May 3, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, DC 20510

Dear Ms. Norwalk:

We, the undersigned hospital organizations, write to urge you to eliminate two provisions in the proposed rule for the FY 2008 hospital inpatient prospective payment system (PPS). At a time when increasing numbers of people rely on the Medicare program for their health care, it is necessary to strengthen the ability of hospitals to care for patients. Yet, inexplicably, the Centers for Medicare & Medicaid Services (CMS) has chosen a different course, one that would weaken hospitals' ability to provide needed services. In its proposed rule, CMS offers two proposals that cut, by $25 billion over the next five years, Medicare payments for hospital services provided to America's seniors and disabled. The first proposal would cut all operating and capital inpatient payments by 2.4 percent in each of FY 2008 and FY 2009 for coding changes that CMS believes "might" happen with the implementation of its proposed changes to the diagnosis-related groups (DRG) classification system. The second proposal would reduce capital payments to hospitals located in urban areas. We strongly urge you to eliminate both provisions from the final regulation.

2.4 Percent Cut for Coding Changes = $24 billion over the next 5 years
CMS bases its proposal to cut hospital operating and capital payments on its misinformed concerns that hospitals would change their coding practices in response to a CMS proposal to modify the existing DRGs to account better for patients' severity of illness. CMS' proposal would reconfigure the existing 538 DRGs into 745 refined Medicare Severity DRGs (MS-DRGs). The underlying system of classifying patients and "rules of thumb" for coding under the proposed MS-DRGs is generally the same as current practice. Therefore, hospitals will have little ability to change their classification and coding practices.

There are no relevant data or experiences to support a prospective 2.4 percent cut for anticipated behavioral changes in each of the next two years. Not even in the initial years of the inpatient PPS was coding change found to be of the magnitude of CMS' proposed cuts for FY 2008 and FY 2009. This type of behavioral offset is unprecedented and unnecessary. CMS' rationale for the 2.4 percent cut stems from the recent transition of Maryland hospitals, which are excluded from Medicare's inpatient PPS, to a completely new type of classification and coding system called All Patient Refined DRGs (APR-DRGs). MS-DRGs and APR-DRGs are two completely different systems for classifying patients, and generalizing from one to the other is completely inappropriate.

Inpatient PPS hospitals have been coding under the DRG system since 1983. That's more than 20 years of experience with coding under today's system. The vast majority of hospitals already are coding as carefully and accurately as possible because of other incentives in the system to do so, such as risk adjustment in various quality reporting systems. Analysis of Medicare claims from 2001 to 2005 suggests that hospitals have been coding complications and co-morbidities (CCs) at high rates for many years. More than 70 percent of claims already include CCs. Most Medicare claims not only include CCs but also include more than 9 CCs, the maximum number accepted by Medicare's computer program for grouping cases into appropriate DRGs. CMS' proposal incorrectly assumes that hospitals have the ability to use even more CCs, but this ability is, in fact, very low and an offset is unnecessary.

Capital-related Payment Cuts = $1 billion over the next 5 years
Medicare is required to pay for the capital-related costs of inpatient hospital services to help fund Medicare's share of expenses for new facilities, renovations, expensive clinical information systems and high-tech equipment (such as MRIs and CAT scanners). Since the PPS for inpatient capital costs uses DRGs in its payment formula, the 2.4 percent cut already reduces payments for urban and rural hospitals. In addition, CMS' proposed rule would eliminate the annual update for capital payments for all hospitals in urban areas, and would eliminate additional capital payments made to large hospitals in urban areas.

These proposed cuts to capital payments would make it more difficult to purchase the advanced technology, equipment and clinical information systems that consumers have come to expect, and could have the effect of slowing clinical innovation. Capital cuts of this magnitude will disrupt the ability of urban hospitals to meet their existing long-term

financing obligations. Hospitals have committed to these improvements under the expectation that Medicare's PPS for capital-related costs would remain a stable source of income. Reducing capital payments creates significant financial difficulties for our nation's most innovative and cutting edge hospitals.

CMS has chosen a path that is in direct opposition to policy makers on Capitol Hill. In fact, 223 representatives and 43 senators recently signed letters clearly stating their opposition to any effort to cut Medicare and Medicaid funding. Hospitals cannot sustain additional cuts in an already under-funded system. In fact, according to the Medicare Payment Advisory Commission, the independent commission that advises Congress on Medicare payment policy, overall Medicare margins will reach a ten-year low in 2007 at negative 5.4 percent.

In short, there is no rationale behind imposing such dramatic cuts to hospital payments for the services that millions of our Medicare patients rely on. They are not mandated; they are not supported by Congress and they are unnecessary. At a time when Medicare should be strengthened to meet rising demand, CMS must eliminate this arbitrary and unwise provision from the final regulation. Today's—and tomorrow's—patients deserve better.

Sincerely,

Rich Umbdenstock
President
American Hospital Association

Darrell Kirsh
President
Association of American Medical Colleges

Charles N. Kahn
President
Federation of American Hospitals

Larry Gage
President
National Association of Public Hospitals and Health Systems

Margaret Reagan
Corporate Vice President
Premier, Inc.

Curt Nomomaque
President and CEO
VHA Inc.