461

WALZ
HART
HEFTER
HARTSTEIN

Submitter : Mr. Stephen Mason

Date: 06/24/2005

Organization : BayCare Health System

Category : Other Health Care Professional

Issue Areas/Comments

TRANSFER

GENERAL

GENERAL

See Attachment

CMS-1500-P-725-Attach-1.DOC

4162

TREITEL
WALZ
HEFTER
HARTSTEIN
Brooks
Fagan
Gruber
Kelly
Hue

Submitter : Mr. Mitch Tibbitts

Organization : St. Mark's Hospital

Category : Hospital

Date: 06/24/2005

NT
DRG/Gen

Issue Areas/Comments

GENERAL

GENERAL

See Attachment regarding DRG 525/VAD reimbursement

CMS-1500-P-718-Attach-1.DOC

Attachment to #718

Mitch Tibbitts, CFO
St. Mark's Hospital
1300 E 3900 S
Salt Lake City, UT 84124

June 28, 2005

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

RE: DOCUMENT CMS-1500-P

To Whom It May Concern:

This letter is written on behalf of St. Mark's Hospital in Salt Lake City Utah. As an introduction to St. Mark's Hospital, we are a 317 bed acute care facility that boasts 133 years of providing quality patient care in Salt Lake City. We continue to focus energies and resources in promoting quality in the patient care we provide. Evidence of success in these efforts has gained the attention of entities in and outside of our hospital system. Some of the most recent recognitions include:

- 100 Top Cardiovascular Hospital for six consecutive years. We are the only hospital in Utah to be named every year since Solucient created this category of award – and one of only six in the nation.
- 100 Top Overall Hospital three consecutive years. We are the only hospital in Utah to be named both a 100 Top Overall Hospital and a 100 Top Cardiology Hospital for three consecutive years.

The above recognition was awarded by Solucient, a leading source of business intelligence. The ranking is based on quality, financial, and efficiency indicators. Generally speaking, award recipients have higher survival rates, lower complication rates and lower expenses than their peers.

These recognitions are not highlighted to draw attention specifically to the awards, but to share additional testimony supporting the level of quality expected to be delivered in patient care at St. Mark's Hospital. It is the relentless pursuit of quality improvement that is my motivation for submitting this formal comment to share with you a perspective from St. Mark's Hospital regarding the Ventricular Assist Device (VAD) and its associated reimbursement.

THE MARGIN VS. MISSION QUANDARY WITH NEW TECHNOLOGY

As new and/or updated technology such as the Ventricular Assist Device (VAD) is introduced and physicians and patients become familiar with its benefits, the facility often finds itself in a dilemma. On the one hand, the main focus and mission of the hospital as a healthcare provider is generally centered around the provision of quality patient care; however, without reimbursement at a level that at least covers the variable cost of making the technology available, the facility cannot continue to support the technology on a long term basis – regardless of the specific technology's potential implications on quality.

To add insult to injury, new technology often requires the acquisition of capital equipment in order to make the technology available to the patient. Such is the case with the VAD. In an environment of limited capital funding, service lines or procedures with no margins or negative margins many times lose to more attractive competitors for limited capital dollars. Not only is there difficulty in overcoming reimbursement levels less than the variable cost in disposables, staffing, and other operational costs, but the initial capital investment is particularly difficult to justify as the struggling service is being compared to more attractive options being presented for access to the same pool of capital dollars. The end result is that new technologies that are reimbursed less than variable cost face double jeopardy as 1) inadequate reimbursement does not support allocation of capital dollars, and 2) ongoing

variable operational costs are not covered. If the reimbursement and incremental expense per case cannot be more closely synchronized, the unfortunate consequence is the patient's reduced or eliminated access to life saving and quality enhancing technologies such as the VAD.

ST. MARK'S HOSPITAL AND THE VAD

St. Mark's has made use of the exterior VAD for a number of years. We were recently confronted with the need to revisit our commitment to this technology when a new machine was made available which provides additional quality enhancing features to the patient. As experienced with past improvements in technology, the trade-off for the potential improved quality in care comes in the form of increased capital need and per-case disposable supply expense.

In evaluating the prudence of making additional investment in the VAD, input was collected from various sources to support the decision-making process. The conflict of margin vs. mission was refueled as the clinical benefits made possible by the VAD technology were met with a dismal reimbursement picture.

Physician Perspective: The following information was provided by physicians in requesting that the improved technology be made available to our patients: *Post-cardiotomy cardiogenic shock occurs in approximately 2-6% of patients undergoing open-heart surgery. Early implantation of an intra-aortic balloon pump (IABP) together with pharmacologic support leads to the successful weaning from bypass in 70-90% of all patients. Complete hemodynamic recovery and successful removal of the IABP is accomplished in 60-70% of patients nationwide. In those patients suffering from low cardiac output syndrome despite these maximal therapies, ventricular assist (VAD) may be necessary.*

349 open-heart procedures were performed at St. Mark's Hospital in the calendar year 2004. According to the physician data presented, of the 349 open-heart cases performed in one year, there is a potential that 21 patients at St. Mark's would experience post-cardiotomy cardiogenic shock. Continuing with the physician data results, between 15 and 19 of the 21 patients could be successfully weaned from bypass by way of IABP and pharmacologic support. The remaining 2-6 patients annually would not be brought off of bypass via routine therapies and would face very limited options – one of which would be the use of the VAD. With the external VAD technology, the patients would also have a very good chance of recovering their natural heart which would result in greatly reduced expense over the life of the patient vs. the transplant alternative.

Financial Perspective: From a financial perspective, the proposition of having more case volume utilizing the VAD was grim. Under the current DRG 525, reimbursement rates were found to fall significantly short of the cost of disposable supplies related to the VAD, not to mention the extended length of stay often required for patients benefiting from this technology. Data was collected from St. Mark's Hospital and 3 other hospitals utilizing the VAD technology and reimbursement was found to fall short of variable cost as much as $28,000 per case.

In addition to the apparent ongoing per-case loss, there was also the challenge in justifying the purchase of the VAD machine to which the patient is connected. With a sample patient population reporting an average double digit shortfall in covering variable costs per case, the VAD could not be justified from a financial point-of-view.

THE DECISION TO INVEST

Generally speaking, when faced with a choice of feasible options, St. Mark's has elected to take the path of highest quality outcomes potential. Although this mentality is becoming more and more challenging to support financially, it is grounded in the underlying assumption that where quality is

consistently delivered, the bottom line will take care of itself. This mode of operation has proven challenging in relation to a few specific service lines, but for the most part, has proven to be of benefit to patients and has been a worthy strategy for the hospital.

After compiling all input related to the VAD, the costs and benefits were carefully assessed. In spite of the financial data strongly suggesting otherwise, St. Mark's elected to make the additional investment in the VAD technology and provide this option to our physicians and patients – at least for the foreseeable future. The hope is that similar to the original bare metal stents, biventricular devices, and other technologies that have proven beneficial in reducing total system costs while enabling quality outcomes, Medicare and other payors will recognize the VAD technology accordingly and reimbursement commensurate to the cost of providing service will follow.

REQUESTED CMS ACTION

In summary, the technology provided to patients via the VAD is critical in providing improved patient outcomes. Current reimbursement rates fall short of covering costs to provide the technology straining the ability of the facility to make the advancements available to patients due to intensity of supplies and increased length-of-stay associated with these patients. The external VAD also makes it possible to recover the patient's natural heart which saves considerable expense over the patient's life.

I am requesting that reimbursement be increased to cover the cost of caring for the patients that can benefit from the VAD technology. Please consider the creation of an additional DRG or adjust rates under the current DRG structure to accommodate this population of cases. With reimbursement brought at least to the level of the variable costs incurred per case, we can continue to make this quality enhancing therapy available to our patients.

Thank you for your consideration,

Mitch Tibbitts
CFO, St. Mark's Hospital

CMS-1500-P-714 463 BODDEN KRUSHAT HEFTER HARTSTEIN

Submitter : Ms. Debra Kiser

Organization : Charleston Area Medical Center

Category : Hospital

Date: 06/24/2005

Issue Areas/Comments

Q DATA

GENERAL

GENERAL

see attachment

CMS-1500-P-714-Attach-1.DOC

Charleston Area Medical Center

Attachment to #714

Regarding data provisions of FY 2006 Medicare Inpatient Prospective Payment System (PPS) Proposed Rule

Compliance with the requirements for accurate data submission has been a contest whereas hospitals must interpret ambiguous communication and documentation. Charleston Area Medical Center (CAMC) would like to suggest that any and all rules concerning the Inpatient Prospective Payment System should be communicated in a clear and concise manner.

Requirements of the data submission process should be documented clearly and extensively and disseminated to hospitals and their vendors within 120 days of the effective date. Additionally, all changes should be permanent for that submission quarter once it has begun.

An evaluation process for validating data submission files should be instituted and measuring methodology established. "Test files" should be provided to hospitals and their vendors for internal verification prior to formal submission. The process should allow for verification of file formats, accuracy of data calculations and other audit criteria related to data submission. The "test file" process should be dispersed each time changes in data submission or measure specifications are proposed.

The validation process should be documented clearly and explicitly, as knowledge related to *what* is being validated is crucial for data abstraction by the hospitals. Presently, by the time hospitals receive validation results for one quarter, almost two quarters have elapsed. These required alterations to the data abstraction process cannot be made quickly under the current method.

Additionally, hospitals and vendors should be notified of any changes to validation regulations at least 120 days prior to the data abstraction period. All changes should be permanent for that abstraction period with no changes being retroactive.

Under current guidelines, 10 days is allowed for a hospital to appeal validation results. This timeframe is not sufficient to produce the necessary documentation. Therefore we ask that 30 calendar days be allowed for an appeal request to the validation results.

Due to the difficulties with communication regarding updates and modifications from CMS, CAMC requests that a process be initiated that would allow simultaneous dissemination of necessary information to all required parties. This would assist to eliminate confusing and potentially conflicting communications that occur between vendors, QIOs and hospitals.

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

464-9 (2) KENLY HEFTER HARTSTEIN

Submitter : Mrs. Crista Durand
Organization : Day Kimball Hospital
Category : Hospital
Issue Areas/Comments

Date: 06/24/2005

HOSP REDES

MB|H
WI|GEN
CBSA
Labor|S
Transfer
IME
IMPACT

T. Jones
Seifert
Knight
Miller
Treitel
WALZ
Hart
Lefkowitz
Ruiz
Truong
Kraemer

GENERAL

GENERAL
See Attachment

CMS-1500-P-713-Attach-1.DOC

Attachment to #713

DAY KIMBALL HOSPITAL

320 Pomfret Street Putnam, Connecticut 06260 860-928-6541 / 860-774-3366 www.daykimball.org

June 24, 2005

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

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

Dear Sir or Madam:

Day Kimball 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 2006 Rates [CMS-1500-P].

Hospital Redesignations and Reclassifications (Pages 23376 – 7)

Under Section 1886(d)(8)(E) of the Act, an urban hospital can apply for redesignation as a rural hospital. Under the proposed rule, the "hold harmless" provisions that occur under section 1886(d)(8)(B) and section 1886(d)(10) when a hospital is granted reclassification, will now be applied when hospitals are approved for redesignation. Day Kimball Day Kimball supports this appropriate extension of the "hold harmless" protection, which is particularly important to many Connecticut hospitals. Day Kimball Hospital thanks CMS for addressing this issue in the proposed rule.

Other Provisions

There are several provisions of the proposed rule that remain harmful to many Connecticut hospitals. Day Kimball Day Kimball opposes the following provisions:

- Moving to wage indices based on 100% of the new CBSAs, rather than retaining the 50% blend;
- Reductions to the labor share;
- Expansion of the transfer policy; and
- Reductions to indirect medical education (IME).

Of particular concern is the proposed expansion of the transfer provision, which is projected to result in a reduction in Medicare funding to Day Kimball Day Kimball $254,000 thousand in FFY 2006, a reduction this hospital simply cannot afford.

Finally, we ask that CMS consider a minimum guaranteed rate of increase 2% for hospital providers and a one-time increase of 3.8% to correct for the consistent under-forecasting of the hospital market basket that occurred in seven of the last eight years. Granting such an increase, while not correcting for the past under funding, will offer great relief by bringing the current rates to their proper level. Setting a minimum increase of 2% will prevent what happened last year when 48 hospitals in the country were paid less in 2005 than 2004; 14 of the 48 were in Connecticut. If the various proposed changes go into effect for FFY 2006, nine hospitals in Connecticut will receive less in 2006 than they received in 2005. We believe CMS should develop and implement a minimum increase for hospitals similar to that developed for Health Plans (i.e. 2% minimum annual increase).

We appreciate your consideration of these comments.

Sincerely,

Crista F. Durand
Senior VP of Finance/CFO

By mail and e-mail
June 24, 2005

465

BODDEN
KRUSHAT
HEFTER
HARTSTEIN

Submitter : Ms. Joy MacLaren **Date:** 06/24/2005

Organization : Tomball Regional Hospital

Category : Other Health Care Professional

9 DATA

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1500-P-709-Attach-1.DOC

Attachment to #709

COMMENTS ON DATA PROVISIONS
FY'O6 Medicare Inpatient Propsective
Payment System (PPS) Proposed Rule

Tomball Regional Hospital
Tomball, Texas 77375
Hospital Provider Number 450670

We are hereby requesting that the final rule governing the FY'06 Inpatient PPS should establish clear documentation requirements related to:

Data Validation:

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

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

- Further, we believe that hospitals should be notified of any validation rule changes at least 120 days prior to the hospital data abstraction period. The validation rules applied by CMS as of June 6, 2005 are, in fact, retroactive to the July—September 2004 data. CMS validated the three test LDL measures for the AMI clinical focus group. Consequently, hospitals are receiving mismatches for not collecting this optional data. The validation documentation for the July 1, 2004 discharges is dated April 29, 2005. Since the data was submitted at the end of January, hospitals have not had sufficient time to make the appropriate change. Our hospital received mismatch in our most recent Validation report of (07/04 – 09/04) related to these optional fields and therefore our score for one AMI chart was listed at 47%. Although I have appealed this ruling, the fact that the abstractors were using validation fields that are optional and calculating a score was unfair and biased. We should have received communication that these data fields would be used for validation prior to receiving the report.

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

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

  Thank you for considering the input from hospitals. We are really trying very hard to comply with the requirements related to this data submission and feel some frustration with the continually changing rules.

  Joy MacLaren
  Director of Quality Managment

CMS-1500-P-708

466

WALZ
HART
HEFTER
HARTSTEIN
Brooks
Kelly
Hule

Date: 06/24/2005

Submitter : Mr. Philip Beauchamp
Organization : Morton Plant Mease Health Care
Category : Hospital
Issue Areas/Comments

TRANSFER

GENERAL

GENERAL
See "Word" document attachment

CMS-1500-P-708-Attach-1.DOC

Morton Plant Mease
HEALTH CARE

Attachment to #708

June 24, 2005

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

Re: CMS-1500-P – Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Proposed Rule (70 *Federal Register* 23306)

Dear Dr. McClellan:

On behalf of Morton Plant Mease Health Care, I am writing to express our serious concerns regarding the May 4, 2005 proposed changes to the hospital inpatient prospective payment system (PPS) proposed rule. The rule recommends an expansion of the "transfer policy" to roughly half of all diagnosis related groups (DRGs). This is the third set of new criteria the Center for Medicare and Medicaid Services (CMS) has proposed for inclusion in the transfer policy in the last three years. The proposed rule inhibits the ability of Morton Plant Mease clinicians to determine the best setting for patients based on their distinct medical needs.

Morton Plant Mease is committed to providing a unique model of efficient care for residents we serve in Pinellas and Pasco Counties, Florida. As such, we are troubled by Medicare's current transfer policy that defines patients in 30 DRGs who are discharged to a post acute setting, such as a skilled nursing facility or a rehabilitation facility, as a "transfer" rather than as a discharge when their acute care length of stay is at least one day less than the national average. Defining these discharges as transfers means that our hospitals are paid at less than the full DRG rate.

Given Morton Plant Mease's pledge to the communities we serve to deliver health care services in the most efficient manner possible, we believe this policy penalizes hospitals for providing the most efficient treatment in the most appropriate setting. CMS' May 4, 2005 proposed regulations would make even more discharges subject to this imperfect policy – despite the fact that the underlying statute as passed by Congress never explicitly proposed adding these new DRGs.

In conclusion, Morton Plant Mease opposes any expansion of the transfer policy. We are also hopeful that CMS will establish clear and consistent processes for the submission and validation of quality data and that hospitals will not be penalized when technical issues outside their control impede data reporting.

Thank you for your consideration of these comments.

Sincerely,

Philip K. Beauchamp
President/CEO
Morton Plant Mease Health Care

4607

Date: 06/24/2005

Submitter : Ms. Patricia Andersen

Organization : Oklahoma Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please see attached letter from the Oklahoma Hospital Association

CMS-1500-P-707-Attach-1.DOC

CMS-1500-P-707-Attach-2.DOC

TRANSFERS
MB/H
PYMT RTS/OUTLIER
WI/Bd
Geo Reclass
CAH/Reloc
SPH
MEDPAC
CBSAs
Out-M
DRG/Gen

WALZ
HART
KNIGHT
SEIFERT
TREITEL
MILLER
KENNY
JONES
COLLINS
MOREY
SMITH
ROMANO
WYNN
HEFTER
HARTSTEIN
Brooks
FAGAN
Gruber
Kelly
Hue

Attachment 1 to #707

Oklahoma Hospital Association
Comment Letter to CMS
RE: IPPS FFY 2006

June 23, 2005

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

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

Dear Dr. McClellan:

The Oklahoma Hospital Association (OHA), on behalf of our more than 130 hospitals, welcomes the opportunity to comment on the proposed rule related to the Medicare Prospective Payment System (PPS) for inpatient admissions.

POST-ACUTE CARE TRANSFERS

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

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

In the proposed rule, CMS says "[T]he purpose of the IPPS transfer payment policy is to avoid providing an incentive for a hospital to transfer patients to another hospital early in the patients' stay in order to minimize costs while still receiving the full DRG payment." The proposal results in expansion of the policy to many DRGs where there is no evidence that hospitals are changing behavior to take advantage of the payment system.

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

OHA opposes the expansion of the post-acute care transfer policy, because it is not in the best interests of patients or caregivers. Expansion of the post-acute care transfer provision undercuts the basic principles

and objectives of the Medicare PPS and undermines clinical decision-making and penalizes hospitals for providing efficient care, at the most appropriate time and in the most appropriate setting.

We urge CMS not to expand the post-acute care transfer rule to include additional DRGs.

HOSPITAL MARKET BASKET

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. These price changes must be projected forward to estimate increases for the subsequent year so that an appropriate marketbasket update can be determined in advance of payment. The payment system is prospective, and the update is not retroactively reconciled to reflect actual price increases for the year. Therefore, a reliable projection methodology is vital to ensure equitable payments.

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

We request that CMS review the methodology that was used to determine the projected FY 2005 marketbasket and make details of the calculation available to the public.

FREQUENCY OF UPDATES TO THE MARKETBASKET

CMS is proposing to rebase the hospital marketbasket every four years. Under the proposal, the marketbasket would be rebased for FFY 2006 and the next rebasing would occur in FFY 2010. The last rebasing of the marketbasket was implemented in FFY 2003. If the CMS proposal for a four-year interval were applied, the next update would be in FFY 2007. However, CMS proposes to update the marketbasket for FFY 2006. There is no compelling reason for a FFY 2006 update. There is no new Census data available and CMS cites no immediate problem that must be addressed. Instead, CMS should follow the four-year schedule and implement the next update in FFY 2007. Moreover, this fits much better with the schedule for the release of the data that is used in the calculation. CMS provided the Chart 9 in the proposed rule.

According to Chart 9 provided in the proposed rule, the next time that a full update of the required Bureau of Economic Analysis' Benchmark Input-Output (I–O) tables and Bureau of the Census' Business Expenses Survey (BES) data will be available is FFY 2011. Therefore, it makes little sense to do marketbasket updates in FFY 2006 and FFY 2010 as proposed. An update in FFY 2010 would require the use of 1997 I–O tables and 1997 BES data. At that point this data would be badly out of date and would need to be "aged" by nine years. It would also mean that there would be no update in FFY 2011, the first year that the 2002 I-O tables and BES data would be available.

Attachment 1 to #707

Oklahoma Hospital Association
Comment Letter to CMS
RE: IPPS FFY 2006

We urge CMS not to rebase the marketbasket in FFY 2006. Instead, we recommend CMS implement the proposed four year schedule for marketbasket rebasing with the next update occurring in FFY 2007 and the subsequent update in FFY 2011.

OPERATING PAYMENT RATES - OUTLIER PAYMENTS

CMS is proposing to establish a fixed-loss cost outlier threshold for FY 2006 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $26,675.

The proposal increases the threshold from $25,800 in FFY 2005 to $26,675 in FFY 2006. While this does not appear to be a significant increase in the threshold, we do not feel that ANY increase in the threshold is warranted. Inpatient rates have been calibrated using a 5.1% target for outlier payments. CMS estimates that actual FFY 2004 outlier payments were 3.5% of total payments and that projected FFY 2005 outlier payments are 4.4% of total payments. Because of the shortfalls in the prior two years compared to the 5.1% target for outlier payments, increasing the threshold will result in another year of underpayments.

We urge CMS to adopt the alternative calculation provided by the American Hospital Association (AHA) in their comment letter and set the FFY 2006 threshold at $24,050.

WAGE INDEX - CBSA

In FFY 2005, CMS implemented revised wage areas based on Core-Based Statistical Areas (CBSAs). This change had a significant redistributional impact with many areas experiencing substantial increases or decreases in their wage adjustment. As a result, CMS provided a blended wage index in FFY 2005 for hospitals that were harmed by the redefinition of wage index areas. Hospitals that would have received a higher wage index under the prior geographic area definitions were provided a blended wage index combining 50% of the wage index based on the new definitions and 50% based on the old definitions. CMS proposes to end this protection and determine 100% of the wage index based upon the new CBSA configurations beginning in FY 2006.

We encourage CMS to continue to apply a blend of 50% of the wage index based on the new definitions and 50% based on the old definitions for hospitals that were harmed by the redefinition of wage index areas in FFY 2006.

GEOGRAPHIC RECLASSIFICATIONS - RURAL URBAN COMMUTING AREAS

Urban hospitals can apply for rural designation based on specified criteria. One of the criteria allows redesignation if the hospital is located in a rural census tract that is part of an urban area. This is determined using the most recent version of the "Goldsmith Modification" as determined by the Office of Rural Health Policy. CMS proposes to revise the regulations to use an updated version of the Goldsmith

Modification called Rural-Urban Commuting Area codes (RUCAs). We urge CMS to provide grandfather protection for hospitals that were redesignated as rural based on the old Goldsmith Modification criteria and no longer qualify under the new RUCAs. Loss of rural status would be devastating for many of these hospitals, particularly for CAHs.

OUT-MIGRATION ADJUSTMENT

Hospitals cannot receive an out-migration adjustment if they have already received a reclassification. Therefore, if a hospital has an existing reclassification, that hospital must withdraw its reclassification within 45 days of the publication of the proposed rule to receive the out-migration adjustment instead. Because of significant changes to the wage index that took place in FY 2005, CMS allowed hospitals to withdraw or reinstate their geographic reclassification applications within 30 days of the publication of the FY 2005 Final Rule. By doing so, CMS acknowledged that changes made between the proposed and final rules could affect whether a hospital was better off accepting the out-migration adjustment or maintaining the geographic reclassification.

There were several revisions to the wage index data subsequent to the publication of the proposed FFY 2006 rule. In addition, CMS has proposed changes to the wage index calculation that may or may not be adopted in the final rule.

Given this uncertainty, OHA requests that CMS implement a policy similar to last year's policy and allow hospitals to withdraw or reinstate their geographic reclassification applications within 30 days of the date that the Final Rule is published.

CRITICAL ACCESS HOSPITALS - NECESSARY PROVIDER RELOCATIONS

CMS proposes to establish a methodology to be used by all CMS Regional Offices in making decisions concerning relocations of CAHs with necessary provider designation. CMS policy holds that the necessary provider designation does not automatically follow the provider if the facility relocates to a different location because it is no longer furnishing services to patients in the area that was originally determined to need a necessary provider.

The rule would allow hospitals to rebuild within 250 yards of their existing site or relocate onto a contiguous piece of property if it was purchased by December 8, 2003. For a hospital that moves any further, the hospital will have to submit an application prior to January 1, 2006; showing that at the relocated site:

- it meets the same criteria for necessary provider status that it did when it originally qualified;
- it serves the same community (75% of the same population, 75% of the same services, 75% of the same staff);
- it complies with the same conditions of participation; and
- the relocation plan was "under development" as of December 8, 2003.

This proposal would severely restrict the ability of CAHs designated as necessary providers to replace their existing facilities. The 250 yard limit is overly restrictive. **We urge CMS to consider any CAH**

that moves within five miles to be rebuilding and not relocating. These facilities have already proven they are in small, generally rural communities—using a limit of 5 miles will still prevent a facility from moving into a metro area or an area that already has adequate access to basic health services.

OHA is also concerned by the requirement that property must have been purchased and plans must have been undertaken prior to December 8, 2003. This will make it impossible for many CAHs to relocate in the future as their physical plants age or market conditions change and could eventually result in the end of health care services in communities served by the CAH. In addition, it is unfair to CAH facilities that have not made construction plans. **We urge CMS to eliminate the December 8, 2003 deadline.**

In addition, the requirement that the CAH provides 75% of the same services to 75% of the same service area with 75% of same staff could unnecessarily curtail service changes intended to benefit the community. The focus should be on ensuring that the CAH still provides services to the same community. **We urge CMS to eliminate requirements based on providing the same services with the same staff.** These requirements would hinder hospital modifications intended to adapt to changes in the needs of the community. **We urge CMS to require that the CAH demonstrate that it will provide services to the same community in the new location.** This could be demonstrated based on providing services to 75% of the same service area, but flexibility should be provided to take individual circumstances into account.

SPECIALTY HOPSITALS

CMS, in addressing issues regarding physician-owned, specialty hospitals, states that an institution must be primarily engaged in furnishing services to inpatients in order to be a Medicare-participating hospital. OHA is concerned that a broad application of the definition of a hospital as "primarily engaged in furnishing services to inpatients" could result in difficulties for other hospitals that are not physician-owned. Many non-profit full-service hospitals, especially CAHs, provide a substantial portion of their services on an outpatient b asis. T his is a result of continued c hanges in the delivery of healthcare services, much of which is encouraged by the Medicare rules and payment mechanisms.

OHA urges that CMS consider the suggestions in the AHA letter regarding this issue. CMS should not apply a definition based solely on whether a hospital is primarily engaged in providing services to inpatients. Instead, CMS should look at a hospital's operation comprehensively to ascertain whether the facility is significantly engaged in providing inpatient hospital care and avoid adopting any rigid standard for the proportion of inpatient versus outpatient care.

We urge CMS to consider whether the inpatient component of the hospital, even if small, represents a vital health care resource as in the case of a small rural hospital or a highly specialized center of excellence.

MEDPAC RECOMMENDATION – APR-DRGS

In the proposed rule, CMS responds to the Medicare Payment Advisory Commission (MedPAC) recommendations regarding physician-owned, specialty hospitals including a recommendation that the CMS improve payment accuracy in the hospital inpatient PPS by refining the current DRGs to more fully

capture differences in severity of illness among patients. One option that is discussed is the use of alternative DRG systems such as the all patient refined diagnosis related groups (APR-DRGs) in place of Medicare's current DRG system.

OHA supports the adoption of a refined DRG system such as the APR-DRGs. The APR-DRGs have a greater number of DRGs, potentially relating payment rates more closely to patient resource needs.

We urge CMS to take positive steps toward the implementation of a refined DRG system as quickly as possible.

Please contact me at ((405) 427-9537 or pandersen@okoha.com if you have any questions.

Sincerely,

Patricia Andersen

Patricia D. Andersen, CPA
VP-Finance & Strategic Information
Oklahoma Hospital Association
4000 Lincoln Blvd
Oklahoma City, OK 73105

Attachment 2 to #707

Oklahoma Hospital Association
Comment Letter to CMS
RE: IPPS FFY 2006

June 23, 2005

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

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

Dear Dr. McClellan:

The Oklahoma Hospital Association (OHA), on behalf of our more than 130 hospitals, welcomes the opportunity to comment on the proposed rule related to the Medicare Prospective Payment System (PPS) for inpatient admissions.

POST-ACUTE CARE TRANSFERS

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

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

In the proposed rule, CMS says "[T]he purpose of the IPPS transfer payment policy is to avoid providing an incentive for a hospital to transfer patients to another hospital early in the patients' stay in order to minimize costs while still receiving the full DRG payment." The proposal results in expansion of the policy to many DRGs where there is no evidence that hospitals are changing behavior to take advantage of the payment system.

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

OHA opposes the expansion of the post-acute care transfer policy, because it is not in the best interests of patients or caregivers. Expansion of the post-acute care transfer provision undercuts the basic principles

and objectives of the Medicare PPS and undermines clinical decision-making and penalizes hospitals for providing efficient care, at the most appropriate time and in the most appropriate setting.

We urge CMS not to expand the post-acute care transfer rule to include additional DRGs.

HOSPITAL MARKET BASKET

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. These price changes must be projected forward to estimate increases for the subsequent year so that an appropriate marketbasket update can be determined in advance of payment. The payment system is prospective, and the update is not retroactively reconciled to reflect actual price increases for the year. Therefore, a reliable projection methodology is vital to ensure equitable payments.

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

We request that CMS review the methodology that was used to determine the projected FY 2005 marketbasket and make details of the calculation available to the public.

FREQUENCY OF UPDATES TO THE MARKETBASKET

CMS is proposing to rebase the hospital marketbasket every four years. Under the proposal, the marketbasket would be rebased for FFY 2006 and the next rebasing would occur in FFY 2010. The last rebasing of the marketbasket was implemented in FFY 2003. If the CMS proposal for a four-year interval were applied, the next update would be in FFY 2007. However, CMS proposes to update the marketbasket for FFY 2006. There is no compelling reason for a FFY 2006 update. There is no new Census data available and CMS cites no immediate problem that must be addressed. Instead, CMS should follow the four-year schedule and implement the next update in FFY 2007. Moreover, this fits much better with the schedule for the release of the data that is used in the calculation. CMS provided the Chart 9 in the proposed rule.

According to Chart 9 provided in the proposed rule, the next time that a full update of the required Bureau of Economic Analysis' Benchmark Input-Output (I–O) tables and Bureau of the Census' Business Expenses Survey (BES) data will be available is FFY 2011. Therefore, it makes little sense to do marketbasket updates in FFY 2006 and FFY 2010 as proposed. An update in FFY 2010 would require the use of 1997 I–O tables and 1997 BES data. At that point this data would be badly out of date and would need to be "aged" by nine years. It would also mean that there would be no update in FFY 2011, the first year that the 2002 I-O tables and BES data would be available.

Attachment 2 to #707

Oklahoma Hospital Association
Comment Letter to CMS
RE: IPPS FFY 2006

We urge CMS not to rebase the marketbasket in FFY 2006. Instead, we recommend CMS implement the proposed four year schedule for marketbasket rebasing with the next update occurring in FFY 2007 and the subsequent update in FFY 2011.

OPERATING PAYMENT RATES - OUTLIER PAYMENTS

CMS is proposing to establish a fixed-loss cost outlier threshold for FY 2006 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $26,675.

The proposal increases the threshold from $25,800 in FFY 2005 to $26,675 in FFY 2006. While this does not appear to be a significant increase in the threshold, we do not feel that ANY increase in the threshold is warranted. Inpatient rates have been calibrated using a 5.1% target for outlier payments. CMS estimates that actual FFY 2004 outlier payments were 3.5% of total payments and that projected FFY 2005 outlier payments are 4.4% of total payments. Because of the shortfalls in the prior two years compared to the 5.1% target for outlier payments, increasing the threshold will result in another year of underpayments.

We urge CMS to adopt the alternative calculation provided by the American Hospital Association (AHA) in their comment letter and set the FFY 2006 threshold at $24,050.

WAGE INDEX - CBSA

In FFY 2005, CMS implemented revised wage areas based on Core-Based Statistical Areas (CBSAs). This change had a significant redistributional impact with many areas experiencing substantial increases or decreases in their wage adjustment. As a result, CMS provided a blended wage index in FFY 2005 for hospitals that were harmed by the redefinition of wage index areas. Hospitals that would have received a higher wage index under the prior geographic area definitions were provided a blended wage index combining 50% of the wage index based on the new definitions and 50% based on the old definitions. CMS proposes to end this protection and determine 100% of the wage index based upon the new CBSA configurations beginning in FY 2006.

We encourage CMS to continue to apply a blend of 50% of the wage index based on the new definitions and 50% based on the old definitions for hospitals that were harmed by the redefinition of wage index areas in FFY 2006.

GEOGRAPHIC RECLASSIFICATIONS - RURAL URBAN COMMUTING AREAS

Urban hospitals can apply for rural designation based on specified criteria. One of the criteria allows redesignation if the hospital is located in a rural census tract that is part of an urban area. This is determined using the most recent version of the "Goldsmith Modification" as determined by the Office of Rural Health Policy. CMS proposes to revise the regulations to use an updated version of the Goldsmith

Modification called Rural-Urban Commuting Area codes (RUCAs). We urge CMS to provide grandfather protection for hospitals that were redesignated as rural based on the old Goldsmith Modification criteria and no longer qualify under the new RUCAs. Loss of rural status would be devastating for many of these hospitals, particularly for CAHs.

OUT-MIGRATION ADJUSTMENT

Hospitals cannot receive an out-migration adjustment if they have already received a reclassification. Therefore, if a hospital has an existing reclassification, that hospital must withdraw its reclassification within 45 days of the publication of the proposed rule to receive the out-migration adjustment instead. Because of significant changes to the wage index that took place in FY 2005, CMS allowed hospitals to withdraw or reinstate their geographic reclassification applications within 30 days of the publication of the FY 2005 Final Rule. By doing so, CMS acknowledged that changes made between the proposed and final rules could affect whether a hospital was better off accepting the out-migration adjustment or maintaining the geographic reclassification.

There were several revisions to the wage index data subsequent to the publication of the proposed FFY 2006 rule. In addition, CMS has proposed changes to the wage index calculation that may or may not be adopted in the final rule.

Given this uncertainty, OHA requests that CMS implement a policy similar to last year's policy and allow hospitals to withdraw or reinstate their geographic reclassification applications within 30 days of the date that the Final Rule is published.

CRITICAL ACCESS HOSPITALS - NECESSARY PROVIDER RELOCATIONS

CMS proposes to establish a methodology to be used by all CMS Regional Offices in making decisions concerning relocations of CAHs with necessary provider designation. CMS policy holds that the necessary provider designation does not automatically follow the provider if the facility relocates to a different location because it is no longer furnishing services to patients in the area that was originally determined to need a necessary provider.

The rule would allow hospitals to rebuild within 250 yards of their existing site or relocate onto a contiguous piece of property if it was purchased by December 8, 2003. For a hospital that moves any further, the hospital will have to submit an application prior to January 1, 2006; showing that at the relocated site:

- it meets the same criteria for necessary provider status that it did when it originally qualified;
- it serves the same community (75% of the same population, 75% of the same services, 75% of the same staff);
- it complies with the same conditions of participation; and
- the relocation plan was "under development" as of December 8, 2003.

This proposal would severely restrict the ability of CAHs designated as necessary providers to replace their existing facilities. The 250 yard limit is overly restrictive. **We urge CMS to consider any CAH**

that moves within five miles to be rebuilding and not relocating. These facilities have already proven they are in small, generally rural communities—using a limit of 5 miles will still prevent a facility from moving into a metro area or an area that already has adequate access to basic health services.

OHA is also concerned by the requirement that property must have been purchased and plans must have been undertaken prior to December 8, 2003. This will make it impossible for many CAHs to relocate in the future as their physical plants age or market conditions change and could eventually result in the end of health care services in communities served by the CAH. In addition, it is unfair to CAH facilities that have not made construction plans. **We urge CMS to eliminate the December 8, 2003 deadline.**

In addition, the requirement that the CAH provides 75% of the same services to 75% of the same service area with 75% of same staff could unnecessarily curtail service changes intended to benefit the community. The focus should be on ensuring that the CAH still provides services to the same community. **We urge CMS to eliminate requirements based on providing the same services with the same staff.** These requirements would hinder hospital modifications intended to adapt to changes in the needs of the community. **We urge CMS to require that the CAH demonstrate that it will provide services to the same community in the new location.** This could be demonstrated based on providing services to 75% of the same service area, but flexibility should be provided to take individual circumstances into account.

SPECIALTY HOPSITALS

CMS, in addressing issues regarding physician-owned, specialty hospitals, states that an institution must be primarily engaged in furnishing services to inpatients in order to be a Medicare-participating hospital. OHA is concerned that a broad application of the definition of a hospital as "primarily engaged in furnishing services to inpatients" could result in difficulties for other hospitals that are not physician-owned. Many non-profit full-service hospitals, especially CAHs, provide a substantial portion of their services on an outpatient b asis. T his is a result of continued c hanges in the delivery of healthcare services, much of which is encouraged by the Medicare rules and payment mechanisms.

OHA urges that CMS consider the suggestions in the AHA letter regarding this issue. CMS should not apply a definition based solely on whether a hospital is primarily engaged in providing services to inpatients. Instead, CMS should look at a hospital's operation comprehensively to ascertain whether the facility is significantly engaged in providing inpatient hospital care and avoid adopting any rigid standard for the proportion of inpatient versus outpatient care.

We urge CMS to consider whether the inpatient component of the hospital, even if small, represents a vital health care resource as in the case of a small rural hospital or a highly specialized center of excellence.

MEDPAC RECOMMENDATION – APR-DRGS

In the proposed rule, CMS responds to the Medicare Payment Advisory Commission (MedPAC) recommendations regarding physician-owned, specialty hospitals including a recommendation that the CMS improve payment accuracy in the hospital inpatient PPS by refining the current DRGs to more fully

capture differences in severity of illness among patients. One option that is discussed is the use of alternative DRG systems such as the all patient refined diagnosis related groups (APR-DRGs) in place of Medicare's current DRG system.

OHA supports the adoption of a refined DRG system such as the APR-DRGs. The APR-DRGs have a greater number of DRGs, potentially relating payment rates more closely to patient resource needs.

We urge CMS to take positive steps toward the implementation of a refined DRG system as quickly as possible.

Please contact me at ((405) 427-9537 or pandersen@okoha.com if you have any questions.

Sincerely,

Patricia Andersen

Patricia D. Andersen, CPA
VP-Finance & Strategic Information
Oklahoma Hospital Association
4000 Lincoln Blvd
Oklahoma City, OK 73105

468

TREITEL
WALZ
HEFTER
HARTSTEIN

Submitter : **Dr. Peter Bonutti**

Date: **06/24/2005**

Organization : **Bonutti Clinic**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

NT

CMS-1500-P-700-Attach-1.DOC

Attachment to #700

June 22, 2005

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

RE: CMS-1500-P
Trident™ New Technology Add-On Application and CMS Response

Dear Dr. McClellan:

I am writing in response to the CMS proposed ruling for an-add-on payment for Ceramic-on-Ceramic total hip arthroplasty. Ceramic bearing surfaces off the opportunity to potentially eliminate the knee for future revision total hip replacements due to wear and debris. This is a substantial and significant improvement over other products on the market today.

In the proposed ruling I read there will be additional ICD-9 codes to support two new DRG's, so revision total hip and total knee arthroplasty can be segmented from primary arthroplasty. I support these in hopes that revisions will see better reimbursement as supported by the data used which clearly demonstrates additional time and costs associated with revision hip and knee procedures.

The primary goal for utilizing Ceramic-on-Ceramic bearing surfaces in a younger patient population (including the young and active Medicare beneficiary) is to significantly reduce revision procedures in the future which are often necessitated by polyethylene wear. The additional costs that result from these revision procedures, which CMS has correctly identified, would see a significant decline if patients had access to Ceramic-on-Ceramic technology.

CMS refers to "Other technologies on the market" - Crosslinked Polyethylene and Metal on Metal Bearing Surface - suggesting that the Ceramic-on-Ceramic technology is only an incremental advance. However, I do not believe that these other technologies merit the safety, efficacy as well as the longevity compared to Ceramic-on-Ceramic technologies.

Attachment to #700

The two technologies which suggest an incremental advance: 1) Crosslinked Polyethylene; 2) Metal-on-Metal Bearing Surface clearly are not the answer. Certain Crosslinked polyethylene has been identified with catastrophic complications. (Longevity, Durasol) When Crosslinked polyethylene is remelted there is a significant reduction in mechanical properties - fracture toughness. The United States FDA Maude Database already identified 13 catastrophic fractures with Longevity Polyethylene. Durasol has had hundreds of adverse effects.

The Metal-on-Metal articulation have another unique set of problems due to metal wear debris. In peer review studies; Willert January 2005, JBJS, Granchi July 2003, JBJS Br., have clearly identified a significant dissemination of Metal-on-Metal ions throughout the body with associated effect on T-lymphocytes (statistically significant) which effects the entire body's immunologic response.

One should use significant care to balance the use of technologies that show promise compared to those who have strong peer reviewed published data, such as the Ceramic on Ceramic hip arthroplasty. One should also take care to review the trial designs of clinical studies to identify what endpoints are analyzed, clinical data available today would not allow one to consider comparing other bearing technologies with their risk of catastrophic complications to this Ceramic-on-Ceramic articulation for total hip arthroplasty. For patients that are young and active today, I feel they deserve products that have been proven, are efficacious, and most important, safe.

Sincerely,

Peter M. Bonutti, MD

PB/nb

1. Granchi D. et al. Immunological Changes in Patients with Primary Osteoarthritis of the Hip after Total Joint Replacement. JBJS Br., July 2003.
2. Willert H et al, Metal-on-Metal Bearings and Hypersensitivity in Patients with Artificial Hip Joints. JBJS, January 2005.
3. US FDA Maude Database. Trilogy Acetabular System Longevity Crosslinked Polyethylene Hip Prosthesis.

CMS-1500-P-702

469

KNIGHT
SEIFERT
TREITEL
WALZ
HART
HEFTER
HARTSTEIN
Brooks
FAGAN
Gruber
Kelly
Hue

Submitter : Mr. Rick Fries **Date:** 06/24/2005

Organization : West Penn Allegheny Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1500-P-702-Attach-1.DOC

MB/H
PYMT RTS/OUTLIER
TRANSFERS
DRG/GEN

Attachment to #702

June 16, 2005

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

Ref: [CMS-1500-P] Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates.

Dear Administrator McClellan:

The West Penn Allegheny Health System (WPAHS) 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) 2006. We ask for your consideration of our concerns as it relates to certain policy and payment changes included in the proposed rule. CMS' willingness in soliciting comments on the numerous changes it proposes to this remarkably complex and difficult payment system is deeply appreciated.

Attached are our detailed comments regarding CMS's proposed changes to the inpatient payment system, most notably the post acute transfer DRG revisions. Expanding the definitions of the covered DRGs under this proposed rule is projected to have a negative impact on funding of $4.1 M for WPAHS member hospitals. This financial impact of this policy change on such a relatively short notice is significant to the operations of our hospitals as it adversely impacts our ability to adequately fund the necessary operations and infrastructure needed to provide continuous quality of care.

We appreciate the opportunity to provide comments on the Proposed Rule on Changes to the Medicare Inpatient Prospective Payment System and Payment Rates for Fiscal Year 2006. We hope that CMS will consider our recommendations and make the appropriate adjustments. Please feel free to contact me at (412) 330-6027 if you have any questions or if you require additional information.

Sincerely,

Rick Fries
Director of Decision Support

Cc: Denis Lukes-Vice President of WPAHS Finance
Peg Mccormick Barron—Vice President, Legislative Affairs.

West Penn Allegheny Health System
Comments on FY 2006 Medicare Hospital Outpatient PPS
October 1, 2006

Hospital Market Basket

WPAHS in conjunction with Hospital Association of Pennsylvania (HAP) questions the accuracy of the FFY 2006 market basket projection. The projected market basket increase provides an estimate of cost increases; however, these increases are not reconciled to the actual increases for the proxies that are used. Some years the results of the projection were higher than the actual; while in other years it is lower. Over the life of the PPS, the differences have balanced out and the cumulative error has been small. However, in recent years the projection has been lower than the actual increase on a consistent basis. The actual increase in FFY 2004 was 3.8 percent compared to a market basket increase of 3.4 percent. In the FFY 2006 proposed rule, CMS reports that the FFY 2005 market basket increase is now estimated to be 4.1 percent compared to the estimated 3.3 percent increase that was projected for use in the update factor. As a result of this, WPAHS and HAP are very concerned that the methods being used by CMS to project the market basket are flawed and do not provide reliable results. Given a 4.1 percent cost increase for FFY 2005, the projected increase of 3.2 percent for FFY 2006 does not seem consistent with evidence that inflation is increasing in the general economy.

Operating Payment Rates

The proposed fixed-loss cost outlier threshold for FY 2006 represents an increase of 3.4 percent from FFY 2005 ($25,800 to $26,675). While this threshold is not a substantial increase, WPAHS and HAP are concerned that the threshold is too high. The increase cited will make it more difficult for hospitals to qualify for outlier payments and will put them at risk for treating those Medicare patients with unusually high costs. Given the shortfall in FFY 2004 and FFY 2005 compared to the 5.1 percent target for outlier payments, WPAHS and HAP are concerned that the proposed 3.4 percent threshold increase will result in another year of underpayments.

Post-acute Care Transfers

WPAHS **strongly** opposes the expansion of the post-acute transfer policy. In this proposed rule, CMS makes substantial revisions to the DRG selection criteria with little evidence or justification. Such an extensive expansion of the post-acute transfer policy acts as an across-the-board reduction in Medicare payments and is not in the best interest of patients. This policy undermines clinical decision-making and penalizes hospitals for providing efficient and effective care in the setting that is most appropriate for the patient. Hospitals should not be financially penalized for making sound clinical judgments regarding the locale to best meet a patient's clinical needs. CMS should not be cutting payments with

shorter stays without increasing payments to longer stays. Has CMS considered those patients that do not have access to post-acute care? How will this impact other venues, such as home health, and will this really save money? The proposed expansion to 231 DRGs will reduce Medicare reimbursement to hospitals in Pennsylvania by a very significant amount: between $50 and $60 million or approximately 1.1 percent of total inpatient Medicare revenues. WPAHS member hospitals will experience a reduction in reimbursement of $4.1 million as a result of this change in policy. Expansion of the transfer policy undercuts the basic principles and objectives of the Medicare prospective payment system, is based on assumption of "gaming" that is not validated by the data, and unnecessarily adds complexity and opportunity for error to an already complex system. Furthermore, reducing reimbursement of this magnitude with a relatively short notice will have a significant impact on the ongoing operations of a large portion of Acute Hospitals within the United States.

Furthermore, in 2003, after "an extensive analysis to identify the best method by which to expand the transfer policy," the agency adopted four specific criteria that a DRG must meet, for both of the two most recent years for which data are available, in order to be added to the post-acute care transfer policy:

1. The DRG must have at least 14,000 cases of post-acute care transfers;
2. The DRG must have at least 10 percent of its post-acute care transfers occurring before the mean length of stay for the DRG;
3. The DRG must have a length of stay of at least three days; and
4. The DRG must have at least a 7 percent decrease in length of stay over the past five years (1999 – 2004).

This resulted in expanding the provision from 10 DRGs in FY 2003 to 29 DRGs in FY 2004. Now, only two years later, the agency is proposing to adopt replacement set of alternative criteria that would be applied to the DRGs. The new criteria state that the DRG only needs to have 2,000 cases of post-acute care transfers, and the percentage of transfer cases that are short-stay transfer cases is at least 20 percent of the discharged cases. Of this 20 percent at least 10 percent of the cases are discharged before the mean geometric length of stay. That means a DRG could qualify to be a transfer DRG with only 200 cases that are discharged before the mean geometric length of stay vs. a minimum of 1,400 cases under the current criteria to qualify as a transfer DRG.

WPAHS objects to the implementation of alternative criteria for which there is no sound policy rationale. We fail to see how 2,000 post acute discharges can be considered "relatively high volume" in contrast to the current methodology that uses 14,000 total post acute care transfer cases as the benchmark.

Further, we believe this expansion of the transfer policy weakens the incentives inherent in the inpatient prospective payment system. A new transfer policy covering 223 DRGs would effectively undermine and incentive based system fueled by per-case cost control, to one focused on per-diem costs.

We do not believe that the expansion would be in the best interests of the patients or providers. We ask that the provision be withdrawn in its final rule.

Pursuant to a review of specific DRGs within the proposed lists of transfer DRGs, we offer the following comments:

DRG 107 Coronary Bypass with Cardiac Cath*
We have strong concerns that DRG 107 is not included as a proposed Special Pay DRG under the transfer DRG proposed methodology.

We do not understand the logic behind DRG 109 (Bypass without Cardiac Cath) being included in the Special Pay DRG listing and DRG 107 (a higher intensity service) not being included in the listing.

DRG 108 Other Cardiothoracic Procedures*
We do not understand how this DRG could be included as a proposed Transfer DRG.

Table 7A of the proposed rule states that the DRG had 8,878 discharges.

In order to meet the criteria to be on the list, the DRG needs to have at least 10,000 discharges (2,000 minimum transfer and 20% of the total = 10,000 minimum necessary). We request that this DRG be removed form the transfer DRG list.

DRG 126 Acute & Subacute Endocarditis*
We do not understand how this DRG could be included as a proposed Transfer DRG.

Table 7A of the proposed rule states that the DRG had 5,823 discharges.

In order to meet the criteria to be on the list, the DRG needs to have at least 10,000 discharges (2,000 minimum transfer and 20% of the total = 10,000 minimum necessary). The DRG does not have a pair based on co-morbidity. We request that this DRG be removed form the transfer DRG list.

DRG 440 Wound Debridement for Injuries*
We do not understand how this DRG could be included as a proposed Transfer DRG.

Table 7A of the proposed rule states that the DRG had 5,613 discharges.

In order to meet the criteria to be on the list, the DRG needs to have at least 10,000 discharges (2,000 minimum transfer and 20% of the total = 10,000 minimum necessary). The DRG does not have a pair based on co-morbidity. We request that this DRG be removed form the transfer DRG list.

DRG 473 Acute Leukemia w/o Major OR Procedure*
We do not understand how this DRG could be included as a proposed Transfer DRG.

Table 7A of the proposed rule states that the DRG had 8,778 discharges.

In order to meet the criteria to be on the list, the DRG needs to have at least 10,000 discharges (2,000 minimum transfer and 20% of the total = 10,000 minimum necessary). The DRG does not have a pair based on co-morbidity. We request that this DRG be removed form the transfer DRG list.

DRG 485 Limb Reattachment, Multiple Significant Trauma*
We do not understand how this DRG could be included as a proposed Transfer DRG.

Table 7A of the proposed rule states that the DRG had 3,420 discharges.

In order to meet the criteria to be on the list, the DRG needs to have at least 10,000 discharges (2,000 minimum transfer and 20% of the total = 10,000 minimum necessary). The DRG does not have a pair based on co-morbidity. We request that this DRG be removed form the transfer DRG list.

DRG 487 Other Multiple Significant Trauma*
We do not understand how this DRG could be included as a proposed Transfer DRG.

Table 7A of the proposed rule states that the DRG had 4,644 discharges.

In order to meet the criteria to be on the list, the DRG needs to have at least 10,000 discharges (2,000 minimum transfer and 20% of the total = 10,000 minimum necessary). The DRG does not have a pair based on co-morbidity. We request that this DRG be removed form the transfer DRG list.

DRG 285 Amputation of Lower Limb*
We do not understand how this DRG could be included as a proposed Transfer DRG.

Table 7A of the proposed rule states that the DRG had 7,623 discharges.

In order to meet the criteria to be on the list, the DRG needs to have at least 10,000 discharges (2,000 minimum transfer and 20% of the total = 10,000 minimum necessary). The DRG does not have a pair based on co-morbidity. We request that this DRG be removed form the transfer DRG list.

DRG 287 Skin Grafts & Wound Debridement *
We do not understand how this DRG could be included as a proposed Transfer DRG.

Table 7A of the proposed rule states that the DRG had 6,114 discharges.

In order to meet the criteria to be on the list, the DRG needs to have at least 10,000 discharges (2,000 minimum transfer and 20% of the total = 10,000 minimum necessary). The DRG does not have a pair based on co-morbidity. We request that this DRG be removed form the transfer DRG list.

DRG 20 Nervous System Infection *
We do not understand how this DRG could be included as a proposed Transfer DRG.

Table 7A of the proposed rule states that the DRG had 6,532 discharges.

In order to meet the criteria to be on the list, the DRG needs to have at least 10,000 discharges (2,000 minimum transfer and 20% of the total = 10,000 minimum necessary). The DRG does not have a pair based on co-morbidity. We request that this DRG be removed form the transfer DRG list.

If CMS chooses to impose the expanded transfer policy, we would ask that each DRG be reviewed again to ensure that it meets the criteria to be included as a transfer DRG.

*Comments are provided through a joint collaboration effort between West Penn Allegheny Health System (WPAHS) located in Pittsburgh, Pennsylvania and Owensboro Medical Health Center in Owensboro Kentucky (OMHS).

470

Submitter : Marilyn Litka-Klein

Date: 06/24/2005

Organization : Michigan Health & Hospital Association

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attached comment letter.

CMS-1500-P-698-Attach-1.DOC

TRANSFERS
Q DATA
IME
LABOR S/N
MB/H
PYMT RTS/OUTLIER
NT
WI/OM
DSH
CAH/RELOC

WALZ
HART
BODDEN
HAMMEL
TRUONG
KEFKOWITZ
RUIZ
HEFTER
HARTSTEIN
KNIGHT
KRAEMER
TREITEL
SEIFERT
MILLER
SMITH
COLLINS
MOREY

ATTACHMENT TO #698

MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Linking patients, communities, and providers together for better health.

June 21, 2005

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

Re: CMS-1500-P — Medicare Program; Changes to the Inpatient Prospective Payment System and FY 2006 Rates; Proposed Rule, May 4, 2005 *Federal Register*

Dear Dr. McClellan:

On behalf of its 145 member hospitals, the Michigan Health & Hospital Association welcomes this opportunity to comment to the Centers for Medicare & Medicaid Services regarding the proposed rule for the FY 2006 Inpatient Prospective Payment System published in the May 4, 2005 *Federal Register*. While the rule provides a 3.2 percent market basket increase for hospitals that participate in the CMS quality initiative project, we are very concerned about other policy changes that will result in significant payment decreases for hospitals that will offset this increase.

The adequacy of Medicare payments to cover the cost of services provided is crucial for ensuring the future viability of Michigan's nonprofit hospitals. Based on the latest data available, **57 percent** of Michigan hospitals experienced an overall negative margin on Medicare services. This represents a 15 percent increase in the number of hospitals that lose money providing services to Medicare beneficiaries when compared to two years earlier. This is very concerning particularly since Michigan's population is aging and the number of Medicare beneficiaries is projected to increase significantly over the next decade. By 2020, the number of Michigan residents who are 65 and older is expected to comprise 16.6 percent of the state's population. We remain gravely concerned about the consequences of the additional negative financial impact of the proposed changes, especially expansion of the post acute transfer policy to 40 percent of the Diagnosis Related Groups (DRGs). Overall, based on the latest data, Michigan hospitals experienced a negative 3.3 percent patient margin with **67 percent** losing money on patient care services. The proposed changes will further threaten the future viability of hospitals and access to healthcare services for Medicare beneficiaries and other residents of the state of Michigan. **We strongly urge the CMS to incorporate revisions to prevent a further decline in Medicare payment levels.**

POST-ACUTE CARE TRANSFERS

(*Federal Register* page 23411)

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

Background: When a patient is transferred from one acute care facility to another acute care facility, the transferring hospital receives a per diem payment with total payment limited to the full DRG amount that would have been made if the patient were discharged without being transferred. Beginning in FY 1999, the transfer policy was expanded to cover selected patients discharged to a post-acute care setting. Initially, this policy applied to cases assigned to one of ten DRGs that had high volumes of cases discharged to post-acute care. The law provided the CMS authority to expand the number of DRGs for FY 2001 and subsequent years resulting in the CMS establishing criteria for determining the DRGs that should be included and extended in the policy, with the policy being applied to 29 DRGs in FY 2004. In FY 2005, CMS found that no additional DRGs met the criteria. However, CMS revised the list of DRGs to adjust for one post-acute transfer DRG current that was split into two new DRGs, resulting in 30 DRGs being subject to the policy.

In a disappointing move, the CMS proposes to expand the post-acute care transfer policy from the current 29 DRGs to 223 DRGs in FY 2006, with a revision recently that included eight additional DRGs, resulting in a total of 231. This expansion undermines the basic concept of averages used in the development of the DRG system whereby some patients have a shorter length of stay, generally resulting in the hospital being paid more than cost, while others stay longer, resulting in the hospital being paid less than cost. Expansion of this policy makes it impossible for hospitals to break even on patients that receive post-acute care upon discharge, meaning that hospitals incur a loss if a patient is discharge prior to the mean length of stay, and also if patients are discharged after the mean length of stay. In addition, research indicates that although the length of stay may be shorter for post-acute transfer cases, the level of services provided during the stay is more intense and costly.

In the proposed rule, the CMS makes substantial revisions to the DRG selection criteria based on the usage of post-acute services. While this category of services has increased over the past five years, the care provided to Medicare beneficiaries allows them to more quickly return to an independent and functioning life. Absent this care, Medicare expenditures would be greater for home health agency and other services. This policy undermines clinical decision-making and penalizes hospitals for providing efficient care at the most appropriate time and in the most appropriate setting. For all practical purposes, such an extensive expansion of the post-acute transfer policy acts as an across-the-board reduction in Medicare payments and will not result in more equitable payments. As a result, hospitals would be penalized for providing efficient care in the setting that is most appropriate for the patient. It is projected that the proposed expansion of the postacute transfer policy to the 231 DRGs will reduce Medicare payments to Michigan hospitals by approximately $40 million, or approximately one percent, during FY 2006. **The MHA strongly opposes the expansion of the post-acute transfer policy, which penalizes hospitals for efficient treatment and for ensuring that patients receive the right care at the right time in the most appropriate setting, and is not in the best interest of patients or caregivers.**

HOSPITAL QUALITY DATA

(*Federal Register* page 23424)

Background: Based on the Medicare Modernization Act of 2003 (MMA), hospital that submit data to the CMS on ten specific measures of heart attack, heart failure, and pneumonia care will receive a full marketbasket update in fiscal years 2005 through 2007, equating to a 3.2 percent increase in FY 2006 for hospitals that submit data and a 2.8 percent update for those that do not, since the MMA provided an increase of marketbasket minus .4 percent for hospitals that fail to submit the necessary data or withdraw from the program. The MMA restricts the application of this provision to hospitals paid under the Inpatient PPS, resulting in being non-applicable for hospitals and hospital units excluded from the Inpatient PPS. It also does not apply to payments to hospitals under other payments systems such as the Outpatient PPS.

CMS Proposal: During the first year, FY 2005, there were no chart-audit validation criteria in place. However, for FY 2006, the CMS is proposing to place the following additional requirements on hospitals for the data in order to receive the full payment.

- In order to receive the full market basket update in FY 2006, the hospital must have passed the CMS validation requirement of a minimum of 80 percent reliability, based upon the chart-audit validation process, for the third quarter data of calendar year 2004.
- The hospital must have two consecutive quarters of publishable data. The information collected by the CMS through this rule will be displayed for public viewing on the Internet. Prior to this display, hospitals are permitted to preview their information as the recorded by the CMS. Based upon past experience, a number of hospitals requested that this information not be displayed due to errors in the submitted data that were not of the sort that could be detected by the normal edit and consistency checks. While the CMS acquiesced to these requests in the public interest and due to the agency's desire to present correct data. However, the CMS continues to believe that the hospital bears the responsibility of submitting correct data that can serve as valid and reliable information.

The rule requires that the accuracy of hospital submitted data be validated through chart re-abstraction. A sample of five charts will be re-abstracted by the Clinical Data Abstraction Center (CDAC) and compared to the hospital's submission. The CMS will require an 80 percent agreement rate between the original submission and the re-abstraction. If a hospital disagrees with the abstraction results from the CDAC, the hospital can appeal the results to their Quality Improvement Organizations (QIO).

While we recognize that audits and data validation are necessary to ensure that the data reported on the internet is reliable, we strongly oppose any attempt by the CMS to link this

receiving the full Medicare market basket update. The validation process is sufficiently flawed that when it identifies a problem, one can only conclude that there is a difference between the information submitted by the hospital and the data abstracted by the contractor. Currently, there are numerous logistical, technical and processing issues within the validation process. **Hospitals should not suffer a payment reduction due to technical problems with the data submission and validation process. The current CMS validation process is unreliable and needs improvement before it is used in determining which hospitals receive full payment updates.**

INDIRECT MEDICAL EDUCATION ADJUSTMENT

The indirect medical education (IME) adjustment factor is calculated using a hospital's ratio of residents to beds and a formula multiplier, which is represented as "c" in the equation: c x [((1 + ratio of residents to beds) raised to the power of 0.405) - 1]. The formula is traditionally described in terms of a certain percentage increase in payment for every 10 percent increase in the resident-to-bed ratio. Before enactment of the Medicare Modernization Act of 2003, the formula multiplier was set at 1.35 for discharges occurring during FY 2003 and thereafter, which equates to a 5.5 percent payment adjustment. The MMA modified the formula as follows:

- For discharges occurring during FY 2005, the formula multiplier is 1.42 (equivalent to a 5.8 percent adjustment).
- For discharges occurring during FY 2006, the formula multiplier is 1.37 (equivalent to a 5.55 percent adjustment).

The MHA is opposed to the reduction in the FY 2006 IME formula, which will result in a projected $13.4 million decrease in payments, and urges the CMS to maintain the formula at its current percentage. Inadequate payments to teaching hospitals will jeopardize the ability of hospitals to adequately train residents of internal medicine, who are the physicians of the future. In addition, during their training, hospital interns and residents are a vital resource for many hospitals since they serve as inexpensive and skilled members of the health care workforce.

LABOR-RELATED SHARE

(*Federal Register* page 23391)

Background: The wage index adjustment is only applied to a portion of the PPS standard rate. This labor-related share is based on an estimate of the national average proportion of hospital operating costs that vary with the local labor market determined using data from the hospital marketbasket calculation. The FY 2005 labor-related share is 71.066 percent. Based on a MMA requirement, effective beginning in FY 2005, the CMS reduced the labor share to 62 percent for hospitals located in areas with an area wage index equal to or less than 1.0. For FY 2003, the CMS rebased the market basket using 1997 data; however, they continued to calculate the labor-related share on based upon the 1992 data since use of the 1997 data would have increased the labor-related share to 72.5 percent from the 71.1 percent, based upon the 1992 data. At that time, the CMS cited the need to conduct additional analyses in deciding to maintain the labor-related share at the 1992-based 71.1 percent. Shortly thereafter, a provision of the MMA reduced the labor-related share to 62 percent for hospitals with a wage index below 1.0.

CMS Proposal: ... *In FY 2006, the CMS is proposing to continue to calculate the labor-related share by adding the relative weights of the operating cost categories that are related to, influenced by, or vary with the local labor markets. These categories include wages and salaries, fringe benefits, professional fees, contract labor and labor-intensive services. Since the CMS no longer believe that postage costs meet the definition of labor-related, those costs are being excluded from the labor-related share. Based upon this methodology, the CMS calculated a labor-related share of 69.731 for FY 2006.*

The proposed elimination of postal services decreases the labor share by 0.272 percent; the most significant factor in the change is a 3.049 percent decrease in the weight for "other labor-intensive services" from 7.277 to 4.228. This category includes costs for landscaping services, services to buildings, detective and protective services, repair services, laundry services, advertising, auto parking and repairs, physical fitness facilities, and other government enterprises.

The MHA opposes the proposed decrease in the labor-related share of the PPS rate. In the inpatient PPS rule for FY 2003, CMS examined the methodology used to determine the labor-related share. The CMS calculation of the labor-related share for FY 2003 resulted in an increase from 71.06 percent to 72.495 percent. However, the CMS did not implement the increase pending further research to determine whether a different methodology should be adopted for determining the labor-related share. In the FY 2006 proposed rule, the CMS discusses continuing research on alternative methodologies for calculating the labor-related share. However, they state that the analysis has not yet produced sound enough evidence to propose a change and that they will continue to study the issue. It is clearly inequitable to decline to implement a labor-share increase pending an analysis of the methodology and then propose a labor-share decrease while that analysis is still not completed. Projections indicate that this change would decrease payment to Michigan hospitals by $3.3 million in FY 2006.

We are concerned about the CMS revising the calculation of the labor-related share, particularly since the CMS was unable to discover an alternative methodology that is accurate, reliable and relatively easy to apply after citing the need for additional analysis after review of the 1997 data. As a result, the MHA recommends that the CMS maintain the labor-related share of the PPS rate at the current 71.066 percent for hospitals with a wage index of 1.0 or greater and 62 percent for hospitals with an area wage index equal to or less than 1.0, until further research is completed.

FREQUENCY OF UPDATES TO THE MARKETBASKET

(Federal Register page 23401)

Background: The MMA requires that the CMS provide an explanation of the reasons for the current marketbasket revision intervals, and provide options for more frequent hospital marketbasket updates. The CMS states that the decision to rebase and revise the index is largely data driven. The calculation depends upon Medicare cost report data that is available on an annual basis and on Bureau of the Census data that are typically available only every five years.

As a result, historically, the CMS has rebased the marketbasket at approximately five-year intervals.

CMS Proposal: First, the CMS reviewed the frequency and availability of the data needed to produce the market basket. Secondly they analyzed the impact on the market basket of determining the market basket weights under various frequencies and used results from these areas of research to assist in determining a new rebasing frequency. Based upon this analysis, the CMS is proposing to rebase the hospital market basket every 4 years, meaning that the next rebasing would occur for the FY 2010 update.

The last update to the marketbasket was implemented in FY 2003. Under the CMS proposal for a four-year interval, the next update would be in FFY 2007. However, as described above, the CMS proposes to update the marketbasket for FY 2006. It is the MHA's position that there is no compelling reason to update the marketbasket for the FY 2006 update since there is no new Census data available and the CMS cites no immediate problem that must be addressed. Instead, we believe that the CMS should adopt the four-year interval and implement the next update in FY 2007. Moreover, this corresponds more closely with the schedule for Census data releases. According to the CMS, the next time that a full update of the required Census data will be available is FY 2011. Therefore, it makes little sense to do marketbasket updates in FY 2006 and FY 2010 as proposed.

COST OUTLIER PAYMENT THRESHOLDS

(*Federal Register* page 23469)

Background: The CMS provides payments for outlier cases involving extraordinarily high costs when compared to average cases in the same DRG. To qualify as a cost outlier, a hospital's cost for the case must exceed the payment rate for the DRG plus a specified amount known as the fixed loss threshold. The outlier payment is equal to 80 percent of the difference between the hospital's cost for the stay and the threshold amount. The threshold is adjusted annually based upon the CMS' projections of total outlier payments to make outlier reimbursement equate to 5.1 percent of inpatient payments.

CMS Proposal: The CMS is proposing to establish a fixed-loss cost outlier threshold for FY 2006 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $26,675, which represents a 3.4 percent increase from the current $25,800 threshold. In addition, the rule proposes to use a one-year average annual rate-of-change in charges per case from the last quarter of 2003 in combination with the first quarter of 2004 to the last quarter of 2004 in combination with the first quarter of 2005 to establish an average rate of increase. This results in an 8.65 percent rate of change over one year or 18.04 percent over two years.

Although the increase is somewhat comparable to the proposed change in the IPPS standard rate from FY 2005 to FY 2006, we are concerned that the threshold is too high and will result in the CMS not distributing the total funds set aside for outlier payments. The CMS estimates that actual FY 2004 outlier payments were 3.5 percent of total payments and that projected FY 2005 outlier payments are approximately 4.4 percent of total payments. Given the shortfall in the

prior two years compared to the 5.1 percent target for outlier payments, we are concerned that the proposed threshold increase will result in another year of underpayments for outliers, which are vital for compensating hospitals for the increased costs of providing care to extraordinarily ill patients. In addition, without a corresponding increase in the standardized amount, this outlier decrease would not maintain budget neutrality. Rather the savings would accrue to the CMS. While we appreciate the CMS's attempt to avoid using data prior to the major changes in the outlier policy, we believe the proposed charge inflation methodology will result in an inappropriately high threshold and payment reduction to hospitals. As a result, we oppose use of the proposed methodology for estimating the outlier threshold. Instead, the MHA supports the methodology proposed by the American Hospital Association, which incorporates both cost inflation and charge inflation. We believe the use of more than a single indicator will make the threshold more accurate and reliable.

Based upon the AHA's analysis, increasing the threshold to the proposed $26,675, rather that decreasing it to $24,050 will result in an under spending of outlier funds by at least $510 million in FY 2006. **The MHA urges the CMS to adopt the AHA's proposed methodology, incorporating both charge and cost inflation, and to decrease the outlier threshold to $24,050.**

NEW TECHNOLOGY APPLICATIONS

(*Federal Register* page 23353)

Section 503 of the MMA provided additional funding for add-on payments for new medical services and technologies under the inpatient PPS. Previously, due to budget neutrality requirements, increases in payments for new technologies decreased payments for all other inpatient services. In addition, the MMA reduced the cost threshold for new technologies to qualify for new technology payments to the lesser of:

- 75 percent of the standardized amount (increased to reflect the difference between costs and charges); or
- 75 percent of one standard deviation for the DRG involved.

For FY 2006, the CMS is essentially proposing to reject all eight applications (six new and two reevaluations) and only maintain payment for only one currently-approved technology. The MHA is concerned that the CMS continues to resist approving new technologies for add-on payments. In addition, the MHA is disappointed that the CMS did not propose to increase the marginal payment rate to 80 percent rather than 50 percent, which the agency has the authority to do without reducing payments to other services. **The MHA urges that the CMS re-evaluate the eight applications that it previously rejected and, upon approval increase the marginal payment rate to 80 percent.** This is essential for ensuring that Medicare beneficiaries continue to have access to new medical devices and technologies.

OCCUPATIONAL MIX ADJUSTMENT

(*Federal Register* page)

Mandated by the Balanced Budget Act of 1997 and implemented in FY 2005, the occupational mix adjustment to the wage index is intended to account for the effect of hospitals' employment choices, such as use of registered nurses instead of licensed practical nurses, rather than geographic differences in actual labor costs. Given the potential financial impact of a full adjustment on hospitals and concerns regarding the data, in FY 2005, the CMS proposed to limit application of the occupational mix adjustment to 10 percent of the wage index and is proposing to maintain the adjustment at the same level in FY 2006. Due to numerous concerns with the occupational mix adjustment, the MHA is supportive of this moderated implementation of the occupational mix adjustment. However, due to requirements that the CMS conduct the OM survey every three years, making it necessary for the CMS to collect updated data for FY 2008, **we urge the CMS to release the proposed survey within the next few months in order to meet the mandated timeframe and allow hospitals adequate time to prepare for the data collection and reporting. We also urge the CMS to issue clarifying instructions to ensure consistent reporting among hospitals since many hospitals indicated much ambiguity in the initial instructions.**

DSH ADJUSTMENT DATA

(Federal Register Page)

The MMA Section 951 required the CMS to provide the necessary data to allow hospitals to compute the number of patient days included in the DSH formula. We believe that this requirement encompasses the Medicare, Medicaid and Supplemental Security Income (SSI) data used in the DSH calculation. Hospitals can use this information to ensure a more accurate calculation of their Medicare DSH adjustment and determine whether the data based on the federal fiscal year or their own fiscal year is advantageous. The MHA supports the CMS' plans to release a MedPAR limited data set for both SSI and Medicare. However, we strongly object to the CMS' decision not to make available Medicaid data. The Congressional intent on the inclusion of Medicaid data is clear, with the explanatory report language stating that the Secretary of Health and Human Services must arrange to provide information hospitals need to calculate the Medicare DSH payment formula. . This same section in the version of the MMA passed by the House of Representatives states specifically that the Secretary is required to provide the information to hospitals so they can calculate the number of Medicaid patient days used in the Medicare DSH formula. Although the hospital industry has brought this issue regarding the problems of obtaining Medicaid information from the state programs to the attention of the CMS for a number of years, the agency continue to ignore this problem.

The CMS states in the rule that it believes hospitals are best situated to provide and verify Medicaid eligibility information and that the mechanisms are currently in place to enable hospitals to obtain the data necessary to calculate their Medicaid fraction. The process for obtaining, reporting, and justifying the Medicaid days is problematic in many states. While some improvements have been made in the process for obtaining Medicaid eligibility and payment information from the states, there is still wide variation in the breadth of information provided as well as its accessibility and its reliability. In addition, the information from the states still must be processed to match claims data with eligibility data and then manipulated to develop reports that are acceptable to the fiscal intermediary. This is a complex process that is extremely time-consuming and labor intensive. As a result, hospitals often find it necessary to

471

BODDEN
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KRAEMER
SEIFERT
TREITEL
WALZ
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HEFTER
HARTSTEIN

Submitter : Mr. Paul Silva

Date: 06/24/2005

Organization : Holyoke Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attached

CMS-1500-P-697-Attach-1.DOC

Q DATA
LABOR S/N
TRANSFERS

Attachment to #697

June 23, 2005

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

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

Holyoke Hospital, Inc. DBA Holyoke Medical Center (Holyoke) Provider #22-0024 appreciates this opportunity to comment on the proposed rule concerning the Hospital Inpatient Prospective Payment System (IPPS) published in the Federal Register on May 4, 2005. We are concerned that several of CMS's proposals for the IPPS will have a significant negative impact on the hospital. We have identified several issues that we would appreciate CMS considering as they prepare the final rule. These issues include the following:

IPPS Changes/Financial Implications:

Hospital Quality Data

In the proposed rule CMS requires that the accuracy of hospital submitted data be validated through chart re-abstraction. A sample of five charts will be reabstracted by the Clinical Data Abstraction Center (CDAC) and compared to the hospital's submission. CMS will require an 80% agreement rate between the original submission and the re-abstraction. If a hospital disagrees with the abstraction results from CDAC it can appeal the results to their Quality Improvement Organizations.

Holyoke believes that audits and data validation are necessary to ensure that the data reported on the internet is reliable. However, we strongly oppose any attempt by CMS to link this validation process with the hospital update factor. CMS is proposing to base the update on the data from the third quarter of 2004. CMS audits of earlier periods in 2004 were often unreliable due to data problems and inconsistent definitions. These issues were not completely resolved by the third quarter of 2004. Hospitals s hould not be penalized via a payment reduction due to technical problems with the data submissions and validation process.

Labor Related Share

CMS is proposing to continue to calculate the labor-related share by adding the relative weights of the operating cost categories that are related to, influenced by, or vary with the local labor markets. These categories include wages and salaries, fringe benefits, professional fees, contract labor and labor intensive services. CMS no longer believes that postage costs meet the definition of labor related and are proposing to exclude them from the labor-related share. Under this methodology, CMS has calculated a labor-related share of 69.731.

Holyoke opposes the proposed decrease in the labor-related share of the PPS rate. In the inpatient PPS rule for FFY 2003, CMS examined the methodology used to determine the labor-related share. The CMS calculation of the labor-related share for FFY 2003 resulted in an increase in the labor-related share from 71.06% to 72.495%. However, CMS did not implement the increase pending further research to determine whether a different methodology should be adopted regarding the labor–related share. In the FFY 2006 proposed rule, CMS discusses continuing research on alternative methodologies for calculating the labor-related share. However, CMS states that the analysis has not yet produced sound enough evidence to propose a change and that they will continue to study the issue. Holyoke feels it is inequitable to decline to implement a labor-related share increase pending an analysis of the methodology and then propose a labor –related share decrease while the analysis supporting the decrease is still incomplete.

Post-acute Care Transfers

CMS is proposing to expand the application of the postacute care transfer policy to 223 DRG's that have both a relatively high volume and a relatively high proportion of postacute care utilization. The rationale being that the purpose of the IPPS transfer payment policy is to avoid providing an incentive for a hospital to transfer patients to another hospital early in the patients' stay in order to minimize costs while still receiving the full DRG payment. The transfer policy a djusts the payments to approximate the reduced costs of transfer cases.

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

Sincerely,

Paul M. Silva
Vice-President of Finance

472.

Submitter : Mr. Edward McDonald
Organization : St. Helena Hospital
Category : Hospital
Date: 06/24/2005

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Hartstein
Miller

Issue Areas/Comments

GENERAL

GENERAL

See Attachemnt

CMS-1500-P-723-Attach-1.PDF

ATTACHMENT TO # 723

St. Helena Hospital
Adventist Health

650 Sanitarium Road
P. O. Box 250
Deer Park, CA 94576
707-963-3611
Fax 707-963-6461

June 23, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Attention: CMS-1500-P

Re: Determination of "Wage Related Costs for Overhead Costs of Excluded Areas"

Dear Sir/Madam:

We write to comment on the change in how CMS calculated the area wage index with respect to the calculation of wage related costs (WRC) attributable to the overhead centers for the excluded areas. Currently, CMS has a multi-step process for calculating the proportion of overhead center dollars and hours attributable to the areas excluded from PPS. Essentially, this formula develops a proportion of excluded hours to total hours. Then that proportion is applied to total overhead dollars and hours to calculate the amounts to be removed that are attributable to the overhead centers. CMS has applied a similar but slightly different calculation for removing the WRC related to these overhead areas.

For FY 2006, CMS made a change in deriving the proportion attributable WRC. This year CMS removes certain hours from the total hours (the denominator) in calculating the proportion of WRC to be removed. This causes an increase in the proportion of WRC to be removed. In certain instances this can cause a significant change in the WRC removed and in turn the average hourly wage and area wage index of the affected area. Such is the case for our hospital.

CMS has not discussed this change in its proposed rule nor why this change is being made. CMS appears to have examined in only a limited way the impact of this change. There are certain areas where this change has a material impact on the hospital's area wage index. These issues have not been discussed in the rule nor have they been considered in its adoption. Given that this change can impact an area quite significantly, it is appropriate that it be discussed and comments requested. Accordingly, the change should not merely be implemented without discussion or comment.

We believe that CMS should not adopt this change for three reasons. First, it has not been proposed in rule making. Second, it represents a significant change for selected areas. Third, the impact does not appear to have been identified in CMS' impact analysis. Accordingly, we recommend that CMS continue with its previous formula as in prior years.

We understand that from time to time CMS may want to make a change in the formulas for calculating the WRC proportion for reasons it might identify. Nevertheless such change needs to be discussed along with the related rationale, proposed in rule making prior to adoption and with the impact of such a change identified and evaluated. From the rule it appears that none of these have been properly performed. Accordingly, CMS should not implement this change and continue with its current formulas.

We appreciate the opportunity to provide these comments. If you have any questions or would like to discuss our comments further, please feel free to contact me.

Sincerely,

Edward McDonald

Edward McDonald
Vice-President, Finance

473 MILLER HEFTER HARTSTEIN

CMS-1500-P-721

Submitter : Mr. Edward McDonald **Date:** 06/24/2005

Organization : St. Helena Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

WI/BEN/UPDATE

See CMS-1500P-723 (#472)

474

Submitter : Mr. Edward McDonald

Date: 06/24/2005

Organization : St. Helena Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Miller
Hefter
Hartstein

See CMS-1500-P 723
(# 472)

475

Submitter : Mr. Don Gerhardt

Organization : Medical Alley/MNBIO

Category : Association

Date: 06/24/2005

Issue Areas/Comments

GENERAL

GENERAL

Please See Attachment.

CMS-1500-P-755-Attach-1.DOC

NT
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DRG|GEN

Hafter
Hartstein
Walz
Treitel
Kraemer
Brooks
Fagan
Gruber
Kelly
Hue

Medical Alley® MNBIO

Attachment to #755

June 24, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Center for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS—1500-P

Dear Dr. McClellen,

I am writing to you on behalf of the over 500 members of Medical Alley®/MNBIO to offer comments and express our concern about the hospital inpatient proposed rule that was published in the Federal Register on May 4, 2005 (CMS—1500-P). Our organization was founded in 1984 as a 501(c)(6) nonprofit trade association to support Minnesota's health care industry. Medical Alley®/MNBIO comprises a broad range of organizations that employ approximately 250,000 people in the state of Minnesota and thousands more throughout the U.S. and world. Medical Alley®/MNBIO is truly a unique organization as its members include medical device, bioscience and pharmaceutical organizations, health plans, hospitals and clinics, education, research and government/trade organizations, and a large variety of health care services.

Medical Alley®/MNBIO appreciates the recent efforts by you and your staff at CMS to create a more transparent and efficient coverage process. While significant progress has been made, the inpatient hospital payment assignment process continues to lack this same approach. Payment rate determinations are being made absent a defined process without the opportunity for stakeholder input or transparency. Historically, this lack of collaboration has led to payment determinations that fail to adequately reimburse for the costs of breakthrough medical technologies, thus creating new barriers to access for Medicare patients. We urge CMS to amend the proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates with a specific provision that provides a more defined and transparent process that provides an opportunity for stakeholder input.

Legislatively, there are statutes which support the movement toward a more transparent process. Specifically, the goal of BIPA (2000) and the MMA (2003) was to ensure the continued access to innovative medical therapies by Medicare beneficiaries. Section 503(c) of the MMA enhanced provisions established in BIPA to encourage the recognition of new medical technologies under the inpatient hospital prospective payment system. It directed CMS to assign new technology into a DRG where the average costs of care most closely approximate the costs of care for the new therapy before considering the option of a new-technology add-on payment.

Since CMS has historically not covered Category A devices during trials for novel treatments and many Category B devices have limited coverage, little or no internal Medicare claims data exists upon which to base an initial DRG assignment for new technologies. Absent claims data,

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