



June 30, 2014

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1607-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record (EHR) Incentive Program

Dear Administrator Tavenner:

On behalf of the more than 104,000 osteopathic physicians and osteopathic medical students we represent nationwide, the American Osteopathic Association (AOA) and the American Association of Colleges of Osteopathic Medicine (AACOM), which represents the 30 accredited colleges of osteopathic medicine in the U.S. that deliver instruction at 41 teaching locations in 28 states, we appreciate the opportunity to comment on Medicare policies set forth in the proposed fiscal year 2015 Hospital Inpatient Prospective Payment System (IPPS) rule.

The AOA promotes public health, encourages scientific research, serves as the primary certifying body for DOs, is the accrediting agency for osteopathic medical schools, and has federal authority to accredit hospitals and other health care facilities. In the 2013-14 academic year the colleges of osteopathic medicine are educating over 23,000 future physicians – more than 20 percent of U.S. medical students.

Our comments focus on the Graduate Medical Education, Hospital Acquired Condition (HAC) Program, Hospital Value-Based Purchasing Program, Disproportionate Share Hospital Payment, and Electronic Health Record System proposals.

Proposed IME Medicare Part C Add-on Payments to Sole Community Hospitals (SCH) that are Paid According to Their Hospital-Specific Rates and Proposed Change in Methodology in Determining Payment to SCHs

Effective with discharges occurring in cost reporting periods beginning on or after October 1, 2014, the Centers for Medicare and Medicaid Services (CMS) proposes: 1) “to provide all SCHs, that are teaching hospitals, IME add-on payments for applicable discharges of Medicare Part C patients regardless of whether the SCH is paid based on the Federal rate or its hospital-specific rate; and 2) that, for purposes of the comparison of payments based on the Federal rate and the hospital specific rate for SCHs, IME add-on payments for Medicare Part C patient discharges would no longer be included in the aggregate payment under the Federal rate.”

The AOA and AACOM support add-on payments to SCHs; however, the proposal does not go far enough to provide full funding (like the urban hospitals receive) for rural hospitals that wish to provide training. Thereby Osteopathic Graduate Medical Education (OGME) development, which proportionately has more rural hospitals, is placed at a major disadvantage.

Sole community hospitals are an incredibly important source of care for millions of Americans who live in rural and geographically isolated areas. With the increased costs associated with caring for this patient population, Medicare makes payments to sole community hospitals based upon one of the following calculations that “yields the greatest aggregate payment for the cost reporting period:

- The IPPS Federal rate applicable to the hospital;
- The updated hospital-specific rate based on fiscal year (FY) 1982 costs per discharge;
- The updated hospital-specific rate based on FY 1987 costs per discharge;
- The updated hospital-specific rate based on FY 1996 costs per discharge; or
- The updated hospital-specific rate based on FY 2006 costs per discharge.”

While this reimbursement calculation is an important source for covering costs for sole community hospitals, it has an unintentional consequence in that it only covers indirect medical education costs for hospitals that had teaching programs in FY 2006, or the other three previous base year periods. By doing so, it essentially eliminates reasonable funding opportunities for sole community hospitals that have never had graduate medical education and worsens the geographical disparity of health care providers in the United States.

Seventy five percent of physicians who train in rural residency programs will practice in a rural location and about 50% of physicians will train within 50 miles of the residency program. Current policies force trainees to continue to train in urban and suburban programs and disadvantage the future health care needs of rural populations. The solution would be to allow rural hospitals to rebase their Hospital Specific Rate (HSR) in the first full 12-month Fiscal Year after a teaching hospital has started a new residency program.

In addition, **the AOA and AACOM seek clarification from CMS regarding its proposed methodology.** As part of its calculation, CMS would remove the Part A add-on prior to calculating

whether the federal rate or hospital specific rate is higher. What ramifications would the removal of the Part A add-on have on Disproportionate Share Hospital (DSH) payments?

Payments for Indirect and Direct Graduate Medical Education (GME) Costs

CMS proposes to simplify and streamline the timing of when full time equivalent (FTE) residents in new medical residency training programs are subject to the FTE resident cap, the three-year rolling average, and the Intern-and-Resident-to-bed (IRB) ratio cap, both for urban teaching hospitals that have not yet had the FTE resident caps established under 42 C.F.R. Sec. 413.79(e)(1) and for rural teaching hospitals that may or may not have FTE resident caps established under 42 C.F.R. Sec. 413.79(e)(3).

The AOA and AACOM commend CMS for acknowledging that existing policies have created challenges and complexities to the extent that the Medicare cost report instructions directed hospitals to contact their contractors for assistance in completing CMS form 2552-10. According to CMS, “if this proposal is finalized, there would no longer be a need for CMS Form 2552-10...to instruct hospitals to contact their contractor for instructions...as both hospitals and Medicare contractors would understand how to report the number of FTE residents in new programs, even when those programs have different accredited lengths.”

The AOA and AACOM support the agency’s efforts to simplify the process. The current forms are not structured to collect the information that the Medicare contracts were instructing the hospitals to provide, making it necessary for them to contact the contractors and adding a burdensome step to the process. The agency’s clarifications will help to resolve the complexities and challenges hospitals and residency programs currently face. We believe the proposal will help alleviate some of the burdens, and urge CMS to maintain the appropriate resources and staffing to provide assistance to hospitals during the application process, especially given the reduced timeline for establishing the FTE resident cap that is a part of this proposed change.

According to CMS, this proposal, if finalized, “would reduce the amount of time that the new medical residency training programs would be exempt from the FTE resident caps.” CMS believes that despite the time reduction, a program should, in most typical circumstances, have grown to its full capacity by the fifth program year; therefore the proposed policy should accommodate the FTE resident count training in the fifth and subsequent program years.

Under the proposed policy, the FTE resident caps would take effect at the beginning of the fiscal year that *precedes* the sixth program year. The AOA and AACOM are concerned that the agency’s proposal could create disincentives for hospitals starting new programs. **The AOA and AACOM recommend that CMS impose the cap established in the program’s fifth year for the cost reporting period which *follows* the start of the sixth program year.**

Proposed Changes to IME and Direct GME Policies as a Result of New OMB Labor Market Area Delineations

The agency proposes to revise its regulations concerning a hospital that was rural as of the time it started training residents in a new program(s) and is re-designated as urban for Medicare payment purposes during its cap building period. The program(s) would be able to continue growing for the remainder of the cap-building period and receive a permanent FTE resident cap adjustment for the new program(s). Once the cap-building period for the new program(s) that was started while the hospital was still rural expires, the teaching hospital that has been re-designated as urban would no longer be able to receive any additional permanent cap adjustments.

CMS proposes that the teaching hospital must be actively training residents in the new program while it is still rural in order for the hospital to continue receiving a cap adjustment for the new program. **The AOA and AACOM recommend that if new programs in rural hospitals have a letter of accreditation prior to the re-designation to urban, they should be allowed to complete their growth and cap-setting.**

With regards to participation of a re-designated hospital in a rural training track, CMS proposes a two-year transition period during which either of two conditions must be met in order for the “original” urban hospital to be able to count the residents under its rural track FTE limitation when the transition period ends. Under the first condition, the re-designated newly urban hospital must reclassify back to rural under section 412.103 of GME regulations. Under the second condition, the original urban hospital must find a new geographically rural site to participate as the rural site for purposes of the rural track.

The AOA and AACOM question whether a re-designated newly urban hospital would want to reclassify back to rural due to the financial challenges that it could create. Under the second condition, would the original urban hospital be allowed to grow its cap? Based on the agency’s own regulations, the hospital’s program would not be classified as new and therefore be unable to grow slots in a rural hospital. **The AOA and AACOM request special consideration be given to the rural and underserved areas. CMS should provide flexibility to allow the original urban hospital to increase its slots for the rural training track. The AOA and AACOM also recommend that CMS increase the transition period from two years to three years.**

Proposed Clarification of Policies on Counting Resident Time in Non-Provider Settings under Section 5504 of the Affordable Care Act

CMS provided clarification on the cost reporting dates for purposes of these provisions to ensure that it was written in accordance with the language of the Affordable Care Act (ACA). In addition, the ACA allowed for more than one hospital to incur residency training costs in a non-provider setting by allocating a proportional share of the training time that a resident spends training in that setting. The AOA and AACOM support the agency’s changes.

Proposed Changes to the Review and Award Process for Resident Slots under 5506 of ACA

CMS proposes for the purpose of applying the requirement of “no duplication of FTE slots”, it would only require that no duplication occur on a hospital-specific basis. The AOA and AACOM agree with the agency’s assessment that its current policy of applying the “no duplication of FTE slot” requirement to all hospitals instead of to each specific hospital applying for the slots has proven to be “a very complex process” and “unnecessarily burdensome.” The AOA and AACOM also agree that there is flexibility in interpreting the ACA statutory language.

In addition, CMS proposes revisions to the ranking criterion to alleviate excessive burdens and delays in awarding slots. The proposed changes would make more FTE resident slots available to award to other hospitals seeking to establish or expand a primary care or general surgery program, according to CMS.

The ACA language was clearly directed at ensuring there was as little disruption to the medical training system as possible when a hospital holding residency slots closes. This enhanced ability for CMS to award permanent residency slots while a different institution completes the training of the residents whose slots were at a now defunct hospital or program is a step toward ensuring continuity in the nation’s medical training programs. The AOA and AACOM appreciate the agency’s efforts to streamline the application and reward process for resident slots.

The AOA and AACOM call on CMS to provide more transparency in awarding slots.

According to Section 5503 of the Affordable Care Act (and by reference also Sec. 5506), hospitals that receive an increase in the otherwise applicable resident limit shall ensure during the 5-year period beginning on the date of the increase, that not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency (as determined by the Secretary). Given the overall complexities of the application process, CMS should demonstrate more clearly that the 75 percent threshold is being met. **We urge CMS to make public information about the types of residency programs that were redistributed from closed hospitals or unused slots and to what types of residency programs those slots were redistributed.**

Other IPPS Proposed Provisions

According to CMS, total Medicare payments to hospitals would decrease by \$241 million. The proposals on Hospital Acquired Conditions, Hospital Value-based Purchasing, and Disproportionate Share Hospital payments would result in additional payment reductions. Overall the AOA and AACOM are concerned about the amount of payment reductions hospitals will face if the agency’s proposals go into effect.

Hospital Acquired Condition (HAC) program

Beginning in October, hospitals with the poorest performance in reducing HACs would have their Medicare pay reduced by 1 percent. CMS estimated about 753 hospitals would lose that 1 percent, and overall payments would decrease \$330 million, or more than \$438,000 per affected hospital.

The AOA and AACOM recognize the importance of targeting hospital acquired conditions; however, certain conditions are not 100 percent preventable despite adherence to evidence-based practices. As we stated in our IPPS comment letter last year, **we urge CMS to explore how information learned from present-on-admission coding and other data sources, such as electronic health records (EHRs) and clinical data registries, could be used to better understand and prevent HACs.**

In addition, the HAC reduction program payment decreases are being layered on top of reductions already being levied on hospitals for the payments for each individual case where CMS determines there was a preventable HAC. We remain concerned that the additional penalties from the HAC reduction program will further deplete resources from the hospitals most in need of making improvements which have already been penalized in their payments for the same HAC.

Hospital Value-Based Purchasing (VBP) Program

CMS proposes to readopt the PSI 90 measure for FY 2019 Hospital VBP program and subsequent years. PSI-90 looks at rates of multiple serious complications that could have been avoided. In our June 11, 2013 comment letter on the FY 2014 IPPS proposed rule, we raised concerns about the use of this measure and urged CMS not to link hospital payments to performance on this measure.

While the AOA and AACOM support efforts to minimize unnecessary complications and infections, we questioned the adequacy of this measure. It is our understanding that this measure has been criticized for not being properly risk-adjusted and for relying on inadequately validated claims data. We caution CMS about the use of claims-based measures in the VBP program because they have shown to be unreliable.

In the FY 2014 IPPS final rule, CMS adopted a 12-month performance period for the Medicare Spending per Beneficiary (MSPB) measure for the FY 2016 Hospital VBP program of CY 2014, with a corresponding baseline period of CY 2012. CMS proposes to adopt a 12-month performance period for the FY 2017 Efficiency and Cost Reduction domain of CY 2015, with a corresponding baseline period of CY 2013.

The AOA and AACOM support efforts to target inappropriate spending in health care; however, we have concerns about the accuracy and value of this measure. **We urge CMS to move carefully as it works with this measure.** We raised these concerns in our June 11, 2013 comment letter. For example, many aspects of efficiency measurement are not well understood. It is unclear how cost variances equate with patient outcomes, and questions remain as to whether patients at low-cost hospitals can access all of the services they truly need. We also are concerned that due to this measure, hospitals may pressure physicians to arbitrarily reduce costs to the detriment of patient care. **We believe the MSPB measure needs adequate testing to determine whether it can reliably indicate better patient care.**

Disproportionate Share Hospital (DSH) Payment

As part of the Affordable Care Act, Medicare DSH payments will be reduced 75 percent by 2019. Under the proposed rule, the overall Medicare DSH payments would be cut by 1.1 percent in FY 2015 from FY 2014 levels. Medicare DSH payments would be distributed based on hospitals' uncompensated care amounts.

The AOA and AACOM continue to have misgivings about the impact the DSH reductions will have on hospitals and indigent patients. CMS must ensure that safety net hospitals have the capacity to treat those individuals who are unable to obtain health care anywhere else. **We call on CMS to closely monitor the effect of DSH payment reductions in order to protect hospitals that do not experience decreases in their uninsured population or significant increases in their Medicaid-covered patient populations.**

Electronic Health Record System

We appreciate the agency's efforts to better align quality initiatives with the Electronic Health Record Incentive payment program. **We further call on the agency to release audit findings including common mistakes and the resulting financial impact.** The provider community needs guidance in moving forward with the incentive program particularly as the penalty phase sets in. The actual impact of Stages 1 and 2 on providers and patients must be taken into consideration before moving forward with Stage 3.

Thank you for the opportunity to provide comments on the proposed changes to the Inpatient Prospective Payment System for FY 2015. The AOA and AACOM look forward to working with CMS on this and other issues of importance to the osteopathic profession.

Sincerely,



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