offices and health care trade and professional associations, HHS has not yet moved forward to adopt the ICD-10 classification upgrades. We believe that absent a switch to ICD-10 soon, there will be a significant data crisis in the U.S. This coding crisis will affect the efficiency of the current coding process, adding significant operational costs. In addition, failure to recognize this looming problem will only impede the efforts to achieve President Bush's goal for an electronic health record by 2014.

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

Category 00 is now full, and the C&M committee is entertaining proposals for codes in category 17. At the April C&M meeting a proposal was presented that would in effect leave only 80 codes available in this category. Many of the specific body system chapters are already filled (e.g., cardiac and orthopedic procedures). In recent years, as many as 50 new procedure codes have been created in a single year. This

means that it is possible for ICD-9-CM to run completely out of space in one-and-a-half years. We concur with the NCVHS recommendation to issue a proposed rule for adoption of ICD-10. We also would support an implementation period of at least two years following issuance of a final rule.

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

Submitter : **Dr. Kevin Cunningham** **Date: 06/12/2006**

Organization : **John Peter Smith Hospital-FMRP**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GME Payments

GME Payments

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.

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#1700

Currently I am completing my residency in family medicine. When I became aware that CMS would stop funding payment to faculty for teaching, preparing curriculum and evaluating my performance through GME -- IME and DME support – I became alarmed.

We are in a state with a huge health care professional shortage in communities under 25,000. These communities cannot afford to support several nurse practitioners and visiting specialists when the services are delivered by a pluri-potential well trained family medicine specialist who is part of their community. The training programs, like mine, which prepare us for these types of venues are in very short supply. We need to be exceptionally well trained.

Someone at CMS will need to explain to me, how the teaching, curriculum development and evaluation process for the six required ACGME physician skill competencies is not related to patient care. Isn't this exactly what the IOM has criticized our training professions for? In fact, our program currently evaluates us in all these competencies as a continuing quality improvement process DURING patient care. Without time to discuss and reflect our experiences and outcomes we will not be serving the needs of our current and future patients.

Should indeed this come to pass, we will have faculty who will be caught in the productivity race with no time for us. We may get pop-up feed back from an Electronic Health Record in sites that have them that we have made an error or we are not following a guideline. No discussion there. What is being proposed is dangerous for our current patients and our future patients. Our patients deserve for us to have a better education than you are proposing.

Why does the American taxpayer support medical students at over $200,000 per student per year and offers the faculty of residencies less than $15,000 for teaching per resident per year? I am getting a lot more from my residency training to protect and serve my patients of the future than all of medical school combined. Please do not cut us any more – rescind the clarification of this dangerous and capricious rule.

Medical Resident