CMS-1428-P-104

Submitter : **Date & Time:** 07/09/2004 02:07:39

Organization :

Category : Hospital

Issue Areas/Comments

Issues 21-30

Hospitals-Within-Hospitals

The regulation as proposed requiring LTAC hospitals only receive 25% of host hospital patients for admission will result in a significant negative impact to the continuum of care in our area. LTACs have proven to provide a differentiated level of care to medically complex patients that these patients would not and will not recieve in an acute care setting nor SNF care setting.

This proposed regulation must be reconsidered and the concern of redundant Medicare payments to LTACs researched further.

Thank you.

CMS-1428-P-105

Submitter : Mrs. Melissa Himes **Date & Time:** 07/09/2004 03:07:36

Organization : Mrs. Melissa Himes

Category : Other

Issue Areas/Comments

GENERAL

GENERAL

I have been involved in the field of Graduate Medical Education for the past 13 years, originally as a Research Coordinator assisting with the publications and presentations of our residents. For the past two years I have worked in Family Practice. It has been my observation that many of our residents have relocated to rural and medically underserved communities, although they have trained in the urban area of Youngstown. It is very important for our community that we continue to have a good supply of residents to care for the needs of our underserved patients and that our teaching hospital continues to exist.

CMS-1428-P-106

Submitter : Dr. James Dewar **Date & Time:** 07/09/2004 04:07:01

Organization : Western Reserve Care System

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See Attached Comment

CMS-1428-P-107

Submitter : Mr. Roy Hinson **Date & Time:** 07/09/2004 05:07:26

Organization : Stanly Memorial Hospital, Inc.

Category : Hospital

Issue Areas/Comments

Issues 1-10

Revised MSAs

Stanly Memorial Hospital, Inc. (Stanly), Provider No. 34-0119, located at 301 Yadkin Street, Albemarle, North Carolina, 28001, respectfully submits this comment on the proposed FY 2005 hospital wage index methodology published by the Centers for Medicare & Medicaid Services (CMS) in the May 18, 2004 Federal Register.

In 2003, the Office of Management and Budget (OMB) revised the nation's Metropolitan Statistical Areas (MSAs) and created new Micropolitan Statistical Areas (Micropolitan Areas). The revisions recognized 565 Micropolitan Areas, consisting of 674 counties. Of these 674 counties, 633 were not previously assigned to an MSA, while 41 counties were and have been moved out of their MSAs into Micropolitan Areas. Stanly County, North Carolina is one of these 41 counties; it was moved from the Charlotte MSA to the newly created Albemarle Micropolitan Area.

CMS has outlined its proposal for incorporating OMB's changes into its definition of hospital labor market areas for purposes of calculating the hospital wage index. CMS plans to continue using the MSAs, as revised, to define the labor market area. However, CMS has proposed it will not use the Micropolitan Areas to define labor market areas. Instead, CMS proposes that hospitals in Micropolitan Areas will be included in the statewide rural labor market areas. Stanly believes that the 41 counties previously included in an MSA should remain there for the purpose of hospital wage index calculation, rather than be considered rural, for several reasons.

First, because a county's previous inclusion in an MSA was deliberate, it should not be quickly discounted. If a county was previously included in an MSA, the hospitals located there had an economic situation comparable to hospitals in the MSA. Although the population of Stanly County is less than that of the counties remaining in the Charlotte MSA, the Stanly County labor market is heavily impacted by its close geographic proximity to the counties in the Charlotte MSA. This is especially true now, in a time of a national nursing shortage, when hospitals are fiercely competing with each other to meet their staffing needs. Recruiting adequate staff in the shadow of nearby more urban areas is virtually impossible to do effectively without offering comparable wages.

Second, there is a significant difference between inclusion in an MSA and inclusion in the statewide rural labor market. CMS notes that the impact will, in some cases, exceed a 20% decrease in the wage index for the hospitals such as Stanly whose geographic classification has changed. With rising expenses and reduced reimbursement, such an effect could be devastating on hospitals, such as ours, providing patient care in communities away from large urban centers. Given the limited number of affected hospitals across the nation, and the potentially significant negative impact on those hospitals, the best alternative for uninterrupted patient care is to include those affected hospitals in their previous MSA.

Finally, a rural designation for Stanly County by CMS for hospital wage index purposes would be inconsistent with the Balanced Budget Act of 1997 (Act). Section 4408 of the Act reads, 'For purposes of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), the large urban area of Charlotte-Gastonia-Rock Hill-North Carolina-South Carolina may be deemed to include Stanly County, North Carolina.' Therefore, while Stanly believes that all counties previously included in an MSA and now assigned to a Micropolitan Area should remain in their previous MSA for hospital wage index purposes, Stanly's situation is unique and CMS must still consider Stanly County a part of the Charlotte MSA, consistent with the Act.

For the reasons stated above, Stanly respectfully requests that CMS continue to classify Stanly County in the Charlotte MSA for purposes of calculating the hospital wage index.

Sincerely, Roy Hinson, President, Stanly Memorial Hospital

CMS-1428-P-108

Submitter : Dr. Robert Metzger **Date & Time:** 07/09/2004 06:07:33

Organization : United Network for Organ Sharing

Category : Health Care Industry

Issue Areas/Comments

Issues 11-20

New Technology Add-On Payments

Please See Attached File.

CMS-1428-P-108-Attach-1.pdf

CMS-1428-P-108-Attach-2.pdf

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700 North 4th Street, Richmond, VA 23219
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fax: 804-782-4816
www.unos.org

Walter Graham, Executive Director

July 8, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room C5 – 14 - 03
Central Building
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Comments Regarding the Centers for Medicare and Medicaid Services (CMS) Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates – **File Code CMS – 1428 – P "Panreatic Islet Cell Transplantation"**

Ladies and Gentlemen:

Our comments on CMS' proposed changes to the Hospital Inpatient Prospective Payment Systems (File Code CMS – 1428 – P) for pancreatic islet cell transplantation focus upon two topics: (1) the proposed reimbursement of pancreatic islet costs differently from whole organ costs, and (2) the diagnosis and procedure codes proposed for pancreatic islet transplantation. The following brief preamble to our comments explains our role in organ procurement and transplantation and the context for these comments.

UNOS is a Virginia non-profit corporation that operates the National Organ Procurement and Transplantation Network (OPTN) under contract with the Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS), and pursuant to the National Organ Transplant Act of 1984, as amended (NOTA), and associated regulations. Among the duties assigned to the OPTN are responsibilities for developing and operating a national computer system for matching candidates in need of organ transplants with available donor organs and for establishing the medical criteria by which these donor organs are allocated among all candidates who are registered with the national matching system. UNOS also is tasked with providing input on proposed Federal regulations with potential impact upon the fields of organ procurement and transplantation as deemed relevant and appropriate by the OPTN/UNOS Board of Directors.

In accordance with these charges, OPTN/UNOS has developed organ-specific policies for the allocation of kidneys, livers, thoracic organs, pancreata (including islets), and intestinal organs. Also pursuant to these charges, OPTN/UNOS has established minimum procurement standards for organs that include requirements to assure organ procurement quality, safe packaging, and prevention of infectious disease transmission for diseases such as AIDS and hepatitis. The

standards anticipate challenges that result from multiple organ recovery from single donors, and try to maximize the number of transplantable donor organs.

We very much appreciate the opportunity to comment on CMS' proposed changes regarding payment for pancreatic islet transplantation. Moreover, we appreciate CMS directing attention to pancreatic islet reimbursement issues, which have been the subject of considerable discussion in multiple venues over the last few years. Comprehensive reimbursement strategies are essential to fully test the efficacy of pancreatic islet transplantation as a safe, appropriate therapy to address the debilitating effects of diabetes. It also could help facilitate pancreas recovery efforts overall, increasing use of a presently under-utilized resource, and providing relief for candidates in need of whole organ as well as pancreatic islet transplantation.

Reimbursement of Pancreatic Islet Costs Differently from Whole Organ Costs. CMS' proposal would pay for pancreatic islet transplantation costs differently from whole organ transplantation costs. The proposal supports this decision by suggesting that, "... the procurement and processing system for islet cell transplants is not the same as for solid organ transplants..." Current OPTN/UNOS policy for allocating pancreata offers all pancreata, first, for whole organ transplantation. Only a selected subset (*i.e.*, donor age > 50 years or body mass index (BMI) > 30 kg/m^2) is next offered for pancreatic islets. This policy is the product of recent revisions to the algorithm that distinguish among organs best suited for whole organ use and those best suited for islet use based upon characteristics of the donor (*i.e.*, age and BMI). The OPTN/UNOS policy provides direction to organ procurement organizations (OPOs) in recovering and placing the organs and expectations for transplant programs regarding organ availability from the time a donor is identified. The intent is to facilitate pancreas recovery and placement, whether for whole pancreas or islet transplantation. Opportunity for use of the organ for whole pancreas transplantation at the local level of organ distribution is provided for all donor pancreata, however, regardless of age and BMI. A minority of pancreata eventually are used for islet transplantation; these organs must be procured in a manner suitable for whole organ transplantation. Moreover, the whole pancreas must be procured, following the standards for quality and safety established through the OPTN, regardless of whether the organ is used for whole pancreas or pancreatic islet transplantation. The pancreas always will be recovered as a whole organ.

The proposal also offers stem cell and corneal transplant reimbursement strategies as precedent for the suggested approach to pancreatic islet transplant. We disagree with this position as well. Stem cells and corneas are procured as tissue; pancreatic islets are recovered from the whole pancreas after procurement of the whole organ. Costs of whole organ recovery are, therefore, incurred regardless of the ultimate use. Islet transplant costs incurred following organ recovery, including, for example, transportation to the processing facility, processing itself, and transportation from the procuring facility to the transplant center will then be incurred in addition to base costs of whole organ procurement.

We suggest, therefore, that OPO reimbursement for pancreas procurement be the same whether the organ ultimately is used for whole organ or pancreatic islet transplantation. In the event the final use is pancreatic islet transplantation, additional costs for transporting the islets to and from the islet processing facility and processing, itself, could be assessed and reimbursed to the OPO and processing facility accordingly.

Diagnosis and Procedure Codes for Pancreatic Islet Transplantation. CMS' proposal identifies three DRGs CMS expects would be assigned for pancreatic islet transplant cases. One of these

codes would require a simultaneous pancreatectomy and two of the codes would require a simultaneous or prior kidney transplant. We are concerned that this inappropriately restricts the type of procedure that would be covered, as well as the reimbursement that would be available. A large fraction, most likely the majority, of candidates with indications for pancreatic islet transplantation will not be kidney transplant candidates or recipients and do not appear to be addressed under the proposed DRG assignments. Those candidates who do require a combined kidney-pancreatic islet transplant often will receive the islet transplant as a procedure separate from the kidney transplant. Moreover, the proposal fails to acknowledge that, in current practice, most pancreatic islet recipients will need islet infusions from more than one donor. Additionally, approximately half of islet isolations performed do not result in yields sufficient for transplantation. This means that whole pancreas recovery costs associated with multiple donors will be designated for the same case. For pancreatic islet transplantation to be a viable therapy, the DRG must be appropriate to accommodate these situations.

We suggest, therefore, that as it does not appear that any of the proposed DRGs would suffice, CMS revise the diagnosis and procedure codes proposed for pancreatic islet transplantation to address the concerns noted above.

Again, we appreciate the opportunity to comment on this important proposal. If you have questions regarding our comments, or if we can provide information that would be useful to you as you reconsider the proposal, please do not hesitate to contact us.

Very truly yours,

Robert A. Metzger, M.D.
President

Russell H. Wiesner, M.D.
Immediate Past President

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Walter Graham, Executive Director

July 8, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room C5 – 14 - 03
Central Building
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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We suggest, therefore, that OPO reimbursement for pancreas procurement be the same whether the organ ultimately is used for whole organ or pancreatic islet transplantation. In the event the final use is pancreatic islet transplantation, additional costs for transporting the islets to and from the islet processing facility and processing, itself, could be assessed and reimbursed to the OPO and processing facility accordingly.

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Again, we appreciate the opportunity to comment on this important proposal. If you have questions regarding our comments, or if we can provide information that would be useful to you as you reconsider the proposal, please do not hesitate to contact us.

Very truly yours,

Robert A. Metzger, M.D.
President

Russell H. Wiesner, M.D.
Immediate Past President

CMS-1428-P-109

Submitter : Mrs. Ellen Kugler **Date & Time:** 07/09/2004 06:07:17

Organization : National Association of Urban Hospitals

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 11-20

Post Acute Care Transfers

See attached.

CMS-1428-P-109-Attach-1.doc

CMS-1428-P-110

Submitter : Mrs. Ellen Kugler **Date & Time:** 07/09/2004 07:07:37

Organization : National Association of Urban Hospitals

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 21-30

Hospitals-Within-Hospitals

see attached

CMS-1428-P-110-Attach-1.doc

CMS-1428-P-111

Submitter : Miss. Ellen Jones **Date & Time:** 07/09/2004 07:07:08

Organization : CHRISTUS St. Patrick Hospital

Category : Hospital

Issue Areas/Comments

Issues 21-30

Hospitals-Within-Hospitals

I have attached my letter of comment concerning recent CMS proposals which will negatively impact our patients in the Lake Charles metropolitan area.

CMS-1428-P-111-Attach-1.pdf

CHRISTUS
ST. PATRICK

July 9, 2004

Dr. Mark McClellan, PhD, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1428-P
PO Box 8010
Baltimore, MD 21244-1850

Re: CMS-1428-P Hospitals-Within-Hospitals

Dear Dr. McClellan:

I am writing to urge you to reconsider the proposed regulatory changes for long term acute care hospitals (LTCH) that are part of the CMS hospital rule for 2006. I am the administrator of CHRISTUS St. Patrick Hospital, located in Lake Charles, Louisiana. Within our facility, we have a "hospital-within-hospital" (HWH) LTCH owned and operated by Dubuis Health System. CMS' proposed changes would certainly result in the closure of this LTCH and ultimately result in a loss of treatment options for some of our most vulnerable patients.

CHRISTUS St. Patrick Hospital is a Catholic, not-for-profit hospital with a mission of helping the poor and underserved in our community. Subsequently, our hospital typically serves as the safety-net provider in our area. We have observed first hand the high level of care and enormous benefit that the Dubuis LTCH provides for our patients. It provides both a medical and spiritual continuity of care that would be a devastating loss for our patients and their families – particularly for those who choose our hospital because it is faith-based.

It is clear that CMS' primary concern is about the rapid growth in hospital-within-hospital LTCHs and the fear that host acute care hospitals are profiting by inappropriately "dumping" what would otherwise be outlier patients into LTCHs even if they are not sick enough to require that level of care. However, the arbitrary referral caps and the ban on common ownership proposed by CMS will do nothing to directly address these concerns. If CMS is concerned about the appropriateness of the care received in LTCHs and acute care hospitals, the proposed changes in regulation should be directed at those issues. MedPAC recently published a set of recommendations regarding LTCH facility and admissions standards that would seem to address CMS' concern far more directly than these proposed rules. We support the adoption of the MedPAC recommendations.

As far as the common ownership and patient dumping issues are concerned, I can assure you that CHRISTUS St. Patrick Hospital and the Dubuis LTCH are completely separate entities and our hospital administrators and physicians have no control over admissions to the LTCH. Dubuis Health System has developed, and adheres to, a very strict set of admissions criteria for their LTCHs. These criteria were refined and adopted by the National Association of Long Term Hospitals (NALTH) and they ensure that only those patients requiring the specialized care of an LTCH are actually admitted. I can also assure you that our hospital is not profiting from our Medicare patients. In fact, our hospital actually has a negative inpatient PPS margin.

I commend CMS for its efforts to identify systemic abuses and to make policy changes that will result in cost savings. Unfortunately, the proposed changes to the IPPS rule would achieve neither and would result in the closure of our LTCH. Its loss would be devastating to our community, our patients and their families.

I strongly urge CMS to reconsider these changes and their impact on patient care, patient access to care, and patient choices in care. Thank you for your attention to this matter.

Sincerely,

Ellen Jones
Chief Executive Officer

cc: The Honorable Tommy Thompson, Secretary, Department of Health and Human Services

CMS-1428-P-112

Submitter : Mrs. Ellen Kugler **Date & Time:** 07/09/2004 07:07:05

Organization : National Association of Urban Hospitals

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 21-30

Graduate Medical Education

see attached

CMS-1428-P-112-Attach-1.doc

CMS-1428-P-113

Submitter : Mr. A. James Budzinski II **Date & Time:** 07/09/2004 08:07:08

Organization : Sparrow Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Please see the attached document for Sparrow Hospital's comments on the May 18, 2004 proposed regulations.

CMS-1428-P-113-Attach-1.doc

CMS-1428-P-114

Submitter : Ms. Jeanne Dolak **Date & Time:** 07/09/2004 08:07:13

Organization : New York Presbyterian Hospital

Category : Hospital

Issue Areas/Comments

Issues 1-10

DRG Reclassifications

New York Presbyterian Hospital supports reclassification of 37.66 to DRG 103 and expansion of DRG 103 for heart transplants to include Destination Therapy and Bridge to Transplant

CMS-1428-P-115

Submitter : **Date & Time:** 07/09/2004 08:07:14

Organization :

Category : Hospital

Issue Areas/Comments

Issues 1-10

DRG Reclassifications

ghlglkglkj

CMS-1428-P-116

Submitter : Mrs. Kathy Idrissi **Date & Time:** 07/09/2004 08:07:31

Organization : New York Presbyterian Hospital

Category : Nurse Practitioner

Issue Areas/Comments

Issues 1-10

DRG Reclassifications

Please see attached

CMS-1428-P-116-Attach-1.doc

CMS-1428-P-117

Submitter : **Date & Time:** 07/09/2004 08:07:43

Organization : Michigan Health & Hospital Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

On behalf of its 143 member hospitals, the Michigan Health and Hospital Association welcomes this opportunity to comment to the Centers for Medicare & Medicaid Services regarding the proposed rule for the FY 2005 Inpatient Prospective Payment System, released on the CMS website on May 11, 2004 and published in the May 18, 2004 Federal Register. Although this rule provides a 3.3 percent market basket increase for hospitals that participate in the CMS quality initiative project, we are very concerned about other policy changes which will result in significant payment decreases for some hospitals.

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, 44 percent of Michigan hospitals experienced a negative margin on Medicare inpatient services while 74 percent experienced a negative margin on Medicare outpatient services. As such, we are gravely concerned about the consequences of the additional negative financial impact of the proposed changes, particularly implementation of the new Core Based Statistical Areas based on the 2000 Census data, the increased outlier threshold, expansion of the post-acute transfer policy, and the long term care hospital changes. These 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.

CMS-1428-P-118

Submitter : Mrs. Ellen Kugler **Date & Time:** 07/09/2004 08:07:25

Organization : National Association of Urban Hospitals

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

CMS-1428-P
NAUH Comments on Outliers.
Please see attached.

CMS-1428-P-118-Attach-1.doc

CMS-1428-P-119

Submitter : Dr. Jeanne Spencer **Date & Time:** 07/09/2004 08:07:32

Organization : Conemaugh Family Practice Residency Program

Category : Physician

Issue Areas/Comments

Issues 21-30

Graduate Medical Education

I thanks CMS for the current investigation into IME payment for teaching in non-hospital sites. Our residency has been in existance for 30+ years and we have never paid our volunteer outpatient preceptors. They teach for the academic stimulation and as a service to our community. Using this system our program has been able to place graduates in all of our surrounding small communities so that their medical needs are met. The fiscal burden of payment to the preceptors would be enormous, but more importantly paying them would make teaching a job, something they do for payment instead of something they donate for the good of humanity. I think this would lessen their motivation as we could never make teaching more finanacialy rewarding than increasing their clinical work.

I thank you for considering relieving us of the burden of teaching agreements.

In terms of redistribution of unused residency slots please consider what unused means. If for one year we had a resident leave and we were unable to replace them, or we were denied payment for an outpatient rotation, should our community lose those positions permanently? One of our denied rotations is community medicine. Because we teach our residents to work with service agencies and hospice and home health or child protective services should we lose a slot in our cap?
I thank you for your consideration.

CMS-1428-P-120

Submitter : Mrs. Ellen Kugler **Date & Time:** 07/09/2004 09:07:01

Organization : National Association of Urban Hospitals

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please see attached general letter re CMS-1428-P from the National Association of Urban Hospitals.

CMS-1428-P-120-Attach-1.doc

CMS-1428-P-121

Submitter : Ms. Anne Cordes **Date & Time:** 07/10/2004 01:07:03

Organization : Amer Academy of Hospice and Palliative Medicine

Category : Physician

Issue Areas/Comments

Issues 21-30

Graduate Medical Education

Please see attached letter.

CMS-1428-P-121-Attach-1.doc

CMS-1428-P-122

Submitter : Dr. Michael Acker **Date & Time:** 07/10/2004 12:07:27

Organization : University of Pennslyvania

Category : Physician

Issue Areas/Comments

Issues 1-10

DRG Reclassifications

The use of LVADS fro permanent or destination therapy for end stage heart failure patients who are not transplant patients has been proven effective and apprved by the FDA and CMS. Currently reimbursement for this procedure is entiely inadequate resulting in hospitals losing significant money on every procedure. The proposal to reclassify this in to the DRG for Heart Transplant with a better reimbursement rate will go a long way to allow all approbriate patients to have access to this new life saving technology.

Submitter : Dr. Robin Winter **Date & Time:** 07/10/2004 03:07:13

Organization : Association of Family Medicine Residency Directors

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Non-hospital settings: Written agreements--there is no need for CMS to require a written agreement, and appreciate the attempt to lighten the regulatory burden. However, any required payment should be payed within the cost reporting period because hospitals are unable to make a monthly payment deadline. Furthermore, if the hospital is paying the resident's salary and benefits, travel costs, etc. and the resident continues to see patients in the family practice center and take call at the sponsoring institution, there may in fact be no cost or payments to the non-hospital site. This is usually the case in Family Medicine where physicians agree to teach residents in their private offices on a volunteer basis. Would also urge a continuation of the moratorium on denying payment for volunteer teaching.

Priority for Redistribution of residency cap:

Suggest CMS move away from its current thinking that only a residency based in a rural area will provide residents who end up setting up to practice in rural areas. We are a suburban based residency program, and every year we have a least one resident choose to practice in a rural setting. Data show that Family Medicine training programs provide more physicians for rural areas than any other primary care specialty. Therefore, this should be taken into account with the redistribution of resident positions in an effort to increase the number of physicians caring for underserved populations.

Submitter : Dr. Patrick Brunett **Date & Time:** 07/11/2004 04:07:01

Organization : Oregon Health

Category : Physician

Issue Areas/Comments

Issues 21-30

Graduate Medical Education

Dear Dr. McClellan:

This letter is submitted as comment on the draft rule: 'Proposed Changes to the Hospital Inpatient Prospective Payment System for Fiscal Year 2005' published in the Federal Register on May 18, 2004.

As director of the Emergency Medicine Residency Program at Oregon Health & Science University, one of the oldest emergency medicine training programs in the country, I am pleased to provide CMS with comments on the provisions of the rule as they pertain to emergency medicine training and practice.

The long-term goal of organized emergency medicine is to assure that every patient seeking care in a U.S. emergency department will be seen by a residency-trained, board-certified emergency physician. Currently only about two-thirds of U.S. emergency departments (EDs) meet this goal. Fortunately, top medical school graduates year after year continue to seek training opportunities in pursuit of careers as emergency physicians, with a program fill rate approaching 100%.

In order for resident emergency physicians to meet ACGME and RRC requirements for clinical preparation, nearly all need to train in high volume EDs. Only by seeing large numbers of patients across a wide range of illness and injury can they gain the skills and experience necessary for the complex practice of emergency medicine.

However, the 'Application for the Increase in a Hospital's FTE Caps under Sec. 422 of the MMA' gives top priority to rural teaching hospitals. While well intentioned, this emphasis on residency programs sponsored by rural hospitals would severely limit training opportunities for high demand specialties such as emergency medicine. Most training programs, including emergency medicine, would not be able to meet ACGME accreditation requirements in rural hospitals, where the patient volume is usually quite low.

Our program in Oregon, like several others around the country, is situated in a moderate sized urban setting but serves a primarily rural state. Our teaching hospital is by necessity in a larger population center, in order to satisfy our training requirements and accreditation standards. It nevertheless trains physicians who go on to practice in hospitals in small towns or other rural areas in the region. With these facts in mind, I would strongly urge CMS to give high priority to emergency medicine residency programs that serve largely rural states.

Bio-terrorism and disaster preparedness have naturally evolved as the purview of emergency medicine over the last two decades, given its position as the vital link between public safety agencies, emergency medical services and definitive care for patients injured in mass casualty incidents. The need for a coordinated response to bio-terrorism has become even more obvious since September 11. This response system was tested recently in Portland with 'Operation Red Rose II,' a region-wide 'dirty bomb' exercise involving more than 30 government, law enforcement and medical agencies and hospitals. The successful event, under medical direction of emergency physicians, involved two simulated radiological dispersal devices detonated miles apart that produced over 300 simulated casualties, contaminated patients or other citizens seeking care. To assure that such programs continue to be a part of emergency physician training, I would urge CMS to include under 'Section C - Evaluation Criteria' recognition of programs that include bio-terrorism and disaster preparedness training and coordination with state EMS organizations and the Department of Homeland Security.

I appreciate the opportunity to offer these comments. Please contact me if you have any questions regarding these recommendations.

Patrick Brunett, MD, FACEP
Associate Professor, Department of Emergency Medicine
Director, Emergency Medicine Residency Program
Oregon Health & Science University
3181 SW Sam Jackson Park Road, CDW-EM

Portland, Oregon 97239-3098
503-494-9590
brunettp@ohsu.edu

CMS-1428-P-124-Attach-1.doc

CMS-1428-P-125

Submitter : Heather Vasek **Date & Time:** 07/11/2004 11:07:00

Organization : Texas Association for Home Care, Inc.

Category : Health Care Provider/Association

Issue Areas/Comments

Issues 31-40

Discharge Planning

Under Section 2, Implementation for Discharge Planning, CMS makes the statement 'We note that even though it was not a requirement under section 4321(a) to provide currently available information on HHAs to the public (as now required under section 1861(ee)(2)(D) of the Act as amended), we have established a Home Health Compare link on the CMS website, www.medicare.gov, that identifies HHAs that are currently participating in the Medicare or Medicaid program.' This statement is not correct. First, the Home Health Compare information on the CMS website only lists those home health agencies who have submitted OASIS data for at least six months. This means that agencies that are new to the program are not listed on the Home Health Compare site. Second, the Home Health Compare information does not accurately portray what a particular home health agency's service area is because when a search is conducted by zip code or county, it will only bring up agencies who have served a patient within that zip code or county in the past year. An agency's licensed service area may include zip codes or counties that the agency is willing and publicly states that they serve, but they have not served a patient in that county or zip code recently. Because of these significant shortcomings in the Home Health Compare website, we do not believe that CMS should instruct hospitals to rely solely on this website for a list of home health agencies to distribute to patients upon discharge. Home health agencies should be allowed to request at anytime to be placed on the hospital's list as long as they are Medicare-certified, even if they do not show up on the Home Health Compare website.

In the proposed rule, CMS proposes that hospitals provide lists of Medicare-certified SNFs located in the geographic area where the patient requests. We believe that this requirement should be extended to home health agencies as well, since in some situations a patient is being discharged to live with a relative and not to their normal place of residence, which may not be in the same geographic area as the hospital.

We would also request that CMS clarify that home health agencies who request to be placed on a hospital's list have the right to request to see a copy of that list at any time in order to verify that the information regarding their agency is current and correct. Agencies in Texas have reported that they have asked hospitals for a copy of the list they have requested to be placed upon only to be refused. In at least one instance, the agency learned from a patient that their phone number on the hospital's list was incorrect by one digit, and therefore patients were unable to contact them. The agency had provided the hospital with the correct phone number via letter, but the hospital did not have it listed correctly.

We would also request that other hospital staff other than discharge planners not discuss particular post-hospital providers with patients prior to the point the patient has selected a provider. We have received several reports from agencies where hospital floor nurses have told patients prior to discharge planning that 'The doctor is going to order home health services from XYZ Home Health agency for you.' This type of subtle steering may lead patients to believe that they have to choose the agency they think the doctor is going to order for them, or that they do not have a choice of agency at all.

We also believe that this Condition of Participation should be expanded to apply to Medicare hospice services as well, since they are considered post-hospital care services under 42 USC 1395c and 1996d(a).

CMS-1428-P-126

Submitter : Dr. Anton Kuzel **Date & Time:** 07/11/2004 11:07:05

Organization : Virginia Commonwealth University

Category : Physician

Issue Areas/Comments

Issues 21-30

Graduate Medical Education

See attached file for full comment.

CMS-1428-P-126-Attach-1.doc

CMS-1428-P-127

Submitter : Mr. David Borgert **Date & Time:** 07/12/2004 02:07:11

Organization : St. Cloud Hospital - CentraCare Health System

Category : Hospital

Issue Areas/Comments

Issues 1-10

Out-Migration of Hospital Employees

St. Cloud Hospital is located in the City of St. Cloud (in Stearns County) and in the St. Cloud Metropolitan Statistical Area (MSA) that includes both Stearns and Benton Counties in Central Minnesota. The City of St. Cloud is unique in the nation because parts of the city are located in three counties (Stearns, Benton and Sherburne) and in two MSAs. The City of St. Cloud is the largest community in those three counties. The St. Cloud MSA is adjacent to the Minneapolis-St. Paul-Bloomington MSA and part of the city (in Sherburne County) is actually located in the Minneapolis-St. Paul-Bloomington MSA. St. Cloud Hospital is physically located about 1.8 miles north of the boundary between the St. Cloud MSA and the Minneapolis-St. Paul-Bloomington MSA.

For this reason, the City of St. Cloud, in which St. Cloud Hospital is located, is an integral part of both the St. Cloud MSA and the Minneapolis-St. Paul-Bloomington MSA. In fact, because the areas are so economically and socially integrated, the Office of Management and Budget (OMB) and the Census Bureau have designated a new Minneapolis-St. Paul-St. Cloud Combined Statistical Area. The Minneapolis-St. Paul-Bloomington MSA consists of a single core based statistical area comprised of 2,388,000 people, just under the newly defined 2.5 million threshold for major urban areas throughout the country.

Section 505 of the Medicare Modernization Act (MMA) allows for hospitals that have a 10 percent out commute from their county into an adjacent area with a higher wage index to receive a Oblended wage indexO that would be higher than the home MSA wage index. We support CMS?s implementation of this provision of the MMA but note that this falls short of definitively establishing the relationships between contiguous metropolitan areas. In fact, the Office of Management and Budget noted, in the Dec. 27, 2000, Federal Register, in establishing the standards for defining metropolitan and micropolitan areas that Othe employment interchange measure offers a more appropriate measure of interaction than determining ties based on the strength of commuting in one direction only.O Unfortunately, the MMA provisions only look at the one way commute rate, which does not adequately measure the degree of social and economic integration between two adjacent metropolitan areas. Thus, we believe there is a need for CMS to address this issue directly and to include a more comprehensive measure of the interchange between adjacent MSAs.

Issues 21-30

Hospital Reclassifications

Re: Ref: CMS-1428-P ? Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2005 Rates; Proposed Rule (69 Federal Register 28196), May 18, 2004

St. Cloud Hospital is located in the City of St. Cloud (in Stearns County) and in the St. Cloud Metropolitan Statistical Area (MSA) that includes both Stearns and Benton Counties in Central Minnesota. The City of St. Cloud is unique in the nation because parts of the city are located in three counties (Stearns, Benton and Sherburne) and in two MSAs. The St. Cloud MSA is adjacent to the Minneapolis-St. Paul-Bloomington MSA and part of the city (in Sherburne County) is actually located in the Minneapolis-St. Paul-Bloomington MSA. St. Cloud Hospital is physically located about 1.8 miles north of the boundary between the St. Cloud MSA and the Minneapolis-St. Paul-Bloomington MSA.

Because the areas are so economically and socially integrated, the Office of Management and Budget (OMB) and the Census Bureau have designated a new Minneapolis-St. Paul-St. Cloud Combined Statistical Area. The Minneapolis-St. Paul-Bloomington MSA consists of a single core based statistical area comprised of 2,388,000 people, just under the newly defined 2.5 million threshold for major urban areas throughout the country. For fiscal year 2003, St. Cloud Hospital was reimbursed $22 million below its cost to provide services to Medicare patients. Not-for-profit St. Cloud Hospital is a tertiary care institution with a case mix adjustment that is higher than 27 of the 30 hospitals included in the Minneapolis-St. Paul-St. Cloud Combined Statistical Area. The hospital must compete for patients, staff and other resources with Twin Cities hospitals despite receiving almost 10 percent less in Medicare payments applicable to the 47 percent of our total patient charges accounted for by the Medicare program.

For these reasons, St. Cloud Hospital has sought a reclassification to receive the Minneapolis-St. Paul wage index for a number of years. It now appears that the hospital could become the sole acute care hospital in the MSA because all the other hospitals in the St. Cloud MSA have applied for critical access status in order to receive higher Medicare payments. Thus, the hospital finds itself in a position of needing to meet the dominant hospital criteria or, in the near future, whatever criteria are available for a single-hospital MSA.

St. Cloud Hospital supports the proposal to allow dominant hospitals (hospitals that pay at least 40 percent of all the wages paid by the hospitals geographically located in the area) that have an average hourly wage of at least 108 percent of the other hospitals in the geographic area to which they are assigned and an average hourly wage of at least 84 percent of the target MSA to be allowed to be reclassified.

St. Cloud Hospital supports the concept of a single-hospital MSA reclassification. As stated above, St. Cloud Hospital will soon find itself as a single acute care hospital in the MSA since critical access hospitals are excluded from the wage index data and all of the other hospitals in the St. Cloud MSA have been able to obtain improved Medicare payment by becoming critical access hospitals.

We recommend that CMS develop countywide or OgroupO reclassification criteria that would allow St. Cloud Hospital to be reclassified into the nearby Minneapolis-St. Paul-Bloomington MSA. The regulation could apply to areas with a CBSA in the larger area in excess of two million people, and could allow counties that are included in the Combined Statistical Area to reclassify into a contiguous MSA, such as Minneapolis-St. Paul-Bloomington MSA, that is also included in the Combined Statistical Area. The advantage of this approach is that it could be applicable even if St. Cloud Hospital was the sole hospital in a single hospital MSA.

CMS-1428-P-128

Submitter : Mr. John Anthony La Pietra **Date & Time:** 07/12/2004 05:07:55

Organization : <none>

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

RE: Docket CMS-1428-P
Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates
ISSUE: Revised MSAs

[NOTE: the links above would not work for me to access the specific issue directly, so I am making my comment here; please index it properly for the issue indicated]

I am writing to urge you to treat hospitals in Calhoun and Kalamazoo Counties as part of the same Metropolitan Statistical Area -- or at least of the same Combined Statistical Area -- for the purposes covered by this docket.

Many people can give you lots of reasons why Kalamazoo and Battle Creek, the central cities in these two counties, are still closely connected. They share the same international airport -- it bears both cities' names. They share the same media market -- and they are much closer to each other than either one is to the other city in the market, Grand Rapids.

But I speak from personal experience. I am an example of someone who lives in Calhoun County and works in Kalamazoo County. And when my father had a heart attack, his initial care was down the street at Marshall's Oaklawn Hospital -- but for further treatment he was sent to Borgess Medical Center in Kalamazoo.

If the Census Bureau cannot find enough people like me to keep the two counties in a single Metropolitan Statistical Area under the new standards, as they were in the 1990 census, they should still be considered for a Combined Statistical Area. Kalamazoo County is larger and should have "top billing" -- but Battle Creek and Calhoun County are worthy of mention as stars in the same constellation.

I urge that you support treatment of Kalamazoo and Calhoun Counties (with Van Buren County linked to western Kalamazoo County included) together as one Metropolitan Statistical Area -- or, failing that, as one Combined Statistical Area. Such a designation addresses the reality on the ground, both in general and specifically in terms of health care . . . and I believe that, if you gathered local opinion in these

two counties (as is provided for in Section 11 of OMB rules published in the December 27, 2000 _Federal Register_), you would find a majority in both communities acknowledging the connection and approving the government's formal recognition of it.

I thank you for your attention to these comments, and I hope to hear that you have taken them to heart and acted as they encourage you to do . . . to re-combine Kalamazoo and Calhoun Counties and treat them properly as being parts of the same area.

John Anthony La Pietra
386 Boyer Court
Marshall, MI 49068
269-781-9478
jalp@internet1.net

CMS-1428-P-129

Submitter : Ms. ELLEN WEISSMAN **Date & Time:** 07/10/2004 12:07:00

Organization : HODGSON RUSS, LLP

Category : Attorney/Law Firm

Issue Areas/Comments

GENERAL

GENERAL

See attached file for comments.

CMS-1428-P-129-Attach-1.doc

CMS-1428-P-130

Submitter : Mr. Edward Berger **Date & Time:** 07/10/2004 12:07:00

Organization : ABIOMED, Inc.

Category : Device Industry

Issue Areas/Comments

GENERAL

GENERAL

Please accept the two attached documents as comments on the Inpatient PPS NPRM File Code CMS-1428-P

CMS-1428-P-130-Attach-1.doc

CMS-1428-P-130-Attach-2.doc

CMS-1428-P-131

Submitter : Ms. Kathy Nelson **Date & Time:** 07/09/2004 12:07:00

Organization : Marshall Medical Center North

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

CMS-1428-P-Medicare Program;Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2005 Rates;Proposed Rule (69 Federal Register 28196), May 18, 2004
Comment letter attached in Word file

Submitter : Mr. Sean Haines **Date & Time:** 07/09/2004 12:07:00

Organization : Veritus Medicare Services

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

Please see attached file Comment 051804 FR.doc. Thanks.

CMS-1428-P-132-Attach-1.doc

CMS-1428-P-133

Submitter : Ms. Kathy Nelson **Date & Time:** 07/09/2004 12:07:00

Organization : Marshall Medical Center North

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

CMS-1428-P-Medicare Program;Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2005 Rates;Proposed Rule (69 Federal Register),May 18, 2004

CMS-1428-P-134

Submitter : Mr. Kathy Nelson **Date & Time:** 07/09/2004 12:07:00

Organization :

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

jkdjdjdj

CMS-1428-P-135

Submitter : Ms. Laura Redoutey **Date & Time:** 07/09/2004 12:07:00

Organization : Nebraska Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment

CMS-1428-P-135-Attach-1.doc

CMS-1428-P-136

Submitter : Mr. Michael Sipkoski **Date & Time:** 07/09/2004 12:07:00

Organization : St. Francis Hospital

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

The attached file is for your review.

CMS-1428-P-136-Attach-1.doc

CMS-1428-P-137

Submitter : Mrs. Ellen Kugler **Date & Time:** 07/09/2004 12:07:00

Organization : National Association of Urban Hospitals

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Comments from the National Association of Urban Hospitals re CMS-1428-P re Postacute Care Transfers

CMS-1428-P-138

Submitter : Mrs. Ellen Kugler **Date & Time:** 07/09/2004 12:07:00

Organization : National Association of Urban Hospitals

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Comments from the National Assocation of Urban Hospitals re: CMS-1428-P, Postacute Care Transfers

CMS-1428-P-139

Submitter : Mr. Gene Milton **Date & Time:** 07/09/2004 12:07:00

Organization : Hackettstown Community Hospital

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Attaching comments from Hackettstown Community Hospital on CMS-1428-P

CMS-1428-P-140

Submitter : Mr. Michael Knecht **Date & Time:** 07/09/2004 12:07:00

Organization : Bayshore Community Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

please review attached correspondence

CMS-1428-P-141

Submitter : Mr. Joseph Willey **Date & Time:** 07/09/2004 12:07:00

Organization : Katten Muchin Zavis Rosenman

Category : Attorney/Law Firm

Issue Areas/Comments

GENERAL

GENERAL

File CMS-1428-P: Comment re: Postacute Care Transfers

Submitter : Mr. James T. Kirkpatrick **Date & Time:** 07/09/2004 12:07:00

Organization : Massachusetts Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attached

Submitter : Mr. James T. Kirkpatrick **Date & Time:** 07/09/2004 12:07:00

Organization : Massachusetts Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attached

CMS-1428-P-144

Submitter : Dr. Paul Larson **Date & Time:** 07/09/2004 12:07:00

Organization : UCSF and San Francisco VA Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

RE: New Technology Applications - Kinetra

I am a movement disorders neurosurgeon at the University of California, San Francisco and the San Francisco VA Hospital. As a group we have implanted more than 500 DBS devices (both Soletra and now Kinetra), so we have a unique perspective that may be useful to you with regards to the Kinetra device.

The Kinetra represents a significant advancement in technology over the Soletra, and should be valued as such. In fact, the Kinetra is really the first "next generation" DBS device we have seen since this technology was first introduced. As you probably know, one Kinetra can be used to power two DBS electrodes, eliminating the need to implant bilateral devices. While many point to the fact that this reduces the invasiveness of the procedure and improves patient recovery time, I feel there are even more important advantages to consider. First, the use of one Kinetra versus two Soletras in my practice reduces my operating room time by at least one hour. At the current charge rates for OR time, this represents a tremendous savings. In addition, the shorter anesthesia time directly reduces the risk of perioperative complications such as stroke or heart attack, and reducing the number of total incisions by half may significantly reduce our post-operative wound healing complications. A wound not healing properly or becoming infected often necessitates IV antibiotics either by re-admission to the hospital or by a home health agency, and very commonly leads to removal and loss of the entire device. This kind of complication represents a significant cost to the entire health care system.

The Kinetra has many other advantages in the postoperative care of the patient as well. I have a number of patients who have enjoyed excellent results with DBS, but require very frequent office visits for postoperative programming to fine tune their stimulator settings. The Kinetra is the first device that allows the patient to make their own stimulator adjustments within parameters that we set for them. In one case, this decreased my office visits with a patient from once every two weeks to once every 4 months. Another excellent feature is the ability of the Kinetra to maintain its battery life above 3.6 volts. As you may know, the Soletra's battery life would fall from 3-5 years to 1-2 years if the voltage was set higher than 3.6 volts due to the circuitry design in the unit. I have a number of patients currently with Soletras that I may be "under-treating" with stimulation because I do not want to exceed the 3.6 volt level. When their Soletras do run out, I plan on replacing them with a single Kinetra unit. Finally, the Kinetra has the advantage of being immune to accidential switching off of the device by environmental factors such as magnetic fields and security devices. Although the Soletras come with a sensor that allows to user to interrogate the device and see if they have been accidentally turned off, my experience is that many of my elderly patients cannot do this readily or reliably, and resort to an urgent office or emergency room visit when their symptoms suddenly get worse.

Finally, I would like to urge you to maintain the ability of surgeons to implant these devices as a staged procedure. There are many instances, two in the last month in my practice, when it is simply too dangerous for the patient to be placed under general anesthesia immediately following a very demanding, stressful 6+ hour awake surgery. If surgeons are placed under reimbursement pressure to implant the entire device in one setting, bad clinical decisions will be made and patient complications will go up.

I would like to thank you for your consideration of these issues regarding the Kinetra, and would urge you to approve the inpatient add-on payment as well as move quicky on the outpatient request. Please do not hesitate to contact me if you have any questions.

CMS-1428-P-145

Submitter : Mrs. Ellen Kugler **Date & Time:** 07/09/2004 12:07:00

Organization : National Association of Urban Hospitals

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Comments from the National Association of Urban Hospitals RE: CMS-1428-P, postacute care transfers.

CMS-1428-P-145-Attach-1.doc

Submitter : Ms. Patricia Mariolis **Date & Time:** 07/09/2004 12:07:00

Organization : Bayshore Community Health Services

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

See attached file

CMS-1428-P-146-Attach-1.doc

CMS-1428-P-147

Submitter : Mr. Peters Willson **Date & Time:** 07/09/2004 12:07:00

Organization : National Association of Children's Hospitals

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-1428-P
Hospital Inpatient PPS Proposed Rule for FY 2005
Graduate Medical Education
Application of Section 422 to Children's Hospitals

CMS-1428-P-148

Submitter : Mr. Peters Willson **Date & Time:** 07/09/2004 12:07:00

Organization : National Association of Children's Hospitals

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

CMS-1428-P
"Hospitals-within-Hospitals"
Comments on Proposed changes to Medicare IPPS Policy
Imapct of Children's Hospitals

CMS-1428-P-148-Attach-1.doc

CMS-1428-P-149

Submitter : Mr. Peters Willson **Date & Time:** 07/09/2004 12:07:00

Organization : National Association of Children's Hospitals

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

CMS-1428-P
Hospital Inpatient PPS Proposed Rule for FY 2005
Graduate Medical Education
Application of Section 422 to Children's Hospitals

CMS-1428-P-149-Attach-1.doc

Submitter : Mr. Jeffrey Wolff **Date & Time:** 07/09/2004 12:07:00

Organization : Bayshore Community Hospital

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See attached letter

CMS-1428-P-150-Attach-1.doc

CMS-1428-P-151

Submitter : Mr. John Muldoon **Date & Time:** 07/09/2004 12:07:00

Organization : Nat'l Assoc. of Children's Hosptials and Related Institution

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

Please see attached letter for comments. Hard copy with 3 attachements will be mailed according to the instructions given in the federal register.

CMS-1428-P-151-Attach-1.doc

Submitter : Ms. Josephine D'Arpa **Date & Time:** 07/09/2004 12:07:00

Organization : Bayshore Health Community Hosp.

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

please see attached.

CMS-1428-P-153

Submitter : Mr. James Lacy **Date & Time:** 07/09/2004 12:07:00

Organization :

Category : Attorney/Law Firm

Issue Areas/Comments

GENERAL

GENERAL

Please find attached comments relating to the propsed rule relating to Hospitals-Within-Hospitals. File Code CMS - 1428 - P

CMS-1428-P-153-Attach-1.pdf

CMS-1428-P-154

Submitter : Mr. James Parobek **Date & Time:** 07/09/2004 12:07:00

Organization : Gateway Rehabilitation Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Attached are comments to the Hospital-Within-Hospital proposed rule modification.

File Code CMS - 1428 - P

CMS-1428-P-155

Submitter : Mr. Stuart Skloot **Date & Time:** 07/09/2004 12:07:00

Organization : Lenox Hill Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Please see attached file

CMS-1428-P-155-Attach-1.doc

CMS-1428-P-156

Submitter : Mr. Stan Broadway **Date & Time:** 07/09/2004 12:07:00

Organization : Southeast Reimbursement Group, LLC

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

Please consider the following comments regarding CMS-1428-P, Proposed Inpatient PPS Rule - ESRD Discharges. See attached letter.

CMS-1428-P-156-Attach-1.doc

CMS-1428-P-157

Submitter : Mr. Ben Cress **Date & Time:** 07/09/2004 12:07:00

Organization :

Category : Attorney/Law Firm

Issue Areas/Comments

GENERAL

GENERAL

Please find attached comments to the proposed rules affecting Hospitals-within-Hospitals.

File Code CMS - 1428 - P

CMS-1428-P-157-Attach-1.doc

CMS-1428-P-158

Submitter : Mr. Michael Ryan **Date & Time:** 07/09/2004 12:07:00

Organization : The Winterberry Group, Inc.

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am submitting this as a test of the system.

CMS-1428-P-158-Attach-1.doc

Submitter : Mr. Francis McGinty **Date & Time:** 07/09/2004 12:07:00

Organization : MaineHealth

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

MaineHealth
465 Congress Street ? Suite 600 ? Portland ? ME 04101-3537
207-775-7001 ? fax 207-775-7029

July 9, 2004

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1428-P,
P.O. Box 8010
Baltimore, MD 21244-1850

RE: CMS-1428-P: Medicare Program: Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005

Dear Sir/Madam:

On behalf of MaineHealth, I am pleased to comment on the proposed changes to the FY 2005 Inpatient Prospective Payment System (IPPS).

Issue:
Wage Area Definitions -
Specifically, combination of Portland MSA and Rockingham-Strafford Metro Divisions.

Comment Basis:
Proposed Rule May 18, 2004, Federal Register.

Proposed Comment:
Comment Reference CMS-1428-P [Office of Management and Budget (OMB) and Application by the Center for Medicare and Medicaid Services (CMS)]

We have reviewed the proposed rule related to the new wage area definitions and the following summarizes our comments:

We analyzed the data related to the proposed individual wage areas of the (a) Portland Maine Metropolitan Statistical Area (MSA) and (b) Rockingham-Strafford Metro Divisions. We believe, upon review of this data, that these areas should be combined. The rationale associated with this conclusion is as follows:

1. The OMB has recognized that the Northeast Wage Market is different from the National Market through its initial creation of New England County Metropolitan Areas (NECMA) and subsequent to that the New England City and Town Areas (NECTA). This is due to the fact that in New England, cities and towns are more important than county lines (which the MSAs are derived from.) Further evidence that these areas should be combined is the fact that various Maine localities are already included in NH NECTAs. For example:
- Elliot and Kittery, Maine are included in the Portsmouth NH-ME NECTA.
- Berwick, Lebanon and South Berwick, Maine are included in the Rochester-Dover NH-ME NECTA.

2. An analysis of the 3-year hourly wage data from the individual hospitals and also for the groups notes very similar wages. Specifically, in the proposed rule, the 3-year average wages for the two wage areas are 24.70 and 25.09 respectively (or within 2% of each other.)
3. An analysis of the most current year data indicates an even narrower difference in wages, specifically 26.62 and 26.90 respectively (or within 1% of each other.)
4. There is history to crossing state lines to develop various MSAs , as such, this should not be a barrier to the proposed combination. (For example, Bristol County, MA is part of the Providence, RI MSA.)
5. The Portland Maine MSA and Rockingham-Strafford Metro Division both are largely influenced by the Boston wage area, relative to its wage issues and work pool.
6. Finally, we believe that the only fair conclusion that can be drawn from the facts cited above is that the Portland Maine MSA should be grouped with the Rockingham-Strafford Metro Division (or wherever Rockingham-Strafford is ultimately deemed to be included for wage purposes.)

The above comments are directed at the development of a more appropriate labor market based on the above presented facts. We wish to thank CMS for its consideration.

Very truly yours,
Francis G. McGinty
Executive Vice President & Treasurer
MaineHealth

CMS-1428-P-159-Attach-1.doc

CMS-1428-P-160

Submitter : Mr. Jeff Samz **Date & Time:** 07/09/2004 12:07:00

Organization : Mission Hospitals

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Re: Hospitals within Hospitals

Comments from Mission Hospitals, Asheville, North Carolina on the above referenced section of CMS-1428-P are attached.

CMS-1428-P-160-Attach-1.doc

CMS-1428-P-161

Submitter : Mr. Robert Baragona **Date & Time:** 07/09/2004 12:07:00

Organization : Holy Name Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1428-P-161-Attach-1.doc

Submitter : Mr. James Wood **Date & Time:** 07/09/2004 12:07:00

Organization : Ocala Regional Medical Center

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attached letter

CMS-1428-P-162-Attach-1.pdf

CMS-1428-P-163

Submitter : Mr. Jeff Farkas **Date & Time:** 07/09/2004 12:07:00

Organization : Medtronic, Inc

Category : Device Industry

Issue Areas/Comments

GENERAL

GENERAL

See attached comment letter (also sent via Fed Ex)

CMS-1428-P-163-Attach-1.doc

CMS-1428-P-164

Submitter : Mr. Peter Marino **Date & Time:** 07/09/2004 12:07:00

Organization :

Category : Attorney/Law Firm

Issue Areas/Comments

GENERAL

GENERAL

Please see attached file.

CMS-1428-P-164-Attach-1.doc

Submitter : Ms. Ann Langan **Date & Time:** 07/09/2004 12:07:00

Organization : St. Cloud Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

July 9, 2004

Mark B. McCellan, M.D., Ph. D.
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W. Room 443-G
Washington, DC 20201

Re: CMS-1428-P Medicare Program; Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2005 Rates; Proposed Rule (69 Federal Register 28196), May 18, 2004.

Dear Dr. McClellan:

I am writing in response to the above-referenced proposed rule. In this proposed rule, the Centers for Medicare and Medicaid Services (CMS) has asked for comments on the various areas of this proposed rule. The following comments are on the section of the wage index.

Wage Index . Wage data:
In the August 1, 2002 Federal register, Final Rule for the inpatient PPS for Fiscal Year 2003, on pages 50022 and 50023, CMS has stated it will begin to collect contract labor costs and hours for management services and the following overhead services: administrative and general, housekeeping, and dietary.
We would like to have contract labor costs and hours for laundry services be added to this list.

Per review of the wage index public use file dated May 13, 2004 for the FY2005 wage index data, I counted 1,468 providers with no amount listed in line 25, column 1 for Laundry & Linen Service on W/S S-3, Part II. In addition, I also counted 1,599 providers that had less than $100,000 in salaries included on line 25, column 1 of W/S S-3, Part II. This file has 3,958 providers in total.
I believe this shows that contracted laundry services should be included in the collection of contract labor for indirect patient care services.

We propose that CMS add a line 25.01 to W/S S-3, Part II to collect the contract labor costs and hours for contracted laundry services.

We also propose that once CMS has gathered the contact labor costs and hours for indirect patient care services that these contract labor costs and hours be included in the wage index computation as soon as possible to .level the playing field. for all hospitals.

Thank you for consideration of our comments on this proposed rule. If you have any questions about these comments, please contact me at (320) 251-2700, extension 54697.

Sincerely,

Ann Langan
Reimbursement Accountant

CMS-1428-P-166

Submitter : Ms. Marilyn Litka-Klein **Date & Time:** 07/09/2004 12:07:00

Organization : Michigan Health & Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please see the MHA's attached comments regarding the FY 2005 inpatient proposed rule.

CMS-1428-P-166-Attach-1.doc

CMS-1428-P-167

Submitter : Mr. Edward Goodman **Date & Time:** 07/09/2004 12:07:00

Organization : VHA Inc.

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Comments from VHA Inc. regarding the proposed changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates

CMS-1428-P-167-Attach-1.doc

CMS-1428-P-168

Submitter : Mr. Thomas Shanahan **Date & Time:** 07/09/2004 12:07:00

Organization : Raritan bay Medical Center

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Enclosed are comments to the proposed rule.

CMS-1428-P-168-Attach-1.doc

CMS-1428-P-169

Submitter : Dr. Anne Deutsch **Date & Time:** 07/09/2004 12:07:00

Organization :

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Issue: Critical Access Hospitals and Distinct Part Units, Specifically Inpatient Rehabilitation Units

Thank you for the opportunity to comment on the "Proposed Changes to the Inpatient Prospective Payment System and Fiscal Year 2005 Rates," which were published in the May 18th Federal Register (Vol. 69, No. 96). I am a registered nurse with certification in rehabilitation nursing.

On page 28330 of the proposed rule describing critical access hospitals (CAH) regulations, it is stated that .&we are proposing that, in accordance with the requirements of section 405(g), a rehabilitation or psychiatric unit meet all the hospital conditions of participation at 42 CFR Part 482, Subpart 412&.

The CMS Manual System Pub. 100-04: Medicare Claims Processing, Transmittal 22, change request 3334, which describes the conditions of participation, specifies that existing (.converted.) inpatient rehabilitation facilities must have admitted a minimum of 50% of patients who had one of 13 medical conditions for the part of the 12-month period (designated by CMS or the Fiscal Intermediary) that is before July 1, 2004.

Given that rehabilitation units within CAH have 10 or fewer beds, it is unrealistic to expect that these units retrospectively treated a mix of patients that included 50% who had 1 of the 13 medical conditions for the part of the 12 months period prior to July 1, 2004.

I suggest that the inpatient rehabilitation units within CAH be designated as a .new unit. so that they can comply with the new regulations on a prospective basis.

Thank you for considering my request.

Anne Deutsch, RN, PhD, CRRN

CMS-1428-P-170

Submitter : Ms. Marilyn Litka-Klein **Date & Time:** 07/09/2004 12:07:00

Organization : Michigan Health & Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please see the MHA's attached comments regarding the FY 2005 inpatient proposed rule.

CMS-1428-P-171

Submitter : Ms. Kathy Francisco **Date & Time:** 07/09/2004 12:07:00

Organization : The Pinnacle Health Group, Inc

Category : Other

Issue Areas/Comments

GENERAL

GENERAL

Comment letter regarding proposed IPPS rule CMS-1428-P has been attached to this document.

CMS-1428-P-171-Attach-1.doc

CMS-1428-P-172

Submitter : Ms. Karen Kofoot **Date & Time:** 07/09/2004 12:07:00

Organization : Children's Hospitals & Clinics

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

We are sending our comments both electronically and via Fed Ex to insure they are received timely by CMS. Thank you for your attention to our concerns.

CMS-1428-P-172-Attach-1.doc

Submitter : Dr. Jeffrey Goldstein **Date & Time:** 07/09/2004 12:07:00

Organization : NYU-Hospital for Joint Diseases

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attached

CMS-1428-P-173-Attach-1.pdf

CMS-1428-P-174

Submitter : Mr. EDWARD QUINLAN **Date & Time:** 07/09/2004 12:07:00

Organization : Hospital Association of Rhode Island

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

CMS-1428-P
see attachments

CMS-1428-P-174-Attach-1.doc

CMS-1428-P-174-Attach-2.doc

CMS-1428-P-175

Submitter : Ms. Kathy Nelson **Date & Time:** 07/09/2004 12:07:00

Organization : Marshall Medical Center North

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

[CMS-1428-P]

CMS-1428-P-175-Attach-1.doc

CMS-1428-P-175-Attach-2.doc

CMS-1428-P-176

Submitter : Mr. Paul Beaudoin **Date & Time:** 07/09/2004 12:07:00

Organization : Kent Hospital

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See attached Letter

CMS-1428-P-176-Attach-1.doc

Submitter : Ms. Barbara Calvert **Date & Time:** 07/09/2004 12:07:00

Organization : Guidant Corporation

Category : Device Industry

Issue Areas/Comments

GENERAL

GENERAL

Please see attached letter.

CMS-1428-P-177-Attach-1.doc

CMS-1428-P-178

Submitter : Ms. Susan Hollander **Date & Time:** 07/09/2004 12:07:00

Organization : Catholic Healthcare West

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Attached is a comment letter from Catholic Healthcare West regarding the CMS Medicare Inpatient PPS Proposed Rule for FY05. Please confirm receipt of this document. Thank you very much.

CMS-1428-P-178-Attach-1.doc

CMS-1428-P-179

Submitter : Mr. Warren Tetz **Date & Time:** 07/09/2004 12:07:00

Organization : Glendale Adventist Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Please see attached document.

CMS-1428-P-179-Attach-1.doc

CMS-1428-P-180

Submitter : Mr. jlkaf;ds dsfka;l **Date & Time:** 07/09/2004 12:07:00

Organization :

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

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CMS-1428-P-181

Submitter : Mr. Richard MacIntosh **Date & Time:** 07/09/2004 12:07:00

Organization : Memorial Health Services

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Graduate Medical Education - The proposed rules on the redistribution of unused residency slots do not adequately address future revisions to the 1996 base year caps. Many providers have appeals pending with the PRRB that could result in changes to their caps. Would a provider currently NOT subject to redistribution (i.e. over their cap) be subject to redistribution in the future if their base year report is revised and their caps increased?

CMS-1428-P-182

Submitter : Dr. Jack Zigler **Date & Time:** 07/09/2004 12:07:00

Organization : Texas Back Institute

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Please see attached file

CMS-1428-P-182-Attach-1.pdf

CMS-1428-P-183

Submitter : Mr. Richard MacIntosh **Date & Time:** 07/09/2004 12:07:00

Organization : Memorial Health Services

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Graduate Medical Education - The proposed rules on the redistribution of unused residency slots does not adequately address providers that do not have their own 1996 caps, but do train residents under an affiliation agreement. Should a provider that was certified after the 1996 base year and is a rotation site for several approved programs, but obtains their entire cap through an affiliation agreement, be subject to the redistribution? The calculations seem to be based on post-affilition caps, but indicate reductions are to be applied to the pre-affiliation caps. This creates the potential for a negative cap at providers that obtain their entire cap through affiliation. The rules should clearly state that providers without their own 1996 caps, or pre-affiliated caps, are not subject to the redistribution provisions.

CMS-1428-P-184

Submitter : Ms. Susan Johnson **Date & Time:** 07/11/2004 12:07:00

Organization : Iowa Health Des Moines

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attached comment letter

CMS-1428-P-184-Attach-1.doc

CMS-1428-P-185

Submitter : Dr. Jonathan Cree **Date & Time:** 07/12/2004 12:07:19

Organization : ISU Family Practice Residency

Category : Physician

Issue Areas/Comments

Issues 21-30

Graduate Medical Education

Traditionally physician community attendings volunteer their teaching of residents for three reasons. 1) teaching the art and science of medicine is an inherent professional obligation and ethic. 2) the teacher gains from professional stimultation of teaching and modeling and in a small way from the work and assistance that the resident provides .3) the teacher recognizes that the parent residency program still has the administrative and salary costs of the resident.

Legislation for funding GME should recognise that the funding is needed by the parent program and is not welcomed by the volunteer teachers. If the volunteer teachers housed the administrative and residency costs then it would be appropriate to direct GME funding to the volunteer teachers. Defunding residency administrative structures will cause the closure of the basic framework of graduate medical education as it is now.

CMS-1428-P-186

Submitter : Dr. James Lloyd Michener **Date & Time:** 07/12/2004 01:07:06

Organization : DUke University Medical Center

Category : Physician

Issue Areas/Comments

Issues 21-30

Graduate Medical Education

See attached

CMS-1428-P-186-Attach-1.doc