

# NPAF National Patient Advocate Foundation

The Patient's Voice | since 1996

## EXECUTIVE BOARD

**Nancy Davenport-Linnis**  
CEO, President  
Patient Advocate Foundation

**Edward G. Connette, Esquire**  
Board President  
Eva-Roberts, PC

**Christian Downs, MHA, JD**  
Board Vice President  
Executive Director  
Association of Community Cancer Centers

**Leah Annett, RN, BSN, MHCA**  
Board Secretary  
Nursing Director  
University Health Services  
University of Texas at Austin

**John L. Murphy**  
Board Finance Officer  
Congressional Capital Hill

**Bruce Avery, MD**  
Hematology Oncology Specialist

**Alan J. Balch, Ph.D.**  
Vice President  
Prosperity Health Partnership

**Rene Cabral-Daniels, JD, MPH**  
Vice President of Legal Programs  
Washington Community Health Foundation

**Richard D. Carter, Esquire**  
Carter & Lee  
Patient Advocate Foundation

**Dennis A. Gastineau, MD**  
Director, Human Cell Therapy Laboratory  
Division of Transfusion Medicine & Hematology  
Mayo Clinic

**Venus Grice, MA**  
Executive & CEO  
The Center for Health Law, Ethics & Policy

**The Honorable Phil Hamilton**  
Voting Board of Delegates

**Pearl Moore, RN, MN, FAAN**  
CEO, Director  
Oncology Nursing Society

**Roy Ramthun**  
President  
PMA Consulting Services

**Sheidon Weinhaus, Esquire**  
Weinhaus & Partridge

## SCIENTIFIC BOARD

**Leri Williams, PhD, DSN, RN, AOCN**  
Chief, RN Research, School of Nursing  
University of Texas  
MD Anderson Cancer Center

**David Bruzel, MD**  
Professor  
State University Health System  
Radiation Oncology Department

**Robert M. Rifkin, MD, FACP**  
Director, Clinical Therapeutics  
Rocky Mountain Blood & Marrow Transplant Program  
Rocky Mountain Cancer Centers

**F. Marc Stewart, MD**  
Professor of Medicine, University of Washington  
Fred Hutchinson Cancer Research Center

**Richard L. Theriault, DO, MBA**  
Professor of Medicine  
MD Anderson Cancer Center

## HONORARY BOARD

**The Honorable Mary I. Christian**  
Voting Board of Delegates, Ret.

**The Honorable Patrick Dougherty**  
Retired State Senator, Ret.

**Paula Trahan-Rieger, RN, MSN, ACON, FAAN**  
Chief Executive Officer  
Oncology Nursing Society

**Leo Sands**  
Executive VP & Chief Administrative Officer  
HCA Healthcare

**Boris Simonson**

## VIA OVERNIGHT COURIER

Charlene Frizzera  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attn: CMS-1406-P  
Mailstop C4-26-05  
7500 Security Blvd.  
Baltimore MD 21244-1850

Re: Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates to the Long-Term Care Hospital Prospective Payment System and Rate Year 2010 Rates (CMS-1406-P)

Dear Ms. Frizzera:

We are pleased to offer comments on the Hospital Inpatient Prospective Payment System proposed rule<sup>1</sup> and give a voice to patient needs and concerns. The advocacy activities of the National Patient Advocate Foundation (NPAF) are informed and influenced by the experience of patients who receive counseling, case management, and co-payment relief services from our companion organization, the Patient Advocate Foundation (PAF), which specializes in mediation for access to care, job retention, and relief from debt crisis resulting from a diagnosis of a chronic, debilitating or life-threatening disease. In 2008, PAF was contacted by over 9.5 million patients requesting information and/or direct professional intervention in the resolution of access disputes and it initiated the provision of direct services to 48,800 individuals. About 22% of the individuals receiving direct professional intervention from PAF were Medicare beneficiaries and about 78% were individuals dealing with a diagnosis of cancer.

## Hospital Cuts

Our nation is suffering one of the worst economic downturns in at least twenty years. According to the Bureau of Labor Statistics, the unemployment rate was 8.9% in April 2009 – up 0.4% from the previous month. Many economists expect the unemployment rate to climb to 10% before a turn-around begins to take hold. Calls to the Patient Advocate Foundation indicate a steady increase in unemployed

<sup>1</sup> 74 Fed. Reg. 24079 (May 22, 2009).

individuals who have lost their health insurance and cannot afford COBRA coverage. Seniors too are suffering because of losses to income attributable to the collapse of the stock and bond markets. The majority of callers to our toll-free assistance line are requesting financial assistance with their medical bills at a time when they are being challenged to keep up with mortgage payments, utilities, and rising food costs.

The proposed FY 2010 Inpatient Prospective Payment System rule projects a \$1 billion loss in inpatient Medicare revenue as a direct result of a negative 1.9% documentation and coding adjustment, assorted decreases in capital payments, and other wage index, coding and budget neutrality changes that together far outstrip the proposed 2.1% market basket update. Because of decisions central to the payment policies adopted in the FY 2010 proposal, even deeper inpatient cuts for hospitals are projected for FYs 2011 and 2012. This despite the fact that hospitals' are experiencing significant financial pressures due to declines in admissions, increased demands on charity care resources, tighter credit markets and losses to investments and endowment resources.

The American Hospital Association (AHA) reports most hospitals are seeing an increase in the proportion of patients unable to pay for care.<sup>2</sup> Their November 2008 survey of over 500 hospitals indicates an 8% increase in demand for uncompensated care in the third quarter in 2008 compared to the same period in 2007. This is happening at the same time that patients are confronted with reduced access to charity assistance both at hospitals and at physicians' practices. In 2007, NPAF provided testimony to the Senate Finance Committee on two occasions addressing the shrinking charitable resources available through nonprofit hospitals. Today, there are hospital systems that now only accept charity applications from completely uninsured individuals. Medicare patients struggling with copayments and deductibles simply are not eligible for charity care in the form of payment waivers at these facilities. When the proposed cuts under the Inpatient Prospective Payment System rule are combined with already shrinking charitable resources available to assist with often unaffordable out-of-pocket expenses, NPAF fears that Medicare beneficiaries will face less access to healthcare through our nation's hospitals than at any point in our country's history.

Hospitals also are seeing faster increases to their Medicaid caseloads during the economic downturn at the same time that many states are attempting to ratchet back payments for services to accommodate the surge in Medicaid enrollment and the nose-dive in state income tax revenues stemming from the growth in the ranks of the unemployed. According to the AHA survey, hospitals serving moderate to substantial percentages of Medicaid patients are experiencing rising Medicaid payment shortfalls relative to the costs of the program.

The depth of the proposed Medicare inpatient payment cuts facing hospitals for FY 2010 will make an already bad situation worse. We appreciate CMS forbearing implementation of the retrospective recovery of overpayments in 2008 and the agency's decision not to address the 2009 prospective documentation and coding

---

<sup>2</sup> American Hospital Association, "Report on the Economic Crisis: Initial Impact on Hospitals," November 2008.

adjustment and the retrospective overpayments yet either. This approach is appropriate in context of the recession's already adverse impact.

NPAF would be interested, however, in hearing more from CMS about the reliability of its actuaries' estimate of the documentation and coding adjustments necessary to account for the behavioral changes associated with the switch to MS-DRGs. The proposed rule fails to provide any explanation for how the actuaries conducted their assessment even though such information is essential to stakeholders trying to evaluate the reasonableness of the agency's conclusion that a 1.9% adjustment is required. We find this lack of transparency troubling, particularly given the central role that the documentation and coding adjustment plays in the proposed reimbursement cuts. If the adjustment could be trimmed, it would enhance the ability of hospitals to address the unusual financial pressures facing them in today's economy.

NPAF is particularly worried about the impact current and future reductions to inpatient reimbursement could have on cancer patients' access to care. We note that the majority of cancer patients require some surgery, which is typically done on an inpatient basis. We fear cuts of the magnitude detailed in the FY 2010 rule could compromise hospitals' ability to offer specialty care, including oncology services. We are especially troubled by the proposal to completely eliminate capital indirect medical education (IME) payments beginning on October 1, 2009. If CMS moves forward with this change, it will strip \$360 million in annual Medicare support from teaching hospitals, many of which serve as centers of excellence for cancer care.

This change is not statutorily mandated. Nor is it consistent with the Administration's declared "war on cancer." CMS has the authority under Social Security Act § 1866(g) to rescind the proposed elimination of the capital IME adjustment. NPAF joins the 56 Senators and 220 House Members who signed letters to CMS in May in urging the agency to rethink its position. We concur with the Members' conclusion that eliminating the capital IME adjustment "threatens the financial viability of teaching hospitals, which serve a high volume of Medicare beneficiaries and provide critical services unavailable elsewhere in communities across the country," including oncology services crucial to Medicare patients battling cancer.

Forty-five percent of hospitals reporting to the AHA November 2008 survey are either reconsidering or postponing capital expenditures as a result of current economic conditions. According to the Medicare Payment Advisory Commission's (MedPAC) March 2009 Report to Congress, capital investments and hospital construction starts reached a virtual standstill in September 2008.<sup>3</sup> Although the bond market has improved somewhat, even today, hospitals with sound financials are facing higher interest costs that could derail or delay planned improvements.<sup>4</sup>

---

<sup>3</sup>Medicare Payment Advisory Commission, 'Report to the Congress; Medicare Payment Policy', February 2009.

<sup>4</sup> *Id.*

MedPAC also reported that hospitals' Medicare margins are growing increasingly negative. Overall Medicare margins under the reimbursement policies proposed for FY 2010 will be a negative 6.9%, one percentage point lower than the negative margins in 2007.<sup>5</sup> In contrast to the realities of cuts proposed in the FY 2010 Inpatient Prospective Payment System rule, MedPAC recommended that hospitals be given a positive update of 2.7% in 2010 with receipt of the full market basket update being linked to implementation of quality improvement programs – a condition that NPAF, speaking as a voice for patients, wholeheartedly endorses.

NPAF encourages CMS to be mindful of the MedPAC recommendation and of the economic conditions currently facing hospitals and the patients they serve. We hope CMS will use the broad discretionary authority it has to design and implement a fair and workable inpatient prospective payment system to scale back the hospital payment cuts it has proposed for FY 2010. To that end, we urge CMS to reassess the need for MS-DRG documentation and coding adjustments of the magnitudes contemplated in the proposed rule and to reconsider the appropriateness of eliminating – as opposed to merely reducing – the capital IME adjustment next year and/or phasing in any necessary adjustment over several years.

#### Technology Add-Ons

NPAF supports the decision by CMS to consider additional factors for determining whether existing drugs that receive new indications can qualify as “new” for new technology add-on payment purposes. As we understand it, in addition to looking at whether a new product is similar to an existing technology and uses the same or similar mechanism of action to achieve a therapeutic outcome, CMS now plans to consider whether a new indication approved for a drug involves treatment of the same or similar type of disease and of the same or similar patient populations. Particularly in treating cancer, it is common for drugs to have clinical benefit to more than one patient population and in other forms of cancer. Therefore, we appreciate the agency's willingness to adjust its evaluation criteria for new technology add-ons, especially in the case of CLOLAR. The revised approach promises to benefit Medicare beneficiaries with cancer who need to start therapy during an inpatient stay.

\* \* \* \* \*

NPAF appreciates the demanding requirements that burden CMS today. However, we must share that in 2008, 44% of Medicare beneficiaries served through PAF were disabled patients under the age of 65. Additionally, when we looked across our Medicare population in 2008, the largest percentage of Medicare beneficiaries at PAF had an average household income of \$23,000 a year. We would urge that each decision being made relative to the Inpatient Prospective Payment System rule take into account the average household income of Medicare beneficiaries. We submit our comments and suggestions with a willingness to lend our support to you and your agency in any way moving forward.

---

<sup>5</sup> *Id.*

Thank you for the opportunity to submit comments on CMS-1406-P. If we can be of assistance, please do not hesitate to contact me.

Sincerely,

A handwritten signature in cursive script, appearing to read "Nancy Davenport-Ennis".

Nancy Davenport-Ennis  
President and Chief Executive Officer

cc: Jonathan Blum, Director, Center for Medicare Management