Massachusetts Association of Behavioral Health Systems, Inc.

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Gary Gilberti
President

David Matteodo
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October 6, 2006

Mark McClellan, M.D. PhD, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
PO Box 8011
Baltimore, MD 21244-1850

RE: CMS-1506-P: Proposed Changes to Hospital Outpatient PPS

Dear Dr. McClellan,

On behalf of the Massachusetts Association of Behavioral Health Systems (MABHS), a statewide organization of 44 hospitals, I appreciate the opportunity to offer these comments regarding proposed Partial Hospital rates. We are extremely concerned that the proposed 15% payment reduction to Partial Hospitals may result in significant problems for our Partial Hospital programs and threatens their ongoing viability.

In Massachusetts, we have seen the situation where several years ago, there was a strong push from government and insurers to provide Partial Hospital services as a less expensive alternative to inpatient care. It also was perceived as beneficial to patients because it could provide them with extensive services, yet allow patients to remain in the community and avoid hospitalization. Many of our hospitals stepped forward and enthusiastically began providing Partial Hospital services. Patients seemed to like it, and clearly the programs had provided significant benefits.

Unfortunately, it seems that much of the initial interest in the service has waned significantly among government and insurers. We have seen programs close in Massachusetts because they could not maintain their fiscal viability. These closures are particularly unfortunate in certain parts of the State, where geographically it is not feasible for patients to travel far distances to another program. Once programs close, most if not all will probably not reopen. We have seen this occurrence with the Detoxification Programs in Massachusetts, many of which closed due to State Budget cuts, only to not reopen when conditions improved.

We fear the proposed 15% payment reduction for beginning in January, 2007 will place an additional enormous strain on our programs. The proposed cut will result in 30% reduction in payments over the last two years. Notwithstanding these reductions, partial hospital programs' costs continue to rise. How are they supposed to maintain their viability in the face of such reductions? It appears part of the reason the hospital partial programs are penalized is because of the rate methodology that CMS uses to measure costs. We believe at a minimum it would be far better to

maintain the current rate structure until a payment methodology which is derived from more reliable data is developed This would help providers understand better why they are being reimbursed a particular rate while also allowing CMS to work in a collaborative manner with providers so that access to this critical service is not threatened.

We are aware that the National Association of Psychiatric Health Systems has submitted more detailed comments on this matter. We strongly support those comments. Many of our programs are also represented by NAPHS and we urge CMS to give serious consideration to their comments.

Please do not reduce the rates for Partial Hospital programs for 2007; but rather delay or table any consideration of a rate cut until a more reliable reporting methodology is devised with input from impacted parties. Surely CMS does not want to see further closures or erosion of this very important service.

Thank you for the opportunity to offer these comments. Should you have any questions, please do not hesitate to contact me.

Sincerely,

David Matteodo, Executive Director
Massachusetts Association of Behavioral Health Systems
DMatteodo@aol.com
(617) 855-3520

1851-13

October 10, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4105-P
Mail Stop C4-4125-P
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-1506-P

Dear Ms. Novak:

On behalf of our 140 member hospitals and health care systems, the Missouri Hospital Association (MHA) welcomes the opportunity to comment on the proposed Medicare changes to the hospital outpatient prospective payment systems (PPS) for fiscal year 2007. The changes were published in the August 23, 2006, *Federal Register*.

CMS-4125-P — Hospital Quality Data

Because there are no nationally recognized outpatient performance measures, the rule proposes using inpatient quality measures to assess outpatient quality. To receive the full marketbasket update, under the outpatient PPS, this inpatient data must be submitted to the CMS' data warehouse by January 15, 2007. If hospitals fail to submit the data on inpatient measures by the deadline, they lose two percent of their outpatient annual payment update. This proposal directly ties quality data on inpatient acute care to outpatient reimbursement.

The inpatient quality measures have been tested and evaluated for specific conditions --- heart failure, acute myocardial infarction, pneumonia, and surgical care improvement. These evidence-based interventions that are appropriate for inpatient care have no documented validity for outpatient care and services. For this reason, MHA does not agree with the CMS' proposal to link outpatient reimbursement to inpatient quality data. Furthermore, MHA does not agree that the CMS has the authority to require hospital data collection outpatient services for the Hospital Quality Alliance without explicit authorization from Congress.

Like the CMS, MHA believes the collection and submission of performance data may provide an incentive to encourage hospital accountability and quality improvement specific to inpatient care. However, MHA does not believe the submission of inpatient quality data has any direct or indirect relationship on accountability and quality improvement of outpatient care.

Implementing outpatient APU based on inpatient quality measures is unfair and inappropriate. MHA believes the outpatient APU should not be implemented until there are quality measures specific to outpatient services nationally recognized and validated. These two service lines are completely different and are not interchangeable, and it is inappropriate to use inpatient measures as a proxy for outpatient services.

Recommendations
MHA recommends the CMS work with the Hospital Quality Alliance to evaluate and standardize quality measures specific to outpatient surgery patients. Until this is available, MHA is opposed to using non-outpatient quality measures for outpatient reimbursement.

Potential Effects
The financial effects of implementing this proposal on outpatient APU varies tremendously among hospitals. In a recent review of Missouri's acute care hospitals, outpatient revenues varied from 28 to 70 percent of total hospital revenues. MHA believes this proposal does not sufficiently provide the hospitals with enough notice about potential future revenue losses. This loss of financial stability may have the exact opposite effect of the proposal's intentions to improve patient care.

Time Frame
MHA does not agree with the time frame for the proposed outpatient quality measures. The rule was published in the August 23, 2006, *Federal Register,* after numerous Missouri hospitals had already finished abstracting July 2006 data for third quarter 2006 discharges. Although, comments on the rule are not due until October 10, 2006, hospitals must comply with the rule and submit third quarter discharge information to the CMS warehouse by January 15, 2007, to qualify for the update. MHA opposes any data collection or reimbursement proposal that is retrospective because it unfair to hospitals that are attempting to improve patient care and provide evidence-based interventions.

CMS-4125-P — FY 2008 IPPS RHQDAPU

The DRA requires expanding to other quality measures. Additional measures include the HCAHPS® patient perception of care survey results and the 30-day mortality for AMI, heart failure, and pneumonia patients.

The HCAHPS® are a new measure set for hospital data collection. Although Missouri hospitals have been measuring patient satisfaction internally for quite some time, they may not be using a vendor's standardized tool that requires following a defined methodology. For this reason, MHA opposes using the HCAHPS® data collection to assess the annual payment update until at least 12 months of

data has been abstracted, submitted and validated.

MHA does not believe the 30-day risk-adjusted mortality rates for AMI, heart failure, and pneumonia represent the best outcome measures that could be selected by Medicare to illustrate the quality of patient care in hospitals. MHA has concerns about using outcome measures derived from claim data which involves a process that hospitals cannot replicate.

Missouri hospitals are uncomfortable comparing 30-day post-acute care discharge mortality rate to assess inpatient care because there are potentially numerous reasons why a patient may expire after discharge that are unrelated to a particular hospital stay. Possible factors outside of the hospital's control include variances in physician care and noncompliant patient behaviors, such as not taking the prescribed medications, an individual's specific lifestyle, or morbid obesity. MHA strongly recommends that the CMS work with the Hospital Quality Alliance to identify outcome measures that better reflect the quality of inpatient hospital care.

MHA does not oppose collecting of data on the proposed measures and publishing the measures for the public. MHA opposes tying reimbursement to the quality of the data during the initial phases of data collection of new measure sets. The hospitals need time to educate staff about the new measure sets and establish processes before they can begin using the data to improve patient care. For this reason, MHA opposes the proposed new measure set because it doesn't give hospitals a transition period to collect data that will affect reimbursements.

MHA greatly appreciates the opportunity to provide comments on the proposed outpatient PPS.

Sincerely,

Wanda Marvel

Sharon Burnett, RN, MBA
Vice President of Licensure,
Regulation and Accreditation

Wanda Marvel, RN, MS
Director of Performance Measurement
and Accreditation

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Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
P.O. Box 8011
Baltimore, MD 21244-1850

Comments
for
The Centers for Medicare and Medicaid Services

File Code: CMS-1506-P

Regarding the August 23, 3006
42 CFR Parts 410, 414 et al. Medicare: Hospital Prospective Payment System and CY 2007 Payment Rates; Proposed Rule

The following comments are provided regarding the proposed regulations published in the Federal Register (FR) on August 23, 2006 to update the hospital outpatient prospective payment system for CY 2007.

1) The proposed payment rate of $208.80 for Partial Hospitalization (PHP) services is low and inadequate considering the scope of services and costs required to render PHP services. The large payment fluctuations ranging from $206.82 to $286.82 and now proposed to $208.80 for PHP services from 2001 to this proposed rate for 2007 indicates that CMS' data and analysis regarding median per diem costs for PHP services have been and remain fundamentally flawed. It is recommended that CMS further research and conduct detailed provider-level research to better understand the costs necessary to deliver PHP services in hospital and CMHC settings.

   Psychiatric partial hospitalization is a distinct and organized intensive outpatient treatment of less than 24 hours of daily care, designed to provide patients with profound or disabling mental health conditions an

individualized, coordinated, intensive, comprehensive, and multidisciplinary treatment program not provided in a regular outpatient setting. Often PHP treatment must offer a minimum of 20 hours a week of structured program provided over at least a five-day time period. The minimum patient participation is three (3) hours per day of care with a minimum of 12 hours per week. Active treatment consists of clinically recognized multi-model interventions including physician services, psychiatric evaluation, history and physical, individual/group/family psychotherapy, education and training, and occupational therapy. PHP group sizes vary with acuity of illness of the participants, but the maximum size of therapeutic group should not exceed 10.

Based upon the above criteria, generally PHP programs average approximately 6.00 FTE staff members to include a program director, therapists, nursing, technicians and program assistants totaling approximately $270,000 annually in salaries and wages. Non-salary direct operating expenses include PRN staffing, education, supplies and other operating expenses averaging approximately $55,000 annually. Generally PHP program services are delivered in approximately 2,000 square feet and entail approximately $300,000 in capital related, employee benefits, administration, plant operations, maintenance, cafeteria, medical records, and other dwelling related costs. Given PHP guidelines to include those stated above generally limiting the maximum size of therapeutic groups to 10, a well operated PHP program averages 8.00 patients per day over a 250 day annual period generating 2,000 PHP days per year. Given the above description of typical PHP services at costs of approximately $625,000 annually to deliver 2,000 PHP patient days, the average PHP cost per PHP day is approximately **$314.24**, representing a cost 50.49% higher than that of the proposed PHP rate of $208.80. ***It is recommended that CMS further research and conduct provider-level research to more accurately understand the costs necessary to deliver PHP services in hospital and CMHC settings***

and establish a more accurate rate for PHP services accordingly. It is recommended the rate for PHP services be set at approximately $314.24 per patient day, and no less than the RY 2006 rate of $245.91.

2) Please see the attached table concerning the historic rates of OPPS Psychotherapy Services and Medication Management.

Rate Year	APC 322	APC 323	APC 324	*APC 325*	APC 374
2001	$65.46	$91.75	$92.74	*$76.88*	$58.03
2002	$59.05	$88.57	$137.95	*$70.25*	$45.30
2003	$69.23	$96.91	$128.35	*$74.28*	$59.63
2004	$69.85	$101.97	$133.53	*$81.10*	$61.39
2005	$73.60	$100.23	$161.59	*$83.62*	$62.06
2006	$73.22	$97.59	$137.58	*$79.95*	$67.07
***2007**	$72.32	$105.68	$135.95	*$66.40*	$70.84
% Change	+.013%	+8.28%	<1.18%>	*<16.94%>*	+5.62%

As detailed within the table above all psychotherapy APC's encompassing CPT Codes 90801 through 90862 have been reasonably consistently valued since 2001. The proposed rates for RY 2007 also are valued consistently from RY 2006, with the major exception of Group Psychotherapy, CPT Codes 90853 and 90849 mapping to APC 325. The proposed rate of $66.40 represents a proposed decrease from RY 2006 of 16.94%.

The APC's listed above to include APC 325 are often utilized within Hospital Outpatient Psychiatric Treatment Services (OPTS) representing a range of services in a continuum of ambulatory psychiatric services. This range of services provides for the diagnosis and active treatment to individuals

with mental disorders using a variety of modalities. Generally patients who need more than eleven (11) hours of psychiatric services per week are considered for PHP services rather than this OPTS level of care. ***In order for hospitals to maintain this important level of care, at a lesser cost when compared to inpatient psychiatry and partial hospitalization, it is recommended that CMS increase the rate for APC 325 Group Psychotherapy to $82.49 which represents the average (3.18%) increase from RY 2006 to RY 2007 for the remaining psychotherapy APC's. The rate for APC 325 should be no less than the RY 2006 rate of $79.95.***

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University of Michigan
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Ann Arbor, Michigan 48105-1500
734-647-3321
734-647-0026 Fax

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P; CMS-4125-P
P.O. Box 8011
Baltimore, MD 21244-1850

October 10, 2006

Temporary Comment Number: 93492
See attached

Re: Medicare Program; Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates Proposed Rule
CMS-1506-P; CMS-4125-P
Federal Register Dated August 23, 2006

The University of Michigan Health System (UMHS) welcomes this opportunity to comment to the Centers for Medicare & Medicaid Services regarding the proposed rule to update the Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates.

Indirect Medical Education Adjustment

With the implementation of an Indirect Medical Education (IME) adjustment in the Inpatient Rehabilitation Facility prospective payment system (PPS) in the fall of 2006 each Medicare PPS except the Outpatient Prospective Payment System (OPPS) contains an IME adjustment factor. UMHS believes that the reasons cited by the Center for Medicare and Medicaid Services (CMS) as support for an IME adjustment for the Inpatient Prospective Payment System (IPPS) also apply to the OPPS. An IME adjustment is needed to reimburse providers for the higher costs incurred by major teaching hospitals to provide outpatient care services to Medicare beneficiaries. The CMS analysis titled "Impact of Proposed Changes for CY 2007 Hospital OPPS" projects that major teaching hospitals will be required to address the 23% shortfall to the market basket update ((2.6% - 3.4%)/ 3.4%).

UMHS recommends CMS implement an IME adjustment to the OPPS system as part of the CY 2007 payment rate updates.

Visits - Proposed Hospital Coding and Payments for Visits (Page 49,604)

The evaluation and management (E&M) codes are designed to record the physician activities and as a result do not provide the range and mix needed by hospitals to capture the activities performed during an encounter. As a result of the deficiency with the E&M codes, CMS has encouraged hospitals to use their internal guidelines (based on hospital resource use) to establish the CPT level code to report. UMHS believes that the CMS approach has resulted in coding inconsistencies between hospitals. In the proposed rule, CMS discusses its objective to implement national coding guidelines and the barriers to doing so, and concludes that national guidelines will not be implemented prior to calendar year 2008 because of its commitment to provide hospitals 6 – 12 months notice prior to implementation.

CMS specifically references the existing reimbursement limitation resulting from only three payment levels and proposes an expansion to five payment levels for calendar year 2007. CMS goes on to describe its intent to implement a coding system that will establish different reimbursement levels between new and established patients as well as differentiate between standard visits and consultation.

UMHS supports CMS' objective to implement national guidelines in an orderly yet timely manner that will reimburse hospitals for the efficient and effective provision of visits in hospital outpatient settings.

Wage Index (Page 49,539)

CMS believes and the UMHS agrees that using the IPPS wage index as the source of the adjustment factor for OPPS is a reasonable approach, given the integrated approach to the delivery of health care practiced at UMHS. The IPPS 2007 final rule (August 18, 2006 Federal Register page 48029) set the labor component at 69.7% of the DRG payment.

It is the UMHS' understanding that the data used to set the IPPS labor related adjustment factor does not separate inpatient and outpatient compensation. Therefore, UMHS believes that the IPPS labor related adjustment should be used by CMS to determine the reimbursement for outpatient services. At a minimum, UMHS requests that the OPPS labor-related share for 2007 be updated from the initial OPPS proposed rule of 60% (63 FR 47581, September 8, 1998), and be set at 63%, the labor-related percentage referenced by CMS in the preamble to both Table 5 and Table 6 of the 2006 OPPS final rule.

UMHS requests CMS to revise the 2007 OPPS labor related share from 60% currently proposed to 69.7%, consistent with the 2007 IPPS final rule.

Outlier Payments (Page 49,546)

With the 2006 OPPS final rule CMS set the size of the OPPS outlier pool at 1% of expected OPPS payments. In the 2007 OPPS proposed rule CMS proposes, for an

outpatient service or procedure performed by a hospital to qualify for an outlier payment, the cost of the procedure or service must exceed the OPPS reimbursement by 1.75 times plus $1,825 (the CMS set outlier fixed-dollar threshold). The hospital having incurred the outlier fixed dollar threshold would qualify for an outlier payment of 50% of the difference between the cost of the service and the computed payment for the service.

UMHS continues to believe that outpatient services that qualify for outlier payments should receive reimbursement at 80 percent of its costs above the threshold, rather than the current level of 50 percent. While teaching hospitals would incur significant non-reimbursed costs, increasing outlier reimbursement would help ameliorate the level of these losses that provide complex outpatient services. Increasing outlier reimbursement to 80% of provider cost would also make the OPPS outlier reimbursement policy consistent with the IPPS policy.

CMS proposes that for 2007, hospitals incur a 46% increase of $575 above the 2006 outlier fixed payment threshold before qualifying for outlier reimbursement. UMHS is concerned that the loss in reimbursement resulting from the increase in the outlier fixed payment threshold will be borne disproportionately by major teaching hospitals including UMHS. Analysis of 2004 and 2005 data demonstrates that outlier payments as a percent of total OPPS payments are substantially greater for major teaching hospitals than non-teaching hospitals. The concern that major teaching hospitals will suffer the majority of the proposed reduction in reimbursement was reinforced as a result of CMS not providing any analysis that would support the 46% increase in the outlier fixed dollar threshold.

UMHS recommends that CMS retain the outlier fixed payment threshold at the 2006 amount of $1,250. Further, UMHS recommends that CMS not implement an increase to the outlier fixed dollar threshold until CMS has published its conclusions and received public comments on its analysis.

Inpatient-Only Procedures (Page 49,621)

Under the Medicare regulations, providers that perform a procedure on an outpatient basis that is referenced on the Inpatient-Only procedure list, will not be reimbursed for that procedure.

CMS proposes that eight procedures would be removed from the Inpatient-Only Procedure list and therefore those procedures would qualify for OPPS reimbursement in 2007. CMS also requests hospitals review the procedures that remain on the list and as part of this comment process recommend those procedures that they feel appropriate for removal.

UMHS supports the reduction of procedures on the Inpatient-Only Procedures list. In addition UMHS believes that the determination of care and its setting (inpatient or outpatient) should reside with the physician and therefore believes that health systems that elect to perform the Inpatient-Only procedures that remain on the list should be reimbursed for the service.

Assuming the Inpatient-Only Procedure regulation is not rescinded in the 2007 OPPS final rule, these additional procedures are offered for CMS consideration for removal as part of the final rule.

CPT / HCPCS	Description
37182	Insert hepatic shunt (tips)
45563	Exploration/repair of rectum
61624	Occlusion / embolization cath

Myocardial PET Scans (Page 49,566)

CMS proposes that the reimbursement for the Positron Emission Tomography (APC 0307) be reduced from $2,484.88 in calendar 2006 to $721.26 for 2007. CMS cites the reason for the $1,763 (70%) proposed reduction: *"as myocardial PET scans are being provided more frequently at a greater number of hospitals than in the past, it is possible that most hospitals performing multiple PET scans are particularly efficient in their delivery of higher volumes of these services and, therefore, incur hospital costs that are similar to those of single scans, which are provided less commonly".*

UMHS recommends that CMS not implement the proposed 70% reduction until CMS has performed a comprehensive analysis of the appropriate reimbursement rate and received public comments on that analysis.

OPPS: Drug Administration (Page 49,599)

In 2005, CMS transitioned from using daily per visit drug administration Q codes to CPT codes. In the 2006 final rule, CMS implemented 20 of the 33 new 2006 CPT codes for drug administration. The 13 CPT codes that were not implemented included concepts such as initial, subsequent and concurrent administration, which were operationally problematic for hospitals to report. CMS instead created six HCPCS C codes that generally paralleled the 2005 CPT codes for the same services.

While hospitals were grateful for CMS' responsiveness to their concerns regarding the operational difficulties of implementing the full range of 2005 CPT codes for drug administration services, they nevertheless had to implement these CPT codes for non-Medicare payers. As such, hospitals have had to overcome those operational challenges while implementing two sets of codes for reporting certain drug administration services, depending on the payer.

UMHS recommends that in 2007, CMS implement the full set of CPT drug administration codes and eliminate the six HCPCS C codes created to parallel the 13 drug administration codes that were not implemented in 2006. This policy change eliminates the burden of having to apply and maintain two sets of codes for essentially the same services.

In addition, in 2005 and 2006 CMS provided special instructions to hospitals for the use of modifier 59 in order to ensure proper outpatient PPS payments, consistent with their claims processing logic. Since CMS did not expect any changes to coding structure for 2007, and because the agency has updated service-specific claims data from 2005, CMS no longer needs specific drug administration instructions regarding modifier 59. **UMHS supports CMS' proposal that hospitals apply modifier 59 to drug administration services using the same correct coding principles that they generally use for other outpatient PPS services.**

CMS also proposes six new APCs in 2007 that are intended to better distinguish costs related to infusions of different types and furnished over different lengths of time. Previously, payment for additional hours of infusion has been packaged due to the inability to use claims data to distinguish costs associated with infusions of different duration. However, in 2005, codes used in the outpatient department distinguished between the first hour of infusion and additional hours of infusion. Using newly available 2005 claims data, CMS proposes to assign CPT/HCPCS codes to six new drug administration level APCs, with payment rates based on the median costs from this 2005 claims data. **UMHS supports CMS' proposal to create six new drug administration APC levels which will provide more accurate payment for complex and lengthy drug administration services.**

Additionally, as part of the implementation of new drug administration codes in 2006, CMS decided to no longer allow for the reporting of separate IV pushes of the same drug. This coding instruction created a situation in which no payment is made for packaged drugs that are given as separate IV pushes. The prime example is pain management where a patient may require multiple IV pushes of morphine, but only one drug administration code could be reported. Because morphine is a packaged drug, not only would the administration services involved in the subsequent IV pushes of morphine not be reimbursed, the drug itself would not be paid. UMHS does not believe CMS' intent was to discontinue payment for this drug when it is medically necessary. **UMHS recommends that CMS make payment for a second or subsequent IV push of the same drug** by instituting a modifier, developing a new HCPCS code for the procedure, or implementing another methodology in 2007 so that an appropriate payment is made for this service.

Further, UMHS also recommends that CMS allow providers to use all available HCPCS codes for reporting drugs to reduce the administrative burden associated with reporting drugs using only HCPCS codes with the lowest increments in their descriptors.

OPPS: Observation Services (Page 49,620)

For 2007, CMS proposes to continue applying the criteria for separate payment for observation services and the coding and payment methodology for observation services that were implemented in 2006. UMHS continues to support CMS' concept of allowing the Outpatient Claims Editor logic to determine whether observation services are

separately payable. This has resulted in a simpler and less burdensome process for ensuring payment for covered outpatient observation services.

In addition, now that the process for determining whether observation is separately payable is largely "automated," CMS should explore a narrow expansion in the diagnoses for which observation may be separately paid. **Therefore, UMHS recommends that CMS consider adding syncope and dehydration as diagnoses for which observation services qualify for separate payment.**

Summary

Outpatient departments and clinics are critical components of teaching hospitals and the 2007 OPPS rule has a number of proposed changes that should be considered prior to implementation. Please contact me at (734) 647 2579 should you or your staff have any follow up questions.

Thank you again for your consideration of these comments.

Cordially,

Robert Reske
Hospital Financial Services
University of Michigan Hospitals and Health Centers

Docket Management Comment Form

Docket: CMS-1506-P - Proposed Changes to the Hospital Outpatient PPS and CY 2007 Rates; Proposed CY 2007 Update to the ASC Covered Procedures List; and Proposed Changes to the ASC Payment System and CY 2008 Payment Rates

Temporary Comment Number: 93492

Submitter: Ms. Robert Reske **Date:** 10/10/06

Organization: The University of Michigan Health Systems

Category: Hospital

Issue Areas/Comments

OPPS Impact
OPPS Impact
See attached document.

Attachments
No Attachments

Print | Comment on Another Docket | Exit

Print - Print the comment
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10/10/06

ERROR OCCURED AT CMS WEB SITE (SEE ERROR MESSAGE WHICH PREVENTED UM#S FROM SUBMITTING COMMENT ELECTRONICALLY

AS A RESULT, COMMENT SENT VIA OVERNIGHT MAIL ON 10/10/06.

PLEASE CONSIDER THESE COMMENTS TIMELY.

R Reske

734 6472579

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Gabriel Soudry, MD
Director

188

Department of Internal Medicine
Section of Nuclear Medicine

Franklin Square Hospital Center

September 15, 2006

The Honorable Mark McClellan
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

ATTN: FILE CODE CMS-1506-P

Re: Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2007 Payment Rates; Payment for PET/CT

Dear Administrator McClellan:

I am writing on behalf of Franklin Square Hospital Center to address an issue of great importance to Medicare beneficiaries with cancer. Franklin Square Hospital Center is a leading oncologic treatment centers, and treats approximately 1300 cancer patients annually. I appreciate the thoughtful attention that the Centers for Medicare and Medicaid Services (CMS) has devoted to cancer care in recent years. I am deeply concerned, however, that the substantial cuts in the payment rate for positron emission tomography with computed tomography (PET/CT) set forth on the proposed hospital outpatient rule will seriously underpay hospitals, and could compromise beneficiary access to this vital technology.

Over the past several years, PET/CT has replaced conventional PET as the standard of care for cancer patients. The fusion of PET and CT into a single imaging modality has enabled earlier diagnosis, more accurate staging, more precise treatment planning, and better therapeutic monitoring. These benefits ultimately reduce the number of invasive procedures—such as biopsies—required during cancer care, thus sparing patients pain and discomfort and saving hospitals valuable resources.

CMS proposes to reduce the Medicare payment rate for PET/CT to $865—the same rate proposed for conventional PET—from its current rate of $1,250. Based on my experience, I believe that $865 is far below the true cost to our hospital outpatient department of providing PET/CT services, and that such a reduction would significantly underpay Franklin Square Hospital Center. The proposal does not recognize the

Gabriel Soudry, MD
Director

Department of Internal Medicine
Section of Nuclear Medicine

Franklin Square
Hospital Center

important clinical and technological distinctions between PET/CT and conventional PET. In fact, the costs to Franklin Square Hospital Center of acquiring, maintaining, and operating a PET/CT scanner are substantially higher than those for a conventional PET scanner. The payment rate for PET/CT should reflect this difference.

Further, CMS bases the proposed rate reduction on only nine months of hospital claims data from 2005. This is inconsistent with the fact that hospitals typically do not update their charge masters frequently enough to account for new CPT codes that are first implemented mid-way through a calendar year. At Franklin Square Hospital Center, for example, we typically update our charge masters at least once or twice per year. Claims data from 2005 therefore does not reflect the current cost to our outpatient department of providing PET/CT.

The proposed payment rate reduction for PET/CT would seriously underpay hospitals, and risk limiting beneficiary access to this vital technology. I respectfully request that CMS maintain the current PET/CT payment rate of $1,250.

Thank you for your attention to this important matter. Please feel free to contact me for additional information.

Sincerely,

Gabriel Soudry

Gabriel Soudry, M.D.
Director, Nuclear Medicine

MedStar Health
9000 Franklin Square Drive, Baltimore, Maryland 21237-9986
phone: 443 777 7492 • *fax:* 443 777 7959

189

MED-EL CORPORATION

October 5, 2006

Dr. Mark McClellan, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
P.O. Box 8011, Baltimore, MD 21244-1850

RE: CMS-1506-P, The Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates and the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates

Dear Dr. McClellan:

I am writing to submit public comment on the proposed ruled indicated above on behalf of MED-EL Corporation, one of the world's three cochlear implant manufacturers. First, I would like to acknowledge the proposed payment increase for CY 2007 for APC 259 (cochlear implantation). Although this amount represents an approximate 7 percent increase from the current base payment rate of $23,431.00, it's still inadequate to cover the cost of both the cochlear device and hospital facility charges. As a result, access to this life-altering technology will continue to be severely compromised.

We appreciate CMS' commitment to an on-going review of their cost methodology in an effort to establish more equitable payment rates in the outpatient setting for advanced technologies such as cochlear implants. However, even with good claims data, strong evidence suggests that charge compression is a significant factor that must be considered when determining payment for high cost, device-dependent procedures. Studies sponsored by MedPAC and AdvaMed have confirmed the existence of charge compression and its adverse impact on high cost technologies such as cochlear implants and therefore we have made this the focus of our comments.

Device Dependent APCs – Cochlear Implants (APC 259)

It is reported that charge compression accounts for approximately 23% underestimation of device costs. Charge compression, decrease in charges for expensive items and increase in charges for less expensive items, has a particularly harmful impact on payment for cochlear implants since the cost of the device makes up greater than 80% of the total procedure costs. Over the past 3 or 4 years, the Lewin Group has studied CMS' cost methodology and it's adverse impact on payment for cochlear implants. Initially, it was determined that device coding errors resulted in inadequate payment for APC 259. Over the years, however, CMS has worked to overcome the limitations resulting from provider uncertainty concerning the coding of devices in a variety of ways (use of a blend of external data with claims data (using only claims that included a device code) to set the medians for device-dependent APCs and adjusting for any APC that declined more than 15 percent; use of a 50/50 blend of external data with claims data containing device codes to set APC medians; mandatory

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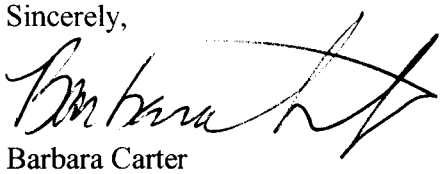
device coding for hospitals and adjustment to those device-dependent APC medians for which the CY2005 OPPS payment median was less than 95 percent of the CY2004 OPPS payment median). However, even with such adjustments, Medicare payment for cochlear implants remain inadequate. We attribute this to charge compression.

Correspondence from AdvaMed dated September, 2005, outline a number of alternatives to CMS for addressing the charge compression issue for high-cost, device dependent procedures (e.g. establish a new cost center for high-cost devices; conduct a study to determine a correction to the CMS CCR for high-cost devices; incorporate external data; and calculation of a charge de-compression factor). MED-EL supports AdvaMed's proposal and encourage CMS to work with stakeholder groups to address the issue of charge compression and it's adverse impact on high-cost, device-dependent procedures. As indicated previously, cochlear implants are especially sensitive to charge compression since the device cost represents greater than 80% of the total procedure costs.

Additionally, we recommend that CMS maintain the mandatory device coding requirement for APC 259. An independent analysis of the 2005 CMS claims database revealed that singleton claims containing the device code (L8614) and procedure code 69930, provide cost data that more accurately reflects total procedure costs for APC 259.

MED-EL Corporation appreciate your willingness to work with device manufacturers and other stakeholder groups to address the issue of charge compression so that Medicare beneficiaries will continue to have access to this life-altering technology.

Sincerely,



Barbara Carter
Manager, Reimbursement Services
MED-EL Corporation

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October 5, 2006

The Honorable Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Proposed Rule: Medicare Hospital Outpatient Prospective Payment System for CY 2007

Dear Dr. McClellan:

On behalf of LYNX Medical Systems, I welcome the opportunity to submit comments on the August 8, 2006 proposed rule relating to the Medicare hospital outpatient prospective payment system (OPPS). LYNX Medical Systems was founded in 1984 and is headquartered in Bellevue, Washington. We have been providing coding and clinical documentation support solutions for hospital emergency departments (EDs) and clinics for more than 20 years. In 2006, our products and services will help more than 350 EDs to code roughly 12 million ED visits. Our hospital ED/clinic customers are located in 35 states, and include both community hospitals (95 percent) and academic institutions (5 percent). We believe that our previous work and ongoing experience can be helpful to CMS as you continue to grapple with the issue of national coding guidelines for hospital ED and clinic services, and the comments that follow will focus on this issue.

At the outset, we wish to note that LYNX Medical Systems:

- **Supports the development of national coding guidelines;**
- **Shares CMS' view that five (5) levels of visits should be recognized for both ED and clinic visits, with national guidelines helping to assure consistent assignment to the correct service level; and**
- **Believes that problem-based guidelines offer several distinct advantages over other available alternatives, including:**
  - **The ability to produce a relatively normal distribution of five service levels;**

- **A closer link to the hospital resources typically involved in providing a certain level of visit services;**
- **A reduced risk of gaming or upcoding compared to purely intervention-based guidelines;**
- **Ease of use by hospital personnel;**
- **The ability to produce more consistent coding decisions; and**
- **The promise of a valuable tool for examining care effectiveness and efficiency (how well different hospitals do in addressing the same presenting problem or patient's reason for visit) and for constructing a pay-for-performance system.**

The comments that follow elaborate on each of these points.

Visits

The proposed rule calls for several changes in coding and payment for ED and clinic visits and critical care services. CMS is proposing to require the use of new HCPCS codes to replace the existing CPT codes for these services, and to make distinctions between two types of emergency facilities. CMS proposes to make these changes while acknowledging that national coding guidelines for ED and clinic services will not be available by the proposed effective date of January 1, 2007, meaning that hospitals would be expected to continue to use their existing internal guidelines to determine the visit levels to be reported for ED and clinic services. The proposed rule also includes an extensive discussion of coding guidelines initially developed by an expert panel convened by the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA), including a CMS critique of these guidelines, which focuses on eight general areas of CMS concern and summarizes the results of an outside contractor's study of a modified version of the AHA/AHIMA guidelines. Further, the proposed rule includes a somewhat briefer, more generic critique of coding guidelines based on: (1) the number or type of staff interventions; (2) the time staff spent with the patient; (3) a point system where a certain number of points are assigned to each staff intervention based on the time, intensity, and staff type required for the intervention; or (4) patient complexity of medical decision making or presenting complaint or medical problem. Finally, the proposed rule invites comments on a CMS-modified version of the AHA/AHIMA guidelines, and emphasizes CMS' commitment to provide a minimum of 6-12 months notice to hospitals prior to implementation of national guidelines.

LYNX Medical Systems strongly supports the development of national guidelines to help hospitals properly code their emergency department (ED) and clinic services. These are important, high volume services for Medicare and other third-party payers, and many hospitals—especially those using "home-grown" guidelines—continue to worry about whether they are properly coding these services. For this reason, **we urge CMS to avoid making major changes to the coding system for ED/clinic visits absent the**

availability of well-tested national guidelines. In fact, any new national guideline system for ED/clinic visits should be thoroughly tested before being proposed for adoption—for accuracy of coding, for inter-coder agreement, for the ability to produce a normal or near-normal distribution of visit levels, and for the degree of resource homogeneity achieved within the various service levels. It is obvious, too, that the number of levels for ED/clinic visits needs to be settled before more definitive work on national guidelines will be possible; this is an open issue subject to comment, and LYNX anticipates that CMS will receive comments on this issue. However, as noted earlier, **LYNX Medical Systems believes that five (5) levels of visits should be recognized for both ED and clinic visits.** This will more properly recognize the full range of hospital resources applied to the care of patients presenting with a wide range of medical problems and concerns.

Finally, given the importance of national guidelines for coding ED/clinic visits and the degree of uncertainty regarding the potential impact of CMS-revised AHA/AHIMA guidelines, more work needs to be done and a more definitive guideline proposal should be brought back for public comment. As noted immediately above, this additional work should include extensive testing of promising guidelines in order to assure that they will meet the needs of all stakeholders.

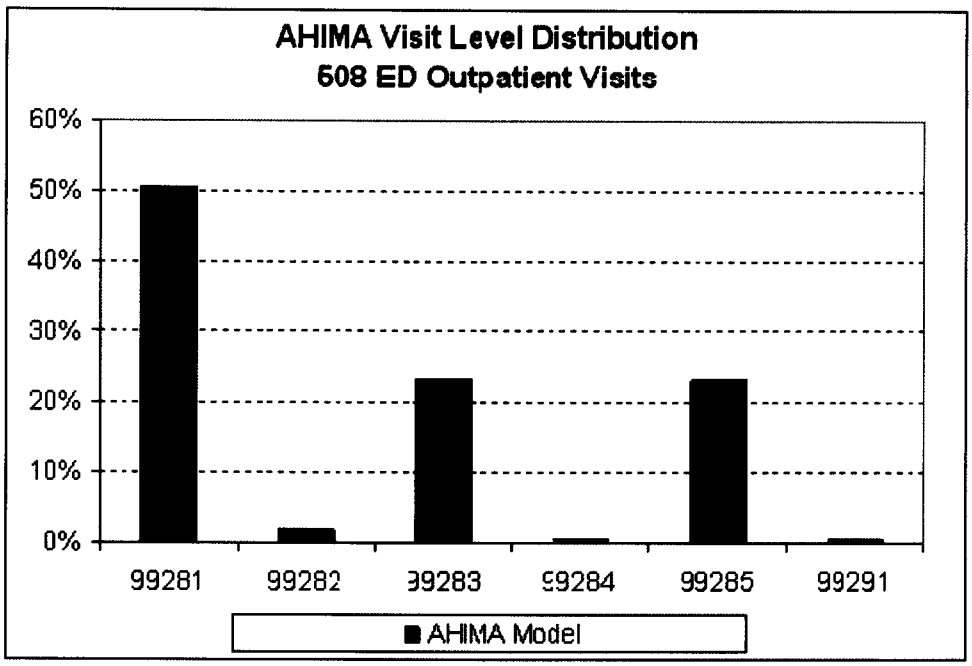
Concerns Regarding the Revised AHA/AHIMA Guidelines

As noted above, the August 8, 2006 proposed rule articulated eight general areas of CMS concern with the AHA/AHIMA guidelines. We would emphasize just a few points.

First, the AHA/AHIMA guidelines, even as revised, are a purely intervention-based system. This means that interventions (needed or not) will determine the visit level. As CMS recognizes, this type of system, once put in place, **could provide undesirable incentives for providing unnecessary interventions or for "upcoding" the care given to a particular patient.**

Second, the system, even as recently modified by CMS, does not appear to come close to producing a normal distribution of services, one criterion CMS has identified as important since as far back as 2002. The independent contractor hired by CMS to evaluate the revised AHA/AHIMA guidelines reported that, of the 750 cases examined, the vast majority of the clinic and emergency visits would have been assigned to Level 1. This could, of course, be due to the fact that important information relating to the care provided during these visits was not available to the contractor, or was not documented in the medical record (something that might well change if and when intervention-based guidelines and the incentives that go with them were put in place). In any case, LYNX expert coders have confirmed the CMS contractor's findings after an audit of the medical records for 508 ED visits from a large volume Level 2 trauma center with

an admission rate from the ED of 23 percent (a high acuity facility), applying the CMS-modified version of the AHA/AHIMA guidelines posted on the agency's Web site. In particular, as noted in the bar chart that follows, they found that relatively few services would be assigned to levels 2 or 4.



Third, many of the interventions listed in the AHA/AHIMA guidelines (for example, tracheal suctioning via tracheostomy, traction set-up, and assistance with or performance of fecal disimpaction) **would apply to only a limited number of encounters, meaning they would rarely be relevant in selecting the most appropriate service level.**

Finally, as noted in the proposed rule, **the CMS contractor identified a number of elements in the guidelines that were difficult for coders to interpret, poorly defined, nonspecific, or regularly unavailable in the medical records.** The contractor's coders were unable to determine any level of service for about 25 percent of clinic cases and about 20 percent of ED cases.

The proposed rule notes that the CMS contractor's study, which began in September 2004 and concluded in September 2005, attempted to apply "modified AHA/AHIMA guidelines." The "Draft Visit Guidelines for Hospital Outpatient Care" posted on the CMS Web site carry a "last revised" date of June 1, 2006, almost a year after completion of the contractor's study. We presume this means that **the latest modification of the AHA/AHIMA guidelines has not been tested, and we believe that careful testing will be key to the adoption of appropriate national guidelines.** In any case, we would suggest that the criticisms leveled by CMS, the results of the special contractor evaluation of modified AHA/AHIMA guidelines commissioned by CMS, and the additional comments and data provided above indicate that more than minor modifications

to these guidelines would be needed to make them workable. In sum, we do not believe that the latest modification to the AHA/AHIMA guidelines shows any promise of achieving important goals identified by CMS (such as a normal distribution of visit levels).

Principles to Guide National Guideline Development

Over the years, CMS has identified a long list of desirable attributes for ED and clinic visit coding guidelines. Among these is that the coding methodology must be reasonably based on the resources utilized during the visit. Said another way, the system should map the provided services or combination of services to the different levels of effort represented by the visit codes. CMS has also said that the guidelines should be tied to actual resource consumption, such as the number and type of staff interventions, staff time, clinical examples or patient acuity. In the November 7, 2003 issue of the *Federal Register* notice, CMS also noted that guidelines should minimize incentives to provide unnecessary or low quality care, or to upcode the level of care provided. **We believe that a problem-based system (or one based on the patient's reason for visit) has a much greater chance of meeting these closely related goals compared to a purely intervention-based system**, such as the modified AHA/AHIMA guidelines.

Another major advantage of a presenting problem-based guideline for ED and clinic visits is that it could be used to examine care effectiveness and efficiency (that is, how well different hospitals do in addressing the same presenting problem or reason for visit), and even to construct a pay-for-performance system. Guidelines based on presenting problem or reason for visit would facilitate meaningful comparisons of performance across institutions, providing a readily understandable common element for analysis—the reason for the patient's visit to the ED or hospital clinic. Such a system would, for example, allow one to compare how different hospitals responded to patients presenting with the same problem, such as chest pain, wheezing, or slurred speech. This system could also help hospitals improve the quality of the services they provide, better capture resource use, and even produce useful information for beneficiaries. For example, hospitals could gain a better appreciation for how their approach to a given presenting problem compares with that followed by other facilities, and they could also measure changes in their performance over time. Ultimately, guidelines based on presenting problem could provide a tool for constructing a pay-for-performance program focusing on the outcomes and efficiency of hospital responses to patients' presenting problems in both the ED and clinic settings. All of this may explain why most payers are already interested in knowing what a patient's reason for visit was. Also, a problem-based system would be more consistent with CMS efforts to refine its Medicare inpatient prospective payment system patient classification system based on the patient's severity of illness, which is highly dependent upon the patient's underlying problem.

Other important principles for national coding guidelines would include the following:

- The system should produce a normal or near-normal distribution of services.
- The guidelines should be clear and whatever system is adopted should produce a high level of inter-coder agreement.
- The guidelines should not be administratively burdensome for hospitals.

A Problem-Based Approach

LYNX Medical Systems has developed one model of a problem-based approach for coding ED and clinic services. Our system begins by considering the patient's presenting problem or reason for visit, since a hospital's response and the associated resource expenditure are largely determined by the patient's presenting problem. Under our approach, the presenting problem is defined as a patient's chief complaint interpreted by a clinician. Working with the Oregon Health Sciences University, we developed a master list of more than 200 presenting problems, some of which are age and gender-specific. In the ED, examples of presenting problems recognized under our system include dysuria, chest pain (adult), altered mental status, and dizziness.

Under the LYNX system, base points are assigned based on the minimum resources that would be required to evaluate essentially every case with a particular presenting problem. For example, in the case of ED services, the base weights account for: nursing and ancillary staff involvement for a routine arrival, triage, registration, basic patient/family communications, and routine discharge; the room time; creation of a medical record; and coding and billing. We developed these based weights by taking into account a large data set of hospital charges.

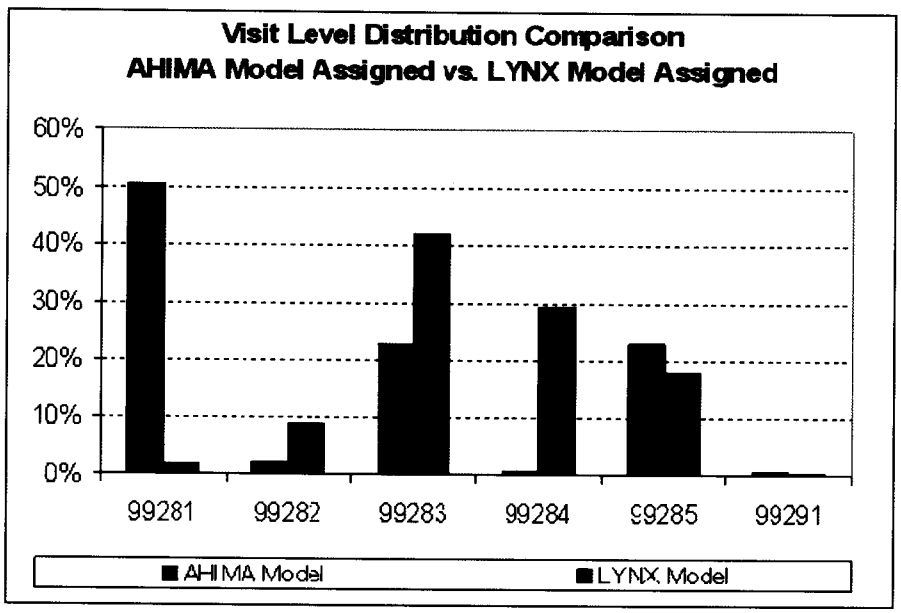
Under the LYNX model, additional points are assigned to a visit based on a relatively modest number of additional factors (to the extent they apply to an individual patient). For example, focusing on ED services, extra points can be assigned for:

- mode of arrival (for example, if a patient arrives by advanced life support transport);
- order management (for example, ED staff management of lab/diagnostic test orders);
- process management (for example, management of a significant patient behavioral issue);
- nursing assessment (for multiple nursing notes); and

- patient disposition (for example, immediate referral to a physician's office or clinic for further treatment).

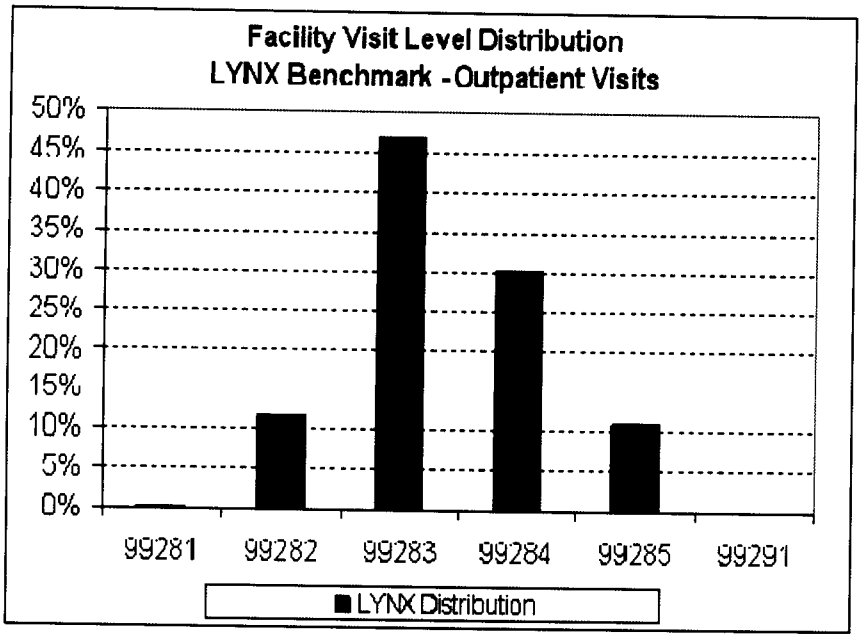
Thus, the system is not purely problem-based but also captures the impact of certain factors known to affect the hospital resources required during a particular patient visit. The total points assigned to a particular ED or clinic visit are used to determine the visit level that should be reported.

Our point system was developed by taking into account the resources typically associated with various presenting problems and certain additional factors (using hospital charges as a proxy for resources). And from the very beginning, **our goal was to develop a system that would produce as normal a distribution of service levels as possible.** As noted in the bar chart below, our system is much more successful in attaining that goal than is the latest modification to the AHA/AHIMA guidelines.

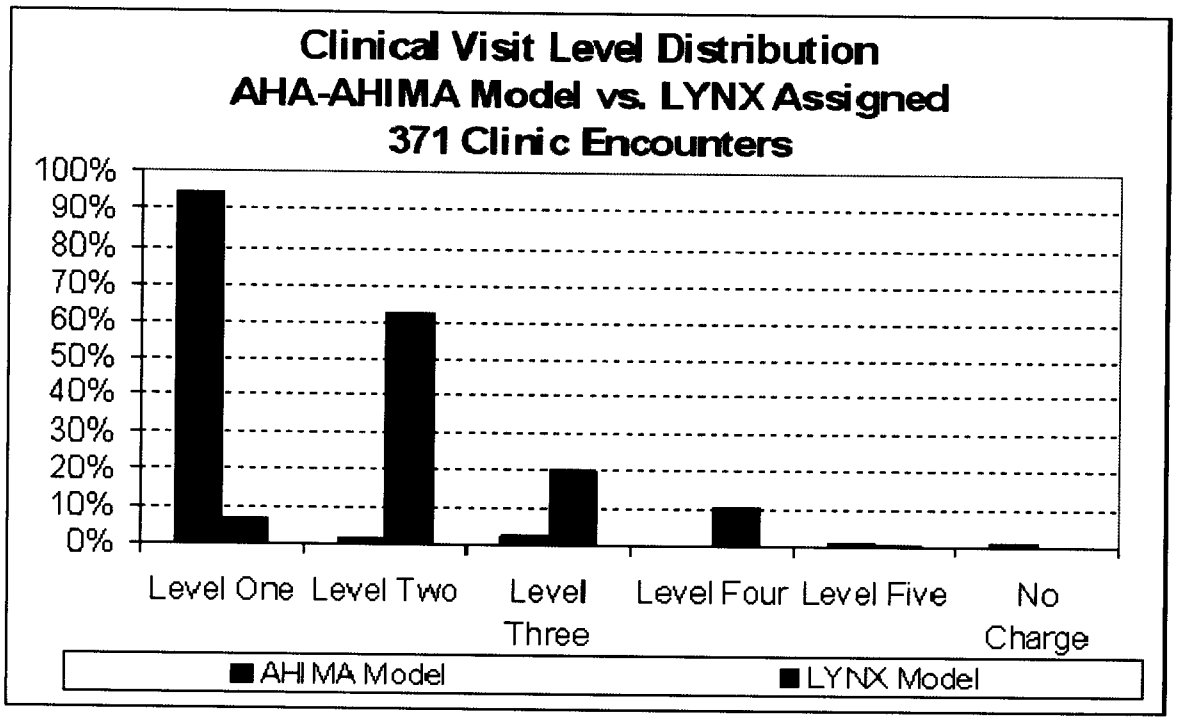


Please note that the above distribution of visits under the LYNX system is based on the recent audit of cases from a single emergency department known to have a relatively high acuity case-load.

Data from over 3 million ED visits in 2005 confirm the ability of a problem-based system to produce a near normal distribution of visit levels as noted in the bar graph that follows.



LYNX Medical Systems also performed two clinic chart audits to compare the CMS-revised AHA/AHIMA clinic facility coding model (AHA/AHIMA Model) against a problem-based approach (LYNX Model). Both audits consisted of an identical set of 317 clinic encounters representing several different outpatient clinics at a large tertiary medical center. The figure below illustrates the visit level distribution resulting from implementing both the problem-based approach and the modified AHA/AHIMA model.



This graphical comparison compares the performance of the two coding models relative to quantitative CMS criteria below:

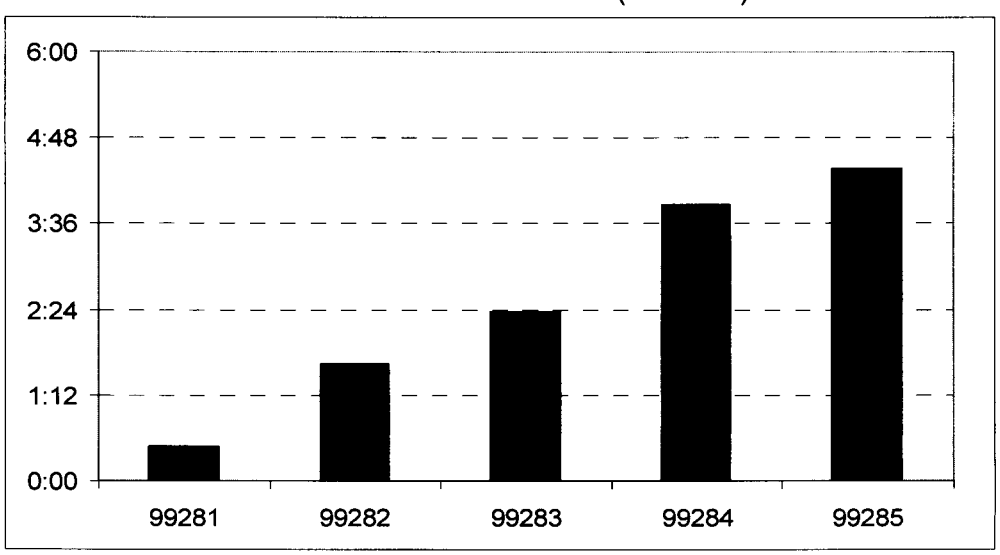
1. The system should map the provided services or combinations of services to the different levels of effort represented by the (CPT) codes; FR 4/7/ 2000.
   - The AHA/AHIMA model based on interventions does not account for non-interventional work, and therefore produces a distribution underestimating the resources expended. A visit level distribution almost entirely composed of level one services poorly accounts for resource differences between different clinic visits. The LYNX Medical Systems approach applied to clinic coding resulted in a visit level distribution representative of the resources utilized.

2. The method used should result in a normal distribution of services; FR 8/9/2002.
   - Over 90% of the visits are assigned a level one service when the AHA/AHIMA model is applied to clinic visits. Conversely, the LYNX problem-based approach resulted in a more normal distribution.

In summary, an audit of the AHA/ AHIMA model applied to clinic code assignment reinforces the problems illustrated during application of the AHA/AHIMA model to emergency department facility coding. Additionally, a problem based approach is more effective and consistent with CMS guidelines.

Our problem-based system has also been validated against another measure of resource utilization, the weighted average length of patient stay in the emergency department (from initial triage to discharge). The bar graph that follows is based on an analysis of 31,000 ED encounters from 2006, and demonstrates a direct relationship between the weighted average of patient ED length of stay and the final visit level assigned under our problem-based system.

Visit Level vs.Time in ED (in hours)



Another test of coding guidelines is their ability to produce relatively homogeneous groupings of visits by resource utilization. In examining the ability of the LYNX system to meet this test, we analyzed data from 31,000 ED encounters for 2006, and compared the length of patient stay in the ED (throughput time, as a proxy for resource utilization) for the most frequent problems at different visit levels. Below we provide the results of this analysis for a mid-level visit (CPT 99283).

Rank	Presenting Problem	% of visits	Avg Throughput
1	Abscess	6.7%	2:48
2	Throat Pain	6.1%	2:22
3	Cough	5.7%	2:21
4	Dental Pain	4.2%	2:07
5	Back Pain	3.8%	2:41
6	Abdominal Pain	3.7%	1:33
7	Lumbar Back Pain	2.8%	2:23
8	Medical Problem - Minor	2.1%	2:33
9	Dysuria	1.7%	2:44
10	Headache	1.7%	1:56
	Group Total	38.5%	2:22

As noted above, **the problem-based approach assigns cases with similar average throughput time (but different presenting problems) to the same visit level.** We recognize, of course, that throughput time is an imperfect measure of resource utilization and, at best, addresses only one aspect of hospital resource expenditure. However, we are not aware of any similar attempt to assess any version of the AHA/AHIMA guidelines.

We also believe it is important to note that, unlike the AHA-AHIMA guidelines, **the LYNX problem-based system was designed—from the very beginning—to be fully compatible with a 5-level visit classification system**, which is the level of service granularity that we believe should be recognized by all payers, including Medicare.

We note, too, that **a problem-based system is easy to use**. Our hospital customers will confirm this. This may be due to the fact that LYNX Medical Systems has developed software to assist hospitals in coding ED and clinic services under our problem-based system. And we have developed a web-based training module and other tools to help new users of the system. In our experience, hospital coding, nursing and other personnel are quickly able to use a problem-based system accurately and efficiently. As noted at the beginning of these comments, roughly 350 EDs are currently using our problem-based system in lieu of internal, "home grown" guidelines, for reporting their ED visits.

Our problem-based system applies to all payers. We believe this is extremely important for hospitals, which are in constant search of ways to make their coding and billing operations more efficient.

As with any set of guidelines, the user of our system retains the option of overriding the recommended coding, if unusual or extenuating circumstances suggest that a lower level of visit should be reported instead (the override option does not permit the reporting of a visit level higher than that recommended by the LYNX algorithm). Our experience to date is that this override option is rarely used (less than 1 percent of cases). Moreover, our system prompts the user to document the reason(s) for exercising the override option, thereby producing a convenient audit trail.

While our system is based on the presenting problem/reason for visit as recorded in the medical record, we believe that a similar approach could be constructed around ICD-9 diagnosis codes for the patient's reason for visit. In the UB-92, space has been provided at Form Locator 76 for reporting this information on outpatient claims since April 1, 2000. The new UB-04 will continue to provide space for recording this information at Form Locator 70.

In addition, a problem-based approach could potentially be combined with a variety of intervention-based models, not just the specific set of factors that now qualify for additional points under the LYNX system. For example, it might be possible to blend a problem-based approach with elements of the intervention-based models developed by other organizations, including the American College of Emergency Physicians, AHA and AHIMA. However, much more work would be needed to determine the most appropriate approach for national coding guidelines.

Finally, a problem-based system can be readily adapted for specialty clinics. Our experience with general medical clinics could be applied to specialty clinics through the incorporation of specific presenting problem lists tailored to the specific clinic.

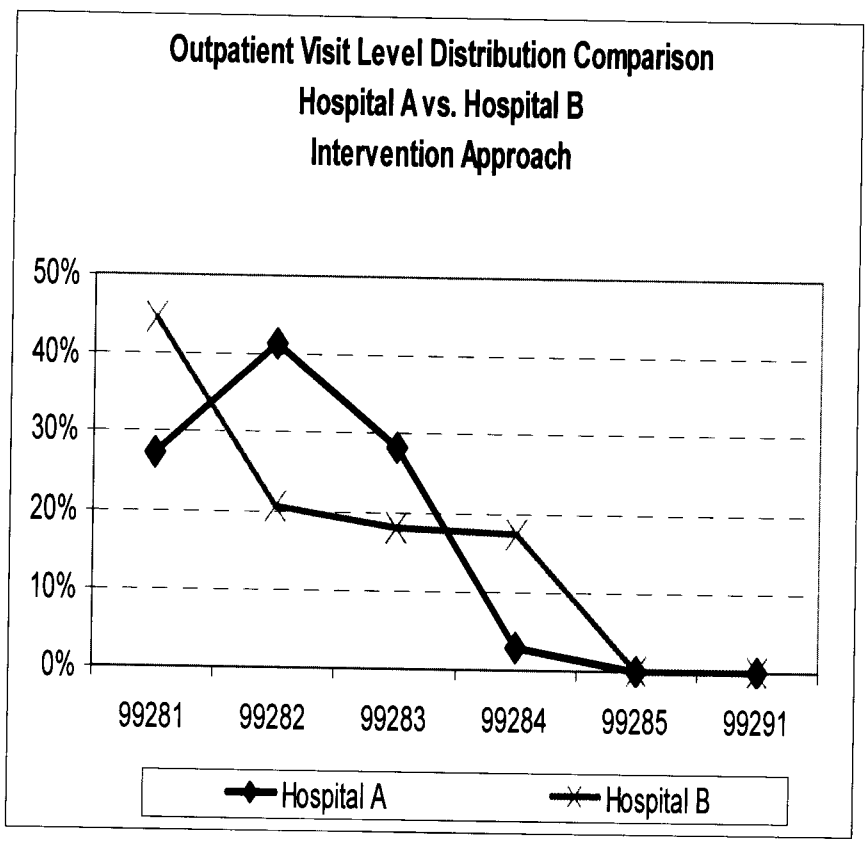
CMS Criticisms of Alternative Guidelines

As noted earlier, the proposed rule briefly reviews CMS concerns about point-based coding guidelines, and guidelines based on presenting complaint or medical problem. In the case of the former guideline type, CMS warns that such a system "could present a significant burden for hospitals in terms of requiring, clinically unnecessary documentation." CMS also worries that: "Point systems that are complex could require dedicated staff to monitor and maintain them." In terms of problem-based guidelines, CMS argues that such systems "are extremely complex, demand significant interpretive work on the part of the coder (who may not have clinical experience), and are subject to variability across hospitals" and fears that such systems would bring "a significant potential for

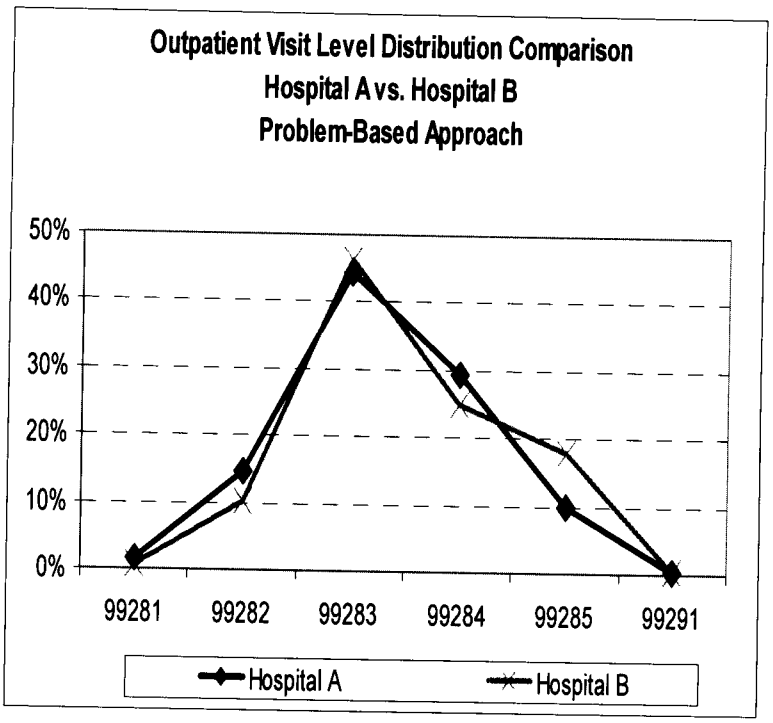
upcoding and gaming." Although it is not clear that the above criticisms are directed against any specific point- or problem-based systems, it is true that the LYNX system is both point- and problem-based. Therefore, we would like to take this opportunity to respond to the concerns expressed by CMS.

We believe that the information provided earlier in these comments serves to rebut the notion that point- and problem-based approaches are unduly complex or burdensome for hospitals. If they were, LYNX would not have the loyal hospital customer following that it does. As it stands, we have developed a system that is relatively easy to use.

Moreover, **we have evidence, thanks to a natural experiment, that our system produces relatively consistent coding decisions.** Below, we show the coding decisions of two hospitals, when using identical "home-grown" intervention-based coding guidelines. As can be seen, these two hospitals had a very different distribution of visit levels—and no where near a normal distribution of visit levels—despite the fact that both of them had a very similar hospital admission rate from their respective EDs (a proxy for patient acuity at the time of presentation to the ED).



When these same two hospitals subsequently switched to our problem-based system, they began showing essentially the same distribution of visit levels, and a relatively normal distribution of visit levels at that (as shown in the following chart).



Further, our problem-based approach was specifically designed to minimize the number of additional factors in play and to avoid giving any role to separately billable procedures. Our list of problems is a relatively modest one, thereby minimizing the potential for "gaming" and it is hard to see how concerns about upcoding could be greater under our system (or any other problem-based approach) than they are for purely intervention-based approaches, such as the AHA/AHIMA guidelines, even as modified by CMS.

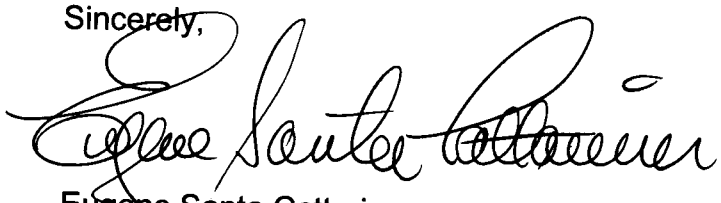
Proprietary vs. Public Domain Guideline Systems

The LYNX system for coding ED and clinic visits is, of course, proprietary, and we acknowledge a frequently expressed CMS preference for various coding, classification, and other systems to be in the public domain whenever possible. In any case, the purpose of our comments is not to recommend adoption of the LYNX system as national coding guidelines for ED and clinic visits. Instead, we believe that our experience with a problem-based system is something that CMS could build upon. And we would be willing to help in any way we can in the development of national guidelines. To the extent that elements of our system appear to offer promising options for national guidelines, we would be prepared to discuss how best to address the CMS preference for a guideline system that would be in the public domain.

Conclusion

We hope the preceding comments are helpful. Given the importance of national coding guidelines for ED and clinic visits for LYNX Medical Systems and our customers, we were pleased to have the opportunity to meet with CMS staff on September 25 to introduce LYNX Medical Systems and talk about the value of a problem-based approach for coding ED and clinic visits. If CMS would like additional information about the LYNX system or any of the issues raised in these comments, please feel free to contact Mike DeTolla, Executive Vice President, at 425-641-4451, X2067, or via e-mail at MikeD@lynxmed.com.

Sincerely,



Eugene Santa Cattarina
Chief Executive Officer

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WESLEY WOODS CENTER OF EMORY HEALTHCARE

October 6, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1506-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, Md. 21244-1850

To Whom It May Concern:

Re: PPS-CMS-1506-P; CY 2007 Proposed Daily Rate for APC Code 0033 - Partial Hospitalization Programs and 0322, 0323, 0324, 0325 – Outpatient psychiatric services

The Wesley Woods Center Geriatric Hospital of Emory Healthcare, Inc. in Atlanta, Georgia provides psychiatric services for our metro area senior population

We are a long-standing provider of Partial Hospitalization services. The initial shock of CMS-1506-P and another 15% rate reduction for CY2007 was an overwhelming blow. The very existence of this service will be threatened for the future if our facility must absorb this extreme revenue reduction again. It is very difficult to convince providers to continue programs year after year on a break-even basis at best.

A $37.64/day reduction in the daily rate will be impossible to absorb. CMS must reconsider this position or many facilities will have to take drastic action, which will likely cause many programs to close or to be severely limited in the services they can provide.

We are a member of the Association of Ambulatory Behavioral Healthcare. Our organization stands firmly behind the comments they submitted. In addition, the following key points represent views that we see differently than CMS:

1. CMS-1506-P pp. 99-105 describes the CMS methodology of rate calculations for PHP each year since 2000. A close review indicates that CMS arbitrarily applies its' own bias assumptions and methodology on a different basis every year from CY2003 through CY2006. Only the methodology from CY2006 and CY2007 are the same and there is no calculation of a methodology. It is nothing more than an arbitrary decision by CMS.

2. We quote CMS on p. 105 to say "To calculate the CY2007 APC PHP per diem cost, we reduced $245.65 (the CY2005 combined hospital-based and CMHC median per diem cost of $289 reduced by 15 percent) by 15 percent, which resulted in a combined median per diem cost of $208.80."

3. CMS-1506-P refers to the CY2005 combined hospital-based and CMHC median per diem costs of $289.00 in the last paragraph of p. 105. As a facility, our costs increased in virtually every area including salaries, benefits, supplies, insurance, dietary support, communications and administrative support. We experienced overall increases in expenses of more than 5% in most areas over the past two years. A daily per diem of $208.27 cannot be justified with these expenses.

4. CMS identified the Median cost of group therapy at $66.40. Our program offers 4 group services per day at a minimum. This summarizes to a median cost of $265.60. A per diem of $208.27 cannot be justified with these expenses.

5. Ninety-nine percent of our patients are Medi-Medi's. Medicaid cuts are strongly threatened here in your state. If the 20% copay is unavailable, the per diem would shrink even further and eliminate any consideration for these programs to exist. This would virtually reduce the per diem to $166.62 ($208.27 x .80). A daily per diem of $208.27 cannot be justified with this situation.

6. Cost reports are never settled in a timely fashion to include in your figures for the current per diem calculations. This can only artificially lower the actual median costs. When cost reports are settled, generally tow years or more after the actual year of service, we have operated on actual revenues of 80% of the per diem. Facilities cannot operate by providing interest-free loans for two year periods.

That being said:

7. Patients already have too few options for psychiatric care. Outpatient care is their best option. Outpatient services are a much less expensive alternative to hospital inpatient care or emergency departments. Rather than spending Medicare dollars on Outpatient services, Medicare will, most assuredly, spend more dollars on patients who use inpatient hospital units or emergency centers because -

8. Patients who need psychiatric care will go where ever they have to go to get care. Why would CMS **not** support the less costly outpatient option? It is a fiscally responsible decision.

Based on the above issues, Wesley Woods Center asks that CMS:

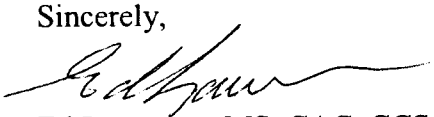
- **Not implement** the PPS-CMS-1506-P; CY 2007 Proposed Daily Rate for APC Code 0033 - Partial Hospitalization Programs and 0322, 0323, 0324, 0325 – Outpatient psychiatric services, until CMS examines the data and researches the numerous problems identified.

- **Consider a consistent methodology** that can stabilize the PHP per diem rate and avoid the drastic year-to-year fluctuations that threaten the very existence of the program services for this targeted, severely mentally ill population.

- **Allow energy, time and resources** to develop a reasonable payment methodology by working with provider and community organizations who would welcome the opportunity to work with CMS to develop a payment rate that is fair, consistent and predictable.

Thank you for your consideration of our comments. We look forward to your response. We are hopeful that we will be able to continue to treat the mentally ill and elderly in the most economically responsible way and at the lowest level of care possible.

Sincerely,



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Delta Medical Systems, LLC. dba New Directions
Community Mental Health Center
990 Hardy Street, Suite 4 · Hattiesburg, MS · 39401

October 4, 2006

FILE CODE: CMS-1506-P PARTIAL HOSPITALIZATION
Re: Prospective Payment System and Calendar Year 2007 Payment Rates – Proposed Rule

In response to the Proposed Rule for Medicare Outpatient Prospective Payment for 2007, I have the following comments and concerns:

I am a provider of Partial Hospitalization services in my CMHC in Hattiesburg, MS. I am currently awaiting certification survey by CMS (Atlanta office) as I opened in June, 2006. The proposed rule referenced above will place extreme hardship on providers of Partial Hospitalization Services. The proposed rate for 2007 will fall below my actual cost of providing this level of service to Medicare beneficiaries in Mississippi and will jeopardize the financial viability of the Center. I may not be able to remain open or at least treat Medicare beneficiaries if the proposed rates are finalized.

The cost of providing services in Mississippi has been impacted by Hurricane Katrina. There's no doubt. It's difficult to find staff, especially ancillary staff who came at a lower cost pre-Katrina. Insurance costs have been raised post-Katrina. Staffing costs have been raised post-Katrina. Service costs have been raised post-Katrina. For example, I had to repair the building I'm leasing myself at my own cost because of the shortage of construction workers in the Hattiesburg area! When you need any work done, it's at an alarming rate because of the supply/demand situation on the Gulf Coast. Yet, the proposed rates for CY 2007 indicate that it costs less to provide services than it did in 2206! I am very confused as to why the proposed wage indexes in Mississippi have been lowered post-Katrina. I am wondering if you have adequate documentation that the wage index for Mississippi after Katrina should be decreased?

My CMHC's Partial Hospital Program is receiving the majority of its patients from the State facilities where they have been treated for several months due to the severity of their mental illness. In the Hattiesburg and surrounding area patients are often forced to be placed in jail or annex to jail facilities while they wait for an open bed in a State hospital. My Partial Hospitalization program has allowed such patients to actually be released from jail/holding while they attend a Partial Hospitalization Program on a Court Order. These patients are getting the benefit of receiving care in the least restrictive setting, allowing them to keep what dignity they have left and remain out of hospital or jail while receiving the intense treatment they so badly need.

My Partial Hospitalization Program provides four groups per day by highly trained professionals including professional Counselors, Registered Nurses and a Certified

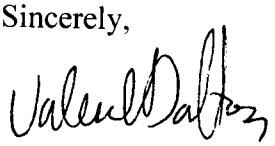
Activity Therapist. A Psychiatrist directs all clinical care at the Clinic and sees the patients at least weekly to provides medication management and evaluation services. The patients also receive individual and family psychotherapy. The intense treatment coupled with the 24-hour emergency care services our Clinic provides has proven to keep patients who have frequently relapsed to hospital out of hospital thus far and in some cases has meant the difference between life and death for some of these seriously ill patients.
I know that payment for four outpatient services per day (provided in another setting like IOP or by individual providers) far exceeds the payment for Partial Hospitalization Services under the proposed rule. I am very confused as to how this new rate has been calculated.

This PHP is a much needed service in the Hattiesburg area. I am the only CMHC in a 50 mile radius. Patients, because of that, do not have the opportunity to access a lesser level of care than inpatient hospitalization when they are too ill for traditional outpatient therapy appointments. The hospitals and outpatient providers in the area have welcomed New Directions and have stated repeatedly that the service is very needed in terms of the continuum of mental health services.

I ask that you consider postponing the proposed rate for PHP services until more data can be secured and the rate appropriately set. Or, pay PHP services at a rate paid for identical outpatient services in another setting.

I appreciate your consideration of my comments.

Sincerely,



Valerie Dalton, RN, BSN
Owner/Manager
New Directions CMHC