



**VIA HAND DELIVERY**

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Acting Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
Room 445-G  
200 Independence Ave, SW  
Washington, DC 20201

Attention: **CMS-1533--P**

Dear Administrator Norwalk:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled "*Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems [IPPS] and Fiscal Year 2008 Rates.*" 72 Fed. Reg. 24680 (May 3, 2007). The Association's Council of Teaching Hospitals and Health Systems (COTH) comprises nearly 300 general acute nonfederal major teaching hospitals and health systems that receive Medicare payments under the IPPS. The Association also represents all 125 accredited U.S. allopathic medical schools; 94 professional and academic societies; 90,000 full-time clinical faculty; and the nation's medical students and residents.

This year's proposed rule contains a major revision to the Medicare case payment classification system by proposing to replace the current 538 diagnosis-related groups (DRGs) with 745 Medicare-Severity DRGs (MS-DRGs). As discussed in section B, below, we support this change but believe it should be accompanied by a transition period. This section also discusses our strong opposition to the 2.4 percent across-the-board prospective payment reduction that CMS seeks to impose for "coding adjustments."

The proposed rule seeks to implement a number of payment reductions to the capital PPS system that we believe are unwarranted and shortsighted. We comment on these proposals, and also share our views on the capital PPS indirect medical education (IME) and disproportionate share (DSH) payment adjustments, in section C.

Our comments on hospital-acquired infections and quality reporting proposals are presented in sections D and E, respectively. Payments for new technologies are addressed in section E.

The DRG, capital, and quality proposed changes have important implications for teaching hospitals and the Association has devoted significant resources and time in analyzing these proposals. However, also in-bedded in the proposed rule is a proposal to modify the methodology for calculating the physician resident full time equivalent (FTE) counts that are used in the calculation of IME and direct graduate medical education (DGME) payments. While seemingly innocuous, the proposed change (regarding how teaching hospitals should account for resident vacation and sick time) would result in fundamental changes to the longstanding methodology used to calculate the resident FTE counts. Not only is such a change unnecessary, it could have unintended policy implications beyond those discussed in the proposed rule. Moreover, it would impose oppressive, and we believe unnecessary, administrative requirements on top of the comprehensive administrative activities that teaching hospitals already undertake to demonstrate the accuracy of their FTE counts. It is this proposal that we would like to address at the outset.

**A. COUNTING RESIDENT TIME FOR DGME AND IME PAYMENT PURPOSES (“IME Adjustment”)<sup>1</sup> (pages 42812-815)**

We strongly urge the Agency to either rescind the proposal regarding how vacation and sick time is accommodated in the resident FTE calculations for IME and DGME payment purposes, or to modify it to make it consistent with how the Agency proposes to account for resident orientation time.

**Background**

The amount of Medicare DGME and IME payments that a teaching hospital receives is, in part, a function of its allowable “full time equivalent” (FTE) count of physician residents that are in accredited residency programs. According to the Medicare regulations, time that is eligible to be counted in the calculation of the FTE count includes time spent training in all areas of the hospital complex. Training time in nonhospital sites also is eligible to be counted if the hospital incurs “all or substantially all” of the training costs at that site (see 42 CFR 413.75 et. seq. (DGME regulations) and 42 CFR 412.105 (IME regulations)).

Hospitals have been allowed to count resident time spent in nonhospital sites for purposes of DGME payments since July 1, 1987 as authorized by the Comprehensive Omnibus Budget Reconciliation Act (COBRA) of 1986. The specific statutory provision states that “only time spent in *activities relating to patient care* shall be counted . . .” (emphasis

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<sup>1</sup> Throughout this letter, phrases in parentheses in the section headings accommodate the request in the proposed rule to include specified captions when addressing various proposals. But note that in this particular instance the heading only lists IME, but the proposal would affect both IME and DGME payments.

added) (Section 1886(h)(4)(E) of the Social Security Act (SSA)). Resident time spent in nonhospital sites could not be counted for IME purposes until 1998, when it was authorized by the Balanced Budget Act of 1997 (BBA). The IME nonhospital site statutory provision states that “all the time spent by an intern or resident *in patient care activities* shall be counted towards the determination of full-time equivalency. . . . (emphasis added) (Section 1886(d)(5)(B)(iv)).

The statutes authorizing DGME and IME payments in the hospital complex contain no requirement that residents be engaged in “patient care activities” in order to include the time in the calculation of the resident FTE count.

Over the strenuous objections of the academic medical community, in the federal fiscal year (FFY) 2007 IPPS final rule CMS stated that didactic activities, such as journal clubs and seminars, cannot be counted for either DGME or IME payment purposes if the activities occur in nonhospital settings, and they cannot be counted for IME payments if they occur in a hospital setting, because CMS does not consider them “patient care activities.” The final rule also added a definition of “patient care activities” in the regulations to mean “the care and treatment of particular patients, including services for which a physician or other practitioner may bill.” (42 C.F.R. §413.75(b)).

### **Proposed Rule**

This year CMS sets forth a proposal for how teaching hospitals should account for residents’ vacation, sick and orientation time for purposes of determining resident FTE counts. CMS notes that currently this time is included in the FTE resident count for both DGME and IME payment purposes.

The issue of how this time should be accounted for is an outgrowth of CMS’ decision last year that only resident time spent in “patient care activities” may be included in resident FTE counts. The proposed rule states that the Agency believes “these types of activities (vacation time, sick leave, and orientation) are inherently different from the types of ‘patient care activities’ and ‘nonpatient care activities’ we have discussed in depth in previous rules. . . .” (72 Fed. Reg. at 24813.) The proposed rule methodology differentiates vacation/sick time and orientation time:

*Vacation and Sick Time*—Viewing vacation and sick leave as a “distinct third category of time” that is “not spent in any aspect of residency training—patient care or nonpatient care” (72 Fed. Reg. at 24814), CMS proposes to remove this time altogether from the FTE count for both IME and DGME purposes. In other words, the time would be removed from both the numerator and denominator of the resident FTE calculation. CMS states that its proposal could have an impact on hospitals’ FTE counts but that the impact would be fact specific: “In some cases, it would result in a lower FTE count, and in some cases, it would result in a higher FTE count.” (Ibid.)

Unfortunately, the proposed rule does not include example calculations that would illustrate CMS's thinking. Our understanding of the proposal is as follows.<sup>2</sup> At the simplest (and rare) end of the spectrum, assume that a resident spends an entire year in a hospital setting and takes two weeks of vacation. Under current policy, the vacation time is counted and the resident FTE count would be 1.0, calculated by dividing 52 weeks by 52 weeks. Under the proposed policy, the vacation time would be excluded from the numerator and denominator, but the result would still be an FTE count of 1.0 (50 weeks divided by 50 weeks).

However, assume another simplified example of a resident who trains half a year at hospital A and the other half year at hospital B, and takes two weeks of vacation during his or her time at hospital A. Under current policy the FTE count would be 0.5 for hospital A and 0.5 for hospital B. But the results under the proposed rule, if our understanding is correct, is that the FTE count for hospital A would be 0.48 (26 weeks minus two vacation weeks divided by 50 weeks) and the FTE count for hospital B would be 0.52 (26 weeks divided by 50 weeks). Both scenarios result in Medicare making payments for 1.0 FTE, but the proposed rule has the effect of changing the resident FTE counts for both hospitals, despite the fact that neither party has modified the rotation arrangement in any way.

The calculations get more complicated as the scenarios become more realistic, such as residents spending time at multiple hospitals, as well as nonhospital sites. In addition, in multiple hospital situations, all of the hospitals involved would seemingly need to know each resident's vacation or sick time amounts, in order to calculate the denominator for each resident that trains at their hospital at some point during the year.

The examples presented presume that the total vacation time provided to residents is actually taken. Again, if we understand the proposed policy correctly, only vacation and sick time that the resident actually takes would be excluded, which further complicates the calculation.

*Orientation Time*—The proposed rule would continue the current policy of including resident time spent in orientation activities in the resident FTE count, the rationale being the “distinct character of orientation activities as essential to the provision of patient care by residents” (72 Fed. Reg. at 24814).

### **Vacation and Sick Time Should be Accounted for Either as is Currently or in the Same Manner as Orientation Time**

At the outset, we reiterate our strong opposition to CMS' decision in last year's final rule that the time residents spend in didactic activities must largely be excluded from the resident FTE count because of CMS' incorrect view that these activities are not related to

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<sup>2</sup> The examples presented assume that all resident training time would be counted.

patient care.<sup>3</sup> (For a full discussion, see the Association's June 12, 2006 Comment Letter.)

Despite this fundamental disagreement, we do appreciate CMS's recognition that "orientation activities" should continue to be counted in both the numerator and denominator for purposes of the resident FTE count, and we support CMS's proposal to appropriately modify the definition of "patient care activities" to make clear that for all purposes, time spent in these orientation activities should be treated as both countable and reimbursable time.

We also appreciate that CMS did not propose to outright exclude vacation and sick time (i.e., remove it only from the numerator) and the Agency's implicit recognition that such a proposal would penalize teaching hospitals for offering sick and vacation leave for their residents. In fact, the proposed rule appears "neutral" in its overall impact because the aggregate physician FTE count used for Medicare DGME and IME payments would be no different than under current policy. Unfortunately, however, as the example above demonstrates, resident FTE counts would artificially be altered at the hospital level.

We believe that if CMS retains its position regarding "patient care activities," it is *imperative* that CMS restrict the application of its policy to didactic activities to prevent going down a policy "slippery slope" that ends up with parsing every aspect of residents' training time into a "patient care," or "nonpatient care" bucket. The vacation/sick and orientation time proposals highlight the downward spiral that starts to occur if CMS attempts to extend its "patient care" analysis beyond didactic activities. For example, if CMS believes that it must regulate how sick time is accommodated in the FTE counts, which may involve as little as a day or two within a year, is it that far-fetched to think that CMS should apply a similar process to lunch and dinner breaks?

Beyond the "slippery slope" implications, the intellectual and administrative difficulty of trying to parse resident time is apparent in the proposed rule when CMS concludes that vacation, sick and orientation time is neither patient care nor nonpatient care but rather a "third category." Even after that decision, further analysis is required to determine whether the time should be included in the FTE calculation, as it is in the proposal for dealing with orientation time, or whether it should be excluded from the calculation process entirely, as it is for the proposal for handling vacation and sick time.

We do not believe CMS's position on didactic activities necessitates this tortured process. Vacation and sick time are integral to any FTE calculation and should be treated accordingly. It is widely accepted that FTE counts for employees as well as students are not adjusted for vacation or sick time. We believe neither the Medicare statute, nor policy or operational reasons require that resident FTEs be calculated differently. Consequently, we believe that CMS should retain the current methodology for dealing with vacation and sick time.

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<sup>3</sup> Under the policy finalized in the FFY IPPS 2007 final rule, time associated with didactic activities is excluded entirely from the IME FTE count determination, and excluded from the DGME calculation if it occurs in a nonhospital setting.

It also is important to remember when thinking about this issue that residents routinely train more than 40 hours a week, and often average up to 80 hours a week. If CMS were to count a resident FTE in the traditional manner of 40 hours a week (as the Agency does for purposes of calculating the hospital wage index) many of the FTE issues of which CMS is concerned would be moot.

Finally, it also is worth noting that in the proposed rule preamble CMS provides no policy justification for the proposal to also exclude vacation and sick time from the direct GME FTE calculations. As noted in last year's rule, for DGME payment calculations hospitals are permitted to claim all resident time during hospital rotations because the Medicare statute does not have a "patient care" requirement. However, in the proposed rule, the Agency seems to believe that vacation and sick time must be excluded in order to "have a consistent conception of an FTE resident for purposes of IME and direct GME payment." While one interpretation of this statement might be that CMS is trying to reduce the administrative burden for hospitals by having a consistent application of the counting rules, it seems that a more straightforward way of not increasing administrative burden would be to retain the current policy for both IME and DGME payments.

### **Implementation of the Proposed Rule Would Involve Oppressive and Impractical Administrative Burdens.**

Teaching hospitals historically have been subjected to substantial and burdensome documentation requirements to substantiate the resident FTE counts they report for DGME and IME payments. The academic medical community has accepted these burdens because our members recognize that DGME and IME payments represent significant outlays from the Medicare trust fund and resident counts are a key determinant in the level of these payments.

Over the last several years, however, the administrative burdens associated with receiving DGME and IME payments have grown exponentially, particularly as a result of the CMS decision that didactic time be excluded from the resident counts and the Agency's decisions regarding claiming resident time at nonhospital sites. This year's proposed rule seems to have achieved a "breaking point" for even the most detail-oriented staff within our teaching hospital members. The Association has received numerous communications expressing confusion, frustration and even outrage at a policy that they believe would increase, unnecessarily and dramatically, their documentation burdens.

First, many teaching hospitals do not currently keep track of vacation time. Even more do not keep track of sick time. In fact, of the hospital personnel with whom we have communicated none of them keep track of sick time and when asked, they know of no teaching hospital that monitors this time unless it becomes significant (which could occur if a resident is sick for three consecutive days, for example).

Vacation time may be uniform for all residents at some hospitals, but for a number of other hospitals the vacation time allocation is determined at the residency program level,

which can involve tracking this time for as many as 50 or more separate residency programs.

Even if the vacation time is accounted for on resident rotation schedules, it often is not possible for hospitals to verify whether the resident did indeed take this time or if, for training or other reasons, the vacation time went unused.

Adding a burden of monitoring and accounting for vacation and sick time also has important implications with the intern and resident information system (IRIS), as discussed in the next section.

Because the vacation and sick time must be excluded from the denominator of the FTE calculations, all hospitals where a resident trains must know that denominator in order to calculate an accurate FTE determination. Ensuring that all of the hospitals involved have this information is particularly daunting when one considers that many COTH members are dealing with hundreds and sometimes a thousand or more residents. Not only would teaching hospitals be affected, but seemingly fiscal intermediaries would be instructed to audit the denominator counts for accuracy and completeness, further increasing their already significant workloads.

### **The Vacation/Sick Proposal Should Not be Finalized Unless and Until IRIS is Modified**

Because we believe strongly that the proposed rule change regarding vacation and sick time should not be finalized, we hesitate to even raise the following issue. However, if for some reason CMS chooses to finalize its policy in some form, we feel strongly that the policy cannot be implemented unless and until the IRIS is modified to accommodate such changes.

All teaching hospitals are required to submit an IRIS report that documents and verifies resident counts and rotations. CMS and the fiscal intermediaries use this system to ensure that no residency training time is counted twice by two different hospitals.

In order to demonstrate that no training “overlap” is occurring between hospitals, teaching hospitals document each resident’s time using up to 60 lines on IRIS. Hospitals tell us that even now, the 60 lines is not enough to fully account for residents’ time. As a result they often have to consolidate training time frames which can create additional overlap potentials which must be investigated by the hospitals involved. Requiring hospitals to now accommodate vacation and sick time intervals in IRIS requires that IRIS be significantly modified. We also understand that there may be an issue as to whether IRIS can accommodate denominator changes because currently the system presumes 365 days when calculating training time percentages. CMS needs to investigate the implications of its proposal on IRIS submissions. It would be unfair and wrong for CMS to prematurely implement the vacation/sick time policy if modifications to IRIS are needed.

**B. PROPOSED CHANGES TO THE DRG CLASSIFICATION METHODOLOGY (“DRG Reform and Proposed MS-DRGs”) (pages 24691-712)**

For FFY 2008, CMS proposes to refine the current DRG system by creating 745 new MS-DRGs to replace the current 538 DRGs. However, the proposed rule also includes a 2.4 percent “coding adjustment” also known as a “behavioral offset” cut to both operating and capital payments in both FFYs 2008 and 2009—a total of \$24 billion over five years—to offset prospective payment increases that CMS estimates will occur due to the effect of changes in patient diagnosis documentation practices that the Agency believes do not reflect real changes in patient severity.

The AAMC appreciates and commends the extensive efforts of CMS staff to develop the MS-DRG proposal and supports its adoption. However, because it is a major change to the current system, we believe that there should be a four-year transition from the current system to the new MS-DRGs. Such a result would be consistent with how CMS has dealt with past major changes to the IPPS.

We strongly object to the proposal to implement the 2.4 percent behavioral offset. Such a reduction is not justified and must be rescinded.

**Background**

Under the IPPS, Medicare pays hospitals a per case payment that varies according to which DRG the case is assigned and the DRG’s payment “weight.”<sup>4</sup> Each weight is intended to represent the average hospital resources required to treat a case within a DRG compared to the average required per case resources across all DRGs. Thus, cases that require higher levels of resources, on average, will have higher weights than cases that require relatively lower levels of average resources.

Currently, cases are assigned to one of 538 DRGs, predominantly based on the patient’s principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay. The determination of which case types comprise a DRG is based on both clinical coherence and similar resource consumption. Hospitals do not decide to which DRG a case is assigned. Rather the assignment is done by the Medicare GROUPER software program, based on the diagnosis and procedure code information provided by the hospital.

Last year, CMS proposed to replace the then-526 DRGs with 861 “consolidated severity-adjusted DRGs” (CS-DRGs). In response to comments, the Agency decided not to adopt CS-DRGs in the FFY 2007 final rule, but stated that the Agency would continue to study the issue.

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<sup>4</sup> These payments may then be adjusted for other purposes, such as whether the hospital is located in a high or low wage area, whether it is a teaching hospital, and whether it treats a disproportionate share of low income patients.

## **Proposed MS-DRGs**

Under the proposed rule, the current DRGs would be replaced with MS-DRGs, although the current DRGs would continue to serve as the foundation of the new MS-DRGs. The difference is that while the current system basically has two tiers of payment for a given DRG (with and without complications/comorbidities (CCs)), most (but not all) MS-DRGs have three payment tiers (with a *major* CC, with a *a* CC, and with *no* CC).

We commend CMS's recognition of the need to better account for patient severity in the IPPS. It is important that the DRG classification system accurately reflect those cases that involve the sickest and most complex Medicare patients. As common sites of care for these patients, ensuring that these cases are assigned to DRGs that adequately reflect the resources needed is a fundamental principle for major teaching hospitals.

We support the implementation of MS-DRGs. However, even though this change has a positive financial impact for most major teaching hospitals, we believe it should be transitioned over a period of time. This is consistent with our historic position that there should be transitions whenever major changes to the IPPS are implemented.

Historically, Medicare changes of significant magnitude have included some type of transition period. For example, the move to a PPS for capital was transitioned in over a 10 year period. Other changes that were accompanied by transitions include: implementation of the operating IPPS (four years), eliminating day outliers (four years), and removing the costs of teaching physicians and residents in the calculation of the wage index (four years). Most recently, CMS last year began implementation of the change from a charge-based methodology to one based on costs over a three year period.

We believe that the transition should begin in FFY 2009 with full implementation in FFY 2011. In FFY 2008, the focus should be on preparation for and testing of the MS-DRGs prior to initial implementation in FFY 2009.

### **CMS Must Rescind the 2.4 Percent Payment Reduction for "Coding Adjustments" (pages 24708-711)**

Under the IPPS, CMS is required by law to recalibrate the DRG weights each year to ensure budget neutrality. CMS is concerned that upon implementation of MS-DRGs, hospitals will improve their coding practices based on the definitions of MS-DRGs and that the result will be an increase in the number of Medicare cases assigned to higher weight MS-DRGs. Because these diagnoses are not available on the dataset used by CMS to calibrate the DRG weights, the result would be an overall increase in Medicare payments contrary to the Agency's budget neutrality mandate.

The proposed rule inclusion of a prospective 2.4 percent cut to the IPPS standardized amount in both FFYs 2008 and 2009 is intended to offset what CMS asserts will be the effect of coding or classification changes that do not reflect real changes in a hospital's

mix of Medicare cases (known as it's case-mix index, or CMI). However, the 2.4 percent "behavioral offset" cut is based on assumptions made with little to no data or experience, and cannot be justified in advance of making the DRG changes.

The comment letter submitted by the American Hospital Association (AHA) comprehensively and convincingly demonstrates that CMS should revisit its decision making process regarding the behavioral offset. We support and endorse the AHA comments on this issue. Briefly summarized, these comments state:

- Implementation of the IPPS in the early 1980s, which involved moving from a cost-based system that did not require significant coding to a system that was dependent on accurate coding, showed only a 0.8 percent growth in case mix due to coding changes. Given that the MS-DRG system represents only a refinement to the current DRG system, it defies logic that coding changes would be greater than, or even as much as, those that occurred when DRGs were first implemented.
- The reliance on the coding experience of Maryland hospitals when they moved to All-Patient Refined DRGs (APR-DRGs) is misplaced. APR-DRGs and MS-DRGs are two completely different ways to classify patients and thus generalizing from one system to another is inappropriate.
- The coding experiences of the recently implemented inpatient rehabilitation facility (IRF) PPS is not a reliable indicator for coding changes in the IPPS. Like the original IPPS, the IRF PPS was the result of moving from a cost-based system to a diagnosis- based system.

The AAMC also collaborated with the AHA and the Federation of American Hospitals (FAH) to conduct a series of analyses of the diagnosis codes on claims data. These results showed that:

- Most hospitals already are coding comprehensively for other purposes, such as risk adjustment in various quality reporting systems. Analysis of Medicare claims from 2001 to 2005 suggests that hospitals have been coding CCs at high rates for many years. More than 70 percent of claims already include CCs, and more than 50 percent of claims have at least eight secondary diagnoses (the maximum number accepted in Medicare's DRG GROUPER). Hospitals' assumed ability to use even more CCs under MS-DRGs is very low.
- Many cases simply do not have additional CCs to be coded. For many claims, additional codes are simply not warranted and not supported by the medical record. Therefore, there is no opportunity for a coding change to increase payment.
- Analyses of all-payer health care claims databases from California, Connecticut, Florida and Michigan support a conclusion that additional coding would have negligible payment implications. Unlike the Medicare Provider and Review

(MedPAR) files, which reflect a maximum of nine diagnoses per claim, regardless of how many diagnoses the hospital actually coded, these state databases include up to 25 diagnoses reported on the claims. This analysis showed that only 0.25 percent of claims had an MCC or CC appear for the first time in positions 10 through 25. Data analyses conducted by the University Healthsystem Consortium of claims data from approximately 80 academic medical centers that also contain complete diagnosis information found similar results as the state database analyses.

This strongly suggests that hospitals will not be able to “re-order” their secondary diagnoses to appear higher on the claim so that CMS will pick them up and pay them at a higher rate. We also understand that many hospitals currently use software that automatically re-sorts the secondary diagnoses to ensure that those pertinent to payment are included in positions two through nine.

- An examination of secondary diagnosis codes found that there were relatively few non-specific codes listed among the common secondary diagnoses of discharges without a CC/MCC. This means that hospitals cannot shift large numbers of discharges to those with CCs or MCCs based on putting in a more specific code to replace a non-specific code.
- There is no opportunity for increased payment due to a change in coding for 77 base DRGs under the MS-DRGs systems, as there is only one severity class and no differentiation in payment.

The foregoing discussion demonstrates conclusively that it would be ill-advised and unfair for CMS to implement a prospective payment cut for purported future coding adjustments. Until MS-DRGs are fully implemented, and CMS can document and demonstrate that any increase in hospitals’ case-mix is a result of changes in coding practices rather than real changes in patient severity, there should be no “behavioral offset.” Moreover, because of the direct and significant impact on Medicare payments, we believe CMS has an obligation to thoroughly explain the analytical framework the Agency would use to differentiate between “real” and “not real” CMI changes.

### **The Hospital Specific Relative Value Cost Center (HSRVcc) Methodology and Charge Compression (“DRGs: Relative Weight Calculations”) (pages 24713-716)**

While not making any specific proposals, CMS asks for input regarding the hospital specific relative value cost center (HSRVcc) methodology and options for addressing “charge compression” in the DRG weights.

In the FFY 2007 final rule, CMS began a three-year transition from using a charge-based methodology for determining the DRG weights to one that is based on hospital costs.

While seemingly a simple concept, developing “cost based” weights is actually a complex undertaking. Calculating the costs for a particular Medicare case cannot be

accomplished directly. Consequently these costs must be “estimated” using cost-to-charge ratios (CCRs) that are derived from hospitals’ Medicare cost reports. The cost-based methodology that CMS is using relies on national aggregate CCRs for 13 hospital departments.

To accurately developed DRG weights that that can be used nationally, the costs must be “standardized” across hospitals. In last year’s final rule CMS retained its process to standardize the cost amounts by the wage index, and IME and DSH adjustments, rather than implement a “hospital-specific relative value” (HSRV) methodology that the Agency had initially proposed. Briefly, the HSRV methodology works by dividing the charges (or costs) for each case at a particular hospital by the average charge (or cost) for all cases at that hospital, thus removing all variation in charges (or costs) across hospitals regardless of the source of the variation.

Moving from a charge- to a cost-based weighting methodology also introduces (or exacerbates) a phenomenon known as “charge compression.” This refers to hospitals’ practice of applying higher percentage markups to relatively lower cost items and lower percentage markups to higher cost items. To the extent that the costs and charges of both types of items are reflected in the calculation of a particular CCR (i.e, the CCR is an average of both low and high markup items) it can introduce bias in the DRG weights, by either artificially understating or overstating cost estimates for specific DRGs. For example, weights for DRGs that contain high costs items (such as devices and implants) tend to be understated.

CMS awarded a contract to RTI to study this issue and their analysis confirmed the existence of charge compression (See “A Study of Charge Compression Calculating DRG Weights”, January, 2007 at 86). RTI made several recommendations that they believed would improve the accuracy and precision of the CCRs which would then result in more accurate DRG weights. These recommendations included revising the Medicare cost reports to modify existing cost centers and/or creating new cost centers, as well as using regression-based methods to modify the national CCRs for certain hospital departments that seem to experience the most “charge compression”-these departments include Medical supplies, drugs and radiology.

While the proposed rule seems to suggest that options to address charge compression should be combined with a consideration for implementing an HSRV methodology, we do not believe these two issues need to be, nor should be, linked. While we believe RTI’s options for addressing charge compression merit serious consideration by CMS, we do not believe the HSRV methodology merits additional consideration by CMS because it would not improve the weights and actually would introduce more bias in the weight calculations.

In terms of dealing with charge compression, along with the AHA and FAH, we are launching an educational campaign to help hospitals report costs and charges, particularly for supplies, in a way that is consistent with how the charges are grouped in the Medicare claims database. We believe that this initiative will help improve the CCRs that are so

critical in the development of cost-based weights. In the meantime, however, we believe the regression approach that was discussed and endorsed in the RTI report merits consideration by CMS as a means of addressing the charge compression issue.

However, we do not believe that the HSRV standardization methodology merits further consideration. The methodology does not recognize legitimate differences in costs across hospitals. Teaching hospitals that have higher costs because of their various missions would be unfairly disadvantaged. The methodology also exacerbates inaccuracies that may arise because of the mix of patients treated at a particular hospital. Consequently, we believe that introduction of the HSRV methodology would not only not improve the current system, but would be deleterious to it.

**C. PROPOSED CHANGES TO THE CAPITAL PPS (“Capital IPPS”) (Pages 24818-823)**

**Background**

The Medicare program pays for a portion of the capital-related costs of hospital inpatient services through a PPS that is separate and distinct from the operating PPS. However, like the operating PPS, capital PPS payments are made for each Medicare case and are based on a standard federal rate that is adjusted by the same DRG determination that is used in the operating PPS. In addition, capital PPS payments are adjusted for IME and DSH payments. Hospitals also may receive outlier payments under the capital PPS for those cases that have unusually high costs.

**The Proposed Payment Cuts Are Excessive and Unwarranted**

Under the proposed rule, CMS would eliminate the FFY 2008 0.8 percent inflation update to the standard federal rate for hospitals located in large urban areas (rural hospitals would still receive the update). The proposed rule also eliminates the three percent add-on payment for hospitals in large urban areas. The impact of these two provisions would be a five-year aggregate loss of \$880 million in capital PPS payments for these hospitals. The proposed rule also would impose the 2.4 percent behavioral offset associated with MS-DRGs to the capital standardized amounts for both urban and rural hospitals.

The cuts, proposed without any direction from Congress, are unprecedented. The payment reductions will affect hospitals’ abilities to meet their existing long-term financing obligations for capital improvements. They could have a negative impact on the adoption and dissemination of new technologies, health information systems, electronic health records and scanning devices that are a critical part of teaching hospitals’ health care delivery systems. Capital requirements associated with improvements needed to enhance patient safety and quality of care also could be affected.

The proposal to eliminate the inflation update and the three percent add-on for urban hospitals is unwarranted. To justify the cuts, CMS asserts what it considers to be large

inpatient capital margins over the period 1996 to 2004. However, CMS' rationale for the proposed reductions is inconsistent with the principles of the capital PPS as enunciated in the August 30, 1991 final rule which implemented the capital PPS.

First, capital investments occur in cycles and the development of the capital PPS envisioned that payments would exceed costs in some time periods. Hospitals were expected to establish funds in anticipation of future capital needs, similar to how funded depreciation reserves had been used under the prior cost reimbursement system. These funds would permit future capital investment to be funded in part with equity financing rather than borrowing.

In the 1991 rulemaking to create the capital PPS, many commenters urged that Medicare's payment amount for capital should recognize the effect of age and financing variables on capital costs, but HCFA (the predecessor agency to CMS) stated in the August 30, 1991 final rule that the Agency

“did not believe that it is appropriate to recognize the effect of age and financing variables on capital costs in the long run. We believe that the Federal capital payment should be independent of the timing and financing of capital acquisitions. Two hospitals that are identical, except that one recently purchased a new piece of equipment, while the other hospital is accumulating funds to purchase the same equipment, should not be paid differently for treating the same case. Further, two identical hospitals, one of which purchased a piece of equipment with funded depreciation, and the other of which financed the same equipment, should not receive different payments. By severing the link between Medicare payment and capital spending, we will provide neutral incentives with respect to the timing and financing of new capital acquisitions.”

Other comments on the original capital PPS proposed rule suggested that Medicare permit hospitals to elect to keep the excess of capital prospective payments above inpatient capital costs on deposit with HCFA in interest-bearing Medicare capital accounts. HCFA responded that deposits could be established with banking institutions, but that such actions by HCFA could be construed as involvement in hospital management practices. Again, the proposed rule recognized a capital cycle and noted that hospitals would establish funds for future capital investment.

The goal of the capital PPS to sever the link between hospitals' capital costs and their Medicare payment is further indicated in this statement from the August 30, 1991 final rule:

“Under a cost-based payment system, hospitals have limited incentive to delay or forego a capital project because Medicare payments increase as capital costs increase and excess capacity is subsidized. Further, the current system favors debt financing over equity financing and capital investment over operating expenditures. By making Medicare's payment

independent of a hospital's decisions with respect to the timing and financing of capital projects and by aligning the incentives of the capital payment system with those of the operating prospective payment system, we expect that hospitals will make efficient capital decisions.”

The principles and structure of the capital PPS are sound and have served the Medicare program well. Since its inception, annual updates to the capital rate have been modest, but they have been based on a rigorous update framework developed by the CMS actuaries. This framework should continue to be used as the basis for updates for all hospitals, not just rural hospitals.

### **Capital IME and DSH Adjustments**

While not making an explicit proposal, CMS seeks input on the value of the IME and DSH adjustments within the capital PPS. Unlike the operating PPS in which these adjustments are mandated by the Medicare statute, the IME and DSH adjustments were included by CMS when it developed the original capital PPS. Consequently, the Agency believes it has the authority to modify these adjustments.

CMS notes that teaching hospitals have “continuous, significant positive margins” and that the DSH and IME payment adjustments are “contributing to excessive payment levels for these hospitals.” (72 Fed. Reg. at 24822). We strongly dispute CMS’s views the payment levels are “excessive.” As discussed above, positive margins are necessary and a desirable outcome of the capital PPS and, in our view, reflect that teaching and DSH hospitals are acting responsibly in terms of preserving payments for future capital needs.

While we believe teaching hospitals need to maintain positive margins for future capital initiatives, a closer examination of the capital margins reveals the absolute necessity for the IME and DSH adjustments. An analysis by Vaida Consulting shows that eliminating the IME adjustment would result in an aggregate capital margin that is only 1.7 percent for major teaching hospitals. Eliminating both the IME and DSH add-ons would result in an aggregate negative capital margin of -4.8 percent for these institutions.

Recognizing the major teaching hospitals total margins (from all payment sources) often hover near zero, it is easy to see the importance of IME and DSH add-ons. Payment cuts would directly affect the fiscal condition of these institutions, which would influence all aspects of their operations. Operations that include providing education for all types of health care professionals; providing an environment in which clinical research can flourish; and offering highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services. Most recently, major teaching hospitals are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and require sufficient financial resources to fulfill that role.

We are disappointed that CMS asked for input on the value of IME and DSH payments in a contextual framework that suggested these payments might not be necessary. However,

we appreciate the opportunity to discuss the importance of these payments to allay any of CMS's concerns.

**D. DRGS: HOSPITAL-ACQUIRED CONDITIONS (pages 24716-726)**

The Deficit Reduction Act of 2005 (DRA) requires CMS to identify by October 1, 2007 at least two preventable complications of care that could cause patients to be assigned to a higher paying DRG. The conditions must be either high cost or high volume or both, result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and could reasonably be prevented through the application of evidence-based guidelines. The DRA mandates that for discharges occurring on or after October 1, 2008, the presence of one or more of these preventable conditions could not result in the case being assigned to a higher-paying DRG. That is, the case would be paid as though the secondary diagnosis were not present. Finally, the DRA requires hospitals to submit those secondary diagnoses that are present on admission when reporting payment information for discharges on or after October 1, 2007.

CMS established a set of criteria to evaluate candidate conditions and from that determined which conditions should be considered for FFY 2009 implementation. The list of candidate conditions is as follows:

- Catheter-associated urinary tract infections;
- Pressure ulcers;
- Object left in during surgery;
- Air embolism;
- Blood incompatibility; and
- Staphylococcus aureus septicemia.

We have several concerns associated with the implementation of this new payment structure. First and foremost is the legislative requirement stating that the selected conditions could reasonably be prevented through the application of evidence-based guidelines. This statement acknowledges that there are instances where even with adherence to appropriate guidelines, these conditions can still occur and hospitals are now being held financially liable for all occurrences irrespective of whether or not they actually could have been prevented. Academic medical centers that treat a large percentage of high risk patients are keenly aware that even with adherence to evidence-based guidelines complications still occur due certain patients' high risk status.

Secondly, this new payment structure is based on the use of the Present on Admission (POA) indicator to determine which cases with the selected conditions were present upon admission and therefore should be excluded. The use of the POA indicator is new and physicians and hospital staff have not had, nor been provided, the opportunity to be educated and trained to ensure its proper use. Currently there are only two states that use the POA indicator and from what we understand, there is a significant learning curve after the initial implementation. Therefore, to put hospitals in the position of utilizing a new coding procedure while trying to identify selected conditions that may not be readily

apparent on admission and link that to possible non-payment is unreasonable. We recommend that CMS implement the collection of the POA indicator but delay the implementation of any conditions that are dependent on its use until physicians and hospitals have had the appropriate level of experience.

Thirdly, there is the possibility that there will be negative and unintended consequences associated with some of the proposed measures. For example, in order to ensure proper identification of urinary tract infections there will be a significant increase in urinalysis testing prior to admission which will result in increased costs, delays in admission and ultimately a delay in the care the patient needs.

Lastly, academic medical centers treat the majority of high risk patients who are more susceptible to infections and complications due to their high risk status. Since adherence to guidelines for these patients oftentimes will not eliminate the risk of complications, CMS should make efforts to ensure that either the selected conditions are not associated with this high risk population or that the high risk patients are excluded. Similarly, academic medical centers receive many of these high risk patients through transfers from other institutions. Transfers should also not be included in determining POA.

Given the above concerns, we would like to make the following recommendations on the list of candidate measures for FFY 2009.

We agree with that CMS the three serious reportable events (object left in during surgery, air embolism and blood incompatibility) should not occur and should not be associated with any additional payment. These conditions are more likely the result of medical misadventures and are avoidable in most instances. Therefore we would like to recommend these conditions for FFY 2009 adoption.

We do not recommend the remaining measures for the following reasons:

*Catheter Associated Urinary Tract Infections* – As mentioned previously this is a very difficult condition to identify at the point of admission. It is also debatable as to whether an infection can be avoided after catheter placement. A study published in the New England Journal of Medicine found that even with optimal bladder care, 3 to 10 percent of patients develop significant bacteriuria each day.

*Pressure ulcers* – A key concern with pressure ulcers that was also noted in the proposed rule is that it is very difficult to detect stage I pressure ulcers on admission. The skin has yet to be broken and even upon careful review they still may not be evident. In addition, there is more than one ICD-9 code for pressure ulcers and therefore it does not meet the criteria, as outlined in the proposed rule, for selection.

*Staphylococcus aureus septicemia* – Accurately diagnosing staphylococcus aureus septicemia on admission would be exceedingly difficult since many patients with community acquired bacteremia have a clinically inapparent source of infection which is not a hospital acquired infection. Patients who develop staphylococcus aureus septicemia

are often immuno-compromised and/or are more severely ill. As mentioned previously, these patients are very complicated and we do not believe that this infection is reasonably avoidable in all circumstances.

**E. HOSPITAL QUALITY DATA (pages 24802-809)**

The Hospital Quality Alliance (HQA) was created to develop a process to submit and publicly report hospital performance data. The initial effort was purely voluntary with no financial incentives in place and generated a high level of participation amongst the nation's hospitals.

The Medicare Modernization Act (MMA) introduced the concept of "pay-for-reporting" by requiring hospitals to submit performance data on an initial "starter set" of ten measures, approved by the HQA, or else they would receive a 0.4 percent payment reduction to the annual update. There is currently nearly a 99 percent submission rate from eligible hospitals. The DRA introduced a new set of requirements for the Hospital Quality Data Payment Update Program. The DRA calls for additional quality measures to be added to the program and increases the penalty for not reporting the hospital quality performance measures from a negative 0.4 percentage point reduction to the annual payment update to a two percentage point reduction.

In the proposed rule, CMS recommends five additional measures to be included for the FFY 2009 payment update. Hospitals would need to report these measures as well as the twenty seven measures from FFY 2008 and pass validation in order to receive their full market basket update. The additional measures proposed are:

- Pneumonia 30-day mortality
- SCIP Infection 4 – Cardiac Surgery Patients with Controlled 6am Postoperative Serum Glucose
- SCIP Infection 6 – Surgery Patients with Appropriate Hair Removal
- SCIP Infection 7 – Colorectal Patients with Immediate Postoperative Normothermia  
SCIP Cardiovascular 2 – Surgery Patients on a Beta-Blocker Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period

We are pleased to see that CMS continues to select measures that have been HQA approved. CMS has also been committed to only using measures that have been NQF endorsed. This ensures that the measures have received a thorough review, have gone through field testing and ultimately been approved by a multi-stakeholder group.

The HQA also bases their measure selection on NQF endorsement status and as a result has withdrawn the SCIP Infection 7 measure since it did not receive NQF approval. Therefore we recommend that the SCIP Infection 7 measure be removed from the proposed list of measures which will be consistent with CMS' commitment to only use NQF endorsed measures.

CMS has also included a list of measures that cover a broad range including efficiency, leapfrog leaps and claims based measures among other conditions and they are seeking comment on what measures should be included in the FFY 2009 payment update or subsequent years. Given our comments above, we have concerns with some of the measures on the list. We believe that the measures used for the payment update should continue to be NQF endorsed and HQA approved for the reasons stated above. Several of these measures have not been through either or both approval processes and therefore we believe should not be considered.

We appreciate that CMS has asked for comments regarding the retiring or replacing of measures. By design, academic medical centers utilize protocols that incorporate the latest advancements in clinical science which can often be ahead of other provider's adoption. Our primary goal is to ensure that the measures are keeping pace with the science and that a process is developed that can respond to these changes in a timely manner. At the same time there is also a need to balance the yearly requirements for the payment programs based on these exact measures. We would like to recommend that a multi-stakeholder group be convened to identify an appropriate and equitable process.

The multi-stakeholder group should also be tasked with developing a process for when a measure needs to be temporarily removed from public reporting as well as eliminated from any payment determination due to changes in clinical science. The current pneumonia antibiotic timing measure is a perfect example of how problematic this can be. The NQF endorsed as a measure the percentage of pneumonia patients receiving initial antibiotics within six hours of arrival at the hospital. This measure replaced a similar one regarding the receipt of antibiotics within four hours of arrival. The four-hour measure is no longer endorsed by the NQF due to clinical concerns that, within this shorter time frame, some patients whose pneumonia diagnoses were not yet confirmed were receiving antibiotics unnecessarily. Despite the fact that the four-hour measure is no longer endorsed by the NQF, it continues to be included as a measure for Medicare's pay-for-reporting program.

**F. NEW TECHNOLOGY ADD-ON PAYMENTS (“New Technology”) (pages 24771-776)**

The MMA provided new funding for add-on payments for new medical services and technologies and provided for more reasonable approval criteria under the IPPS. This important provision was enacted to ensure that the IPPS would better account for expensive new drugs, devices and services. Yet each year only a few new technologies are approved. Currently, only three technologies receive add-on payments and only one application was evaluated by CMS for possible add-on payments in FFY 2008. The paucity of new technologies that currently are eligible for add-on payments and the paucity of applications that have been submitted over the recent past are at odds with the advances that are occurring in medical care on an almost daily basis. We urge the Agency to review its criteria for approving add-on payments for new technologies to ensure that all innovative and cutting edge services are appropriately reimbursed.

Acting Administrator Leslie Norwalk

June 12, 2007

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We also urge CMS to raise the add-on payment level for new technologies from 50 percent to 80 percent of the difference between the standard DRG payment and the cost of the procedure using the new technology. This change is supported in the MMA's report language. In addition, it would mirror the current 80 percent marginal cost factor for inpatient outlier payments.

#### **G. CONCLUSION**

Thank you for this opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health care community.

If you have questions concerning these comments, please do not hesitate to contact me or Karen Fisher, Senior Associate Vice President. We may be reached at (202) 828-0490, or [rdickler@aamc.org](mailto:rdickler@aamc.org) and [kfisher@aamc.org](mailto:kfisher@aamc.org).

Sincerely,

/S/

Robert M. Dickler  
Senior Vice President  
Division of Health Care Affairs

cc: Karen Fisher, AAMC