AMA
AMERICAN
MEDICAL
ASSOCIATION

Michael D. Maves, MD, MBA, Executive Vice President, CEO

June 12, 2007

Leslie Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS—1553—P
P.O. Box 8011
Baltimore, MD 21244-1850

Re*:* *Medicare Inpatient Prospective Payment System (IPPS) Proposed Rule*

Dear Acting Administrator Norwalk:

The American Medical Association (AMA) appreciates the opportunity to provide its views on the Centers for Medicare and Medicaid Services' (CMS) proposed rule on the Medicare Inpatient Prospective Payment System, which would make payment reforms for inpatient hospital services.

The proposed rule would implement a provision of the Deficit Reduction Act of 2005 (DRA) that would allow Medicare to refuse to reimburse hospitals for the additional costs of treating a patient that acquires a condition (including an infection) while in the hospital. The DRA requires hospitals to begin reporting secondary diagnoses that are present on the admission of patients, beginning for discharges on or after October 1, 2007. In the meantime, the DRA requires the Secretary of Health and Human Services (HHS) to select at least two secondary medical conditions that would not be paid at a higher diagnosis related group (DRG) unless they were present on admission. The conditions would need to be: (1) high cost, high volume, or both; (2) assigned to a higher paying DRG when present as a secondary diagnosis; and (3) reasonably preventable through application of evidence-based guidelines. Thus, beginning in FY 2009, these secondary medical conditions would not be reimbursed.

We are very concerned by this provision, as we believe it could have significant unintended consequences for patients. The concept of not paying for complications that are often a biological inevitability regardless of safe practice is discriminatory and could be punitive to

those patients at the greatest risk. Certain patients, including those that are older, have medical co-morbidities, or have otherwise compromised immune systems, are more susceptible to infection and other complications. Continued access to care for these patients has already become more difficult due to the costs of care and this policy could significantly compound the problem by leading hospitals to erect barriers to admission of these types of patients. Ironically, while the intent of this provision is to improve quality and reduce cost, it could have just the opposite effect if it results in the delay or denial of care to vulnerable patients until their condition has deteriorated and more extensive and expensive treatment is necessary. Refusal to reimburse hospitals for providing care for known and unavoidable medical complications is discriminatory and potentially injurious to those who are most in need of care.

We appreciate the opportunity to provide our views on the implementation of the proposed rule and look forward to working further with CMS on this important matter.

Sincerely,

Michael D. Maves, MD, MBA