CMS-1306-P-1 **Medicare Program; Inpatient Psychiatric Facility Prospective Payment System Update for Rate Year Beginning July 1, 2006 (RY 2007)**

Submitter : **Renato Gomes** **Date & Time:** **01/26/2006**

Organization : **Wilson COunty Hospital**

Category : **Psychiatric Hospital**

Issue Areas/Comments

GENERAL

GENERAL

I am the program director for a inpatient geriatric psychiatric unit under the new PPS system. I have questions about the allowed codes for medical comorbidities. We see many, many, many elderly with acute psychiatric conditions accepted to our units and with medical co-mobidities such as asthma, Unrinary Track Infection, arthritis, osteorarthritis and osteoporosis and these codes are not accepted un der the list of acceptable medical comorbidities ICD-9 COdes. We are a small hospital and we do an INCREDIBLE work in our unit, however we are not able to bill for all these services that we provide. SOme of these medical-comorbidities might be under control, however we still treat them in our unit, but we cannot bill for them. I am very concerned because might hospital is thinking about closing our unit because the money has been very short and we are not billing any medical comorbidities for our patients since most of the medical comorbidities we are treating are not included in your list. I would like you attention to this matter and also would like to participate in meetings within CMS when you are discussing this issue. Please let me know how can I become a better advocate for inpatient, short-term, geriatric pasychiatric units. Also, are you planning on revising this ICD-9 codes for medical comorbidities? I have so many questions and cannot find answers. My fiscal intermediary here in Kansas does not seem to know much about it and does not give me any hope. I am very concerned about my community and the lack of my unit here will greatly affect our senuor citizens. I much appreciated your reply.
Thanks for your time and consideration
Renato Gomes

Issue

OTHER ADJUSTMENTS AND POLICIES

OTHER ADJUSTMENTS AND POLICIES

Submitter : **Mr. Robert Hails** **Date: 03/07/2006**

Organization : **St. Joseph Hospital**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

In the Proposed Rule in the Federal Register, Vol. 71, No. 14, page 3645 published on January 23, 2006, in the middle column, end of the last paragraph in the section titled "3. Physician Certification and Recertification Requirements": I am requesting clarification on the use of the word "daily" (capital letters below), i.e. it states "As a result, we are proposing to add language to clarify that for purposes of payment under the IPF PPS, the physician would also recertify that the patient continues to need, on a DAILY basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel." My question is does this mean that a physician needs to chart DAILY, i.e. 7 days per week, in the patient's record that the patient still needs active treatment ....? If this is a correct assumption this new requirement causes a major conflict for our group of medical hospitals (with psychiatric units)in northeast Indiana. Our medical staff by-laws currently require a physician progress note in the patient's chart a minimum of every 48 hours AND at least 5 out of every 7 days each week. There are NO hospitals within this region, which services 500,000(+) people, that require 7/week patient visits on psych units. All of the units have the same M.D. practice minimums as stated above. If the intent of the new language in this proposed rule is to require 7/week psychiatrist visits all of the hospitals within our region are directly opposed to that new standard. Thank you.

Submitter : **Ms. Marilyn Litka-Klein** **Date: 03/10/2006**

Organization : **Michigan Health & Hospital Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

Please see the attached letter.

Thanks!

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : Mr. Mark Covall **Date:** 03/10/2006

Organization : National Association of Psychiatric Health Systems

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Mr. David Buckley** **Date: 03/10/2006**

Organization : **St. John Health**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1306-P-5-Attach-1.DOC

SENT VIA E-MAIL

March 10, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS - 1306-P
P.O. Box 8010
Baltimore, MD 212448012

Re: CMS-1306-P – Medicare Program; Prospective Payment System for Inpatient Psychiatric Facilities Rate Year 2007 Proposed Rules Dated January 23 2006

Dear CMS:

St. John Health appreciates this opportunity to provide comments to the center for Medicare and Medicaid Services regarding the proposed policy, which updates the prospective payment system for inpatient psychiatric facilities.

St. John Health is a leading provider of Behavioral Medicine Services in the state of Michigan providing inpatient psychiatric services at five separate locations in Southeast Michigan. Inpatient Psychiatric Facility (IPF) service locations include:

1) St. John Hospital & Medical Center- Detroit, Michigan

2) St. John Detroit Riverview Hospital- Detroit, Michigan

3) Providence Hospital & Medical Centers- Southfield, Michigan

4) St. John Oakland Hospital- Madison Heights, Michigan

5) St. John Macomb Hospital- Warren, Michigan

As a result of analyzing this proposed rule, St. John Health has identified the following issue for clarification by CMS should specify during development of the final rule. This issue is identified below.

IME TEACHING ADJUSTMENT FOR NEW MEDICAL RESIDENCY PROGRAMS

In the proposed rule CMS discusses IPF's who did not train residents during the time period of the IPF's most recent cost report filed before November 15, 2004 FTE and initially received an FTE cap of "0", but subsequently began training residents in a new GME program that began after November 15, 2004, may be eligible to receive a subsequently adjustment the IPF's FTE cap of "0"in accordance with the IPPS policies.

St. John Health is requesting confirmation regarding IPF's located within a teaching PPS hospital which had no residents rotating into the IPF during the time period of the IPF's most recent cost report filed before November 15, 2004, but may be eligible for an adjustment to IPF "base year" FTE cap of "0". In this situation described due to the IPF having no rotations during the time period of the IPF's most recent cost report filed before November 15, 2004, the IPF must have an opportunity to permanently adjust upward their "0" base year cap. The following describes how an IPF could be eligible to receive such an adjustment.

A teaching hospital begins a new residency that was accredited after November 15, 2004. The new residency program accredited after November 15, 2004 requires rotations into an IPF. The IPF had no resident rotations during the time period of the IPF's most recent cost report filed before November 15, 2004. Thus, the IPF's "base year" FTE cap is established at "0". Due to the "base year" FTE cap being "0", the IPF should be eligible to receive an adjustment for the new program residents who rotate into the IPF.

For the lesser of the first three years of a new residency program, or the initial residency period of the new program, the IPF should be eligible to receive an exception to their IPF "base year" FTE cap of "0" based upon the actual number of new program resident FTE's who rotate into the IPF during the year. After the new residency program's third year, a permanent adjustment would be established to equal to the highest number of residents in a training year multiplied by the number of years required to complete the new resident training program. This IPF new resident program permanent adjustment would become effective in the earlier of year four or the first year following the initial residency period of the new program.

To illustrate this scenario the following example is provided. Hospital A had no rotations into its IPF during the time period of the IPF's most recent cost report filed before November 15, 2004. Thus, the IPF's "base year" FTE cap is "0". Hospital A's fiscal year end is June 30.

On December 15, 2006, Hospital A receives accreditation for a new residency program that begins July 1, 2007. The new training program is three years in duration and is approved for a maximum of four (4) residents per each training year, for a total of twelve. During the training year, residents spend 25% of their training rotating into the IPF. The remaining 75% of resident training is spent outside the IPF, rotating to outpatient and inpatient acute care settings.

The teaching hospital successfully fills 3 first year residents in Year 1 of the new training program, adds 3 first year residents in Year 2 of the program, and adds 4 first year residents in Year 3 of the program.

For year 1 of the new training program, the IPF should receive a 0.75 FTE exception, (3 FTE's *25% of training time rotating into the IPF) to the IPF's "base year" resident FTE cap.

For year 2 of the new training program, the IPF should receive a 1.50 FTE exception, (3 first year plus 3 second year resident FTE's *25% of training time rotating into the IPF) to the IPF's "base year" resident FTE cap.

For year 3 of the new training program, the IPF should receive a 2.50 FTE exception, (4 first year plus 3 second year plus 3 third year resident FTE's *25% of training time rotating into the IPF) to the IPF's "base year" resident FTE cap of "0".

For year 4 and future years, the IPF should receive a permanent adjustment of 3.00 FTE's, (4 first year resident FTE's *3 years of training *25% of training time is for IPF rotations).

St. John Health fully supports the inclusion of an IME adjustment as proposed by the CMS and believes the need for the IME adjustment was clearly indicated in CMS' original IPF PPS analysis. This clarification requested will allow teaching hospitals who have an IPF, but did not train residents in the IPF during their most recent cost report filed before November 15, 2004, to develop new training programs that involve training in the IPF setting and allow CMS to recognize the additional costs teaching IPF's will incur to operate their training programs through CMS' existing IME payment formula.

Thank you for considering this comment on the proposed rule. If you have questions about the above comments, please contact me at (586) 753-0099 or via email at david.buckley@stjohn.org.

Sincerely,

David R. Buckley

David R. Buckley
Corporate Director of Reimbursement
St. John Health

Submitter : Ann D. Huston **Date:** 03/12/2006

Organization : American Therapeutic Recreation Association

Category : Other Health Care Professional

Issue Areas/Comments

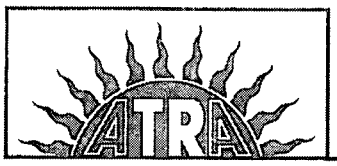
GENERAL

GENERAL

Please see attached response to CMS - 1306-P from the American Therapeutic Recreation Association. Thank you.

CMS-1306-P-6-Attach-1.PDF

Attachment # 6



AMERICAN THERAPEUTIC RECREATION ASSOCIATION

Founded 1984

March 12, 2006

VIA ELECTRONIC MAIL

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1282-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Comments to CMS-1306-P: Recreational Therapy and Inpatient Psychiatric Facilities

Dear Dr. McClellan:

Thank you for the opportunity to comment on the proposed inpatient psychiatric facilities (IPF) prospective payment system (PPS) update for the rate year beginning July 1, 2006. I am writing on behalf of the American Therapeutic Recreation Association (ATRA) to request that the Centers for Medicare and Medicaid Services (CMS) withdraw its proposal to remove the reference to recreational therapy from 42 C.F.R. § 412.27(b). As discussed below, the cost of recreational therapy has been built into IPF PPS and we believe that regulatory references to recreational therapy are necessary to ensure that IPFs continue to provide medically necessary recreational therapy services so that Medicare beneficiaries who need them will have access to them.

ATRA is the largest, national membership organization representing the interests and needs of recreational therapists. Recreational therapists are health care providers who use recreational therapy interventions for improved functioning of individuals with illnesses or disabling conditions.

CMS has proposed to amend 42 C.F.R. § 412.27(b) – the criteria that an inpatient psychiatric unit must satisfy in order to be excluded from inpatient hospital PPS – to remove the current reference to recreational therapy. CMS states that the basis for this proposed amendment is because "we believe it is no longer appropriate to include references to specific therapies in § 412.27."

Nevertheless, the criteria at § 412.27 would continue to require inpatient psychiatric units to furnish psychological services, social work services, psychiatric nursing, and occupational therapy. As discussed below, we feel that CMS's proposed removal of recreational therapy from section 412.27 is inconsistent and unwarranted. We believe that additional regulatory references to recreational therapy and guidance are needed to ensure that this covered service is furnished to Medicare beneficiaries when medically necessary.

As discussed in the preamble to the proposed regulation, Medicare has a longstanding history of covering recreational therapy furnished in an IPF. *See* 71 Fed. Reg. 3645 (Jan. 23, 2006). Recreational therapy is covered in an IPF when: (1) provided under an individualized treatment or diagnostic plan; (2) reasonably expected to improve the patient's condition or for the purpose of diagnosis; and (3) supervised and evaluated by a physician. *See id.*; Medicare Benefit Policy Manual, Ch. 2, § 20. Furthermore, payment for recreational therapy is included in the IPF PPS payment rates. *See* 71 Fed. Reg. 3646; *see also* Letter from Herb B. Kuhn, Director, Center for Medicare Management, to the Honorable Rick Santorum, dated Sept. 28, 2005 (stating that "under the IPF PPS, the costs of recreational therapy services, among other therapy services, are bundled in the Federal per diem 'base payment.'").

The Proposed Amendment Will Lead to Further Confusion Regarding Coverage of Recreational Therapy

ATRA has received a substantial number of reports over the past decade or more from recreational therapists throughout the country who practice in inpatient settings such as IPFs. The consistent theme of these reports is that significant confusion exists in the field as to whether recreational therapy services are covered in this setting. This lack of clarity manifests itself in reductions or eliminations of recreational therapy staff and programs, resulting in a denial of access to recreational therapy for Medicare patients who need these services.

While CMS has provided regulatory preamble language confirming that recreational therapy is a covered service, such language is often insufficient to convince a facility to provide medically necessary recreational therapy. Obviously, because facilities receive a fixed payment amount per discharge under IPF PPS, IPFs have a strong financial incentive to provide a minimal level of services. We believe that the regulations governing IPFs should be amended to confirm that such facilities must provide recreational therapy services when provided under an individualized treatment or diagnostic plan, reasonably expected to improve the patient's condition, and supervised and evaluated by a physician.

Accordingly, the amendment to remove the reference to recreational therapy represents a substantial step in the wrong direction. This amendment, if promulgated in final form, will lead to a more widespread misconception that IPFs need not provide medically necessary recreational therapy services. The removal of recreational therapy from the Medicare regulations will exacerbate an already prevalent problem of facilities refusing to provide medically necessary services because the regulations do not explicitly state that they are covered. The impact on beneficiaries will be an increased lack of access to medically necessary recreational therapy services. The impact on Medicare will be that the program continues to pay for recreational therapy services (through IPF PPS payments) that are not furnished.

In the preamble to the IPF PPS update, CMS suggests that the specific inclusion of recreational therapy in the regulations is "overly and unnecessarily prescriptive." We do not believe that it is overly prescriptive to clarify that, as a covered Medicare benefit, IPFs must provide recreational therapy as necessary. Because Medicare is making payment for recreational therapy services, it is not overly prescriptive for the regulations to clarify that facilities must provide recreational therapy services when required by the patient and prescribed by a physician.

If the Reference to Recreational Therapy Is Removed, Then Section 412.27 Should More Generally Require the Provision of "Therapeutic Activities"

The conditions of participation for psychiatric hospitals at 42 C.F.R. § 482.62 require such hospitals to provide: (a) nursing services; (b) psychological services; (c) social services; and (d) therapeutic activities. In contrast, the proposed amendment to section 412.27 requires psychiatric units to provide: (a) psychiatric nursing; (b) psychological services; (c) social work services; and (d) occupational therapy. Accordingly, under the proposed amendment, the regulations governing psychiatric hospitals and units generally would be consistent, except that the former generally requires the furnishing of therapeutic activities while the latter would only require the provision of one skilled modality (i.e. occupational therapy). We do not believe that there is any difference between psychiatric hospitals and units that merits this discrepancy. Furthermore, the proposed amendment's inclusion of only one skilled modality invariably comes at the expense of all other medically appropriate therapy modalities by suggesting that they are less necessary.

We believe that CMS is acting inconsistently by stating that it is "overly and unnecessarily prescriptive" to specifically require recreational therapy while still maintaining a specific reference to another skilled modality at 42 C.F.R. § 412.27. Accordingly, if CMS believes that it is overly prescriptive to single out skilled modalities such as recreational therapy, then we recommend that the agency further amend 412.27 to replace the specific reference to one of the skilled modalities with a more general

reference to "therapeutic activities," which would include recreational therapy, occupational therapy, and other skilled modalities. This will better conform the regulations for psychiatric units and psychiatric hospitals, and will ensure that facilities do not interpret the inclusion of one therapy modality as indicating that other modalities are unnecessary.

CMS Should Issue Additional Guidance Regarding the Coverage of Recreational Therapy.

As discussed above, our organization has received widespread reports of inpatient facilities, including IPFs, refusing to provide access to recreational therapy services. The most appropriate remedy to address this problem is to retain the current regulatory reference to recreational therapy at section 412.27(b) and to add a reference to recreational therapy at 42 C.F.R. § 482.62 to conform the criteria for inpatient psychiatric units and inpatient psychiatric hospitals (*e.g.*, amending § 482.62(g)(2) to state "[t]he number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each patient's active treatment program, *including occupational and recreational therapy, as needed.*"). It is also critical for CMS to clarify the coverage of recreational therapy in the final IPF PPS update and in formal program guidance.

Even CMS' attempt to clarify coverage in the preamble of the proposed IPF rule has the potential to cause additional confusion. The current preamble language states that "recreational therapy is, and would continue to be, an accepted therapeutic intervention in psychiatric treatment." Unfortunately, we believe that this language is insufficient to alleviate current confusion among certain facilities regarding recreational therapy. Instead, we request a more explicit statement that: (1) recreational therapy is a covered Medicare service in the IPF setting; (2) the costs of recreational therapy have been built into the IPF PPS; and (3) IPFs are required to provide recreational therapy when it is provided under an individualized treatment or diagnostic plan, reasonably expected to improve the patient's condition, and supervised and evaluated by a physician.

We recommend that CMS make the above clarifications to the final IPF PPS update in the Medicare regulations and in the preamble. We also believe that Medicare's program guidance should be amended accordingly. For example, while Medicare Benefit Policy Manual, Ch. 2, § 20.1.2 specifically references recreational therapy as a service that a psychiatric hospital may provide, we recommend that CMS further clarify this manual section to state that an IPF must provide recreational therapy (and other appropriate services) when medically necessary (since the IPF is receiving payment for such services through the IPF PPS).

* * * * *

Thank you for your consideration of our comments. We hope that CMS will ensure that the regulations and Medicare program guidance continue to recognize the important role of recreational therapy in the inpatient psychiatric treatment setting. If you have any questions, please feel free to contract our Washington counsel, Peter Thomas, at (202) 466-6550.

Sincerely,

Ann D. Huston, MPA, CTRS
Executive Director

cc: ATRA Board of Directors
Peter Thomas, ATRA Legislative Counsel

Form Letter 7-2

Submitter : **Mr. Paul Altovilla** **Date: 03/13/2006**

Organization : **Diamond Healthcare**

Category : **Health Care Industry**

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT.

CMS-1306-P-7-Attach-1.DOC

Comments
for
The Centers for Medicare and Medicaid Services

File Code: CMS-1306-P

Regarding the January 23, 2006 42 CFR Parts 412 and 424 Medicare Program; Inpatient Psychiatric Facilities Prospective Payment Update for Rate Year Beginning July 1, 2006 (RY 2007); Proposed Rule

The following comments are provided regarding the proposed regulations published in the Federal Register (FR) on January 23, 2006 to update the Prospective Payment System for Inpatient Psychiatric Facilities for the Rate Year Beginning July 1, 2006 (RY 2007).

1. According to the IPF-PPS Proposed Rule of November 28, 2003 and subsequently in the IPF-PPS Final Rule of November 15, 2004 CMS was in the process of developing a patient classification system based on a standard assessment tool, the Case Mix Assessment Tool (CMAT). It was indicated that the Tool had been submitted to the Office of Management and Budget (OMB) and that a public comment period would be available as part of the OMB process. ***Please provide the public updated information concerning the intent and status of the CMAT instrument. The current proposed rule updating IPF-PPS does not cite the CMAT instrument.***

2. The IPF-PPS Final Rule of November 15, 2004 adopted an "interrupted stay" policy that indicated "if a patient is discharged from an IPF and admitted to *ANY* IPF within 3 consecutive days of discharge from the original IPF stay, the stay would be treated as continuous for purposes of the variable per diem adjustment and any applicable outlier payment." Subsequently on a CMS conference call and within CR 3541 dated December 1, 2004 the term "ANY" was replaced with the term "SAME" and the Business Requirement was revised to state "CWF shall reject as an interrupted stay, IPF bills where patient returns to the SAME IPF within three days of being discharged." ***Please provide clarifying information regarding the FINAL CMS interrupted stay policy for IPF providers. The original interrupted stay policy referring to "any" IPF was unfair to***

psychiatric facilities accepting committed patients (such as state hospital facilities) which in many instances admit a psychiatric inpatient directly from another IPF. It is recommended the final interrupted stay policy continue to be limited to when a patient returns to the "same" IPF within three days of being discharged.

3. The Diagnosis (ICD-9) Codes for the Co-Morbidity Categories continue to be markedly segmented in some areas, as well as omit increased-cost diagnoses/treatments. Many co-morbid conditions that require increased resources, ancillary services, and costs remain without an appropriate adjustment factor. ***It is recommended that CMS develop more complete co-morbidity adjustments for the listed ICD-9-CM codes. The co-morbid conditions that need to be added to the list include, but are certainly not limited to:***

   1) 041.0 – 041.9 – Bacterial Infections
   2) 274.0 – 274.8 – Gout
   3) 278.00 - Obesity
   4) 290.0 – 294.9 - Complicating Organic Psychotic Conditions
   5) 331.0 – 332.1 - Complicating Cerebral Degenerations (to include Alzheimer's and Parkinson's disease)
   6) 369.4 - Legal Blindness
   7) 401 – 405 - Complicating Hypertension Conditions
   8) 414.0 – 414.9 - Chronic Ischemic Heart Disease
   9) 428.0 – 428.1 - Heart Failure (Congestive Heart Failure)
   10) 429.0 – 429.9 - Complications of Heart Disease
   11) 491.0 – 496 - More complete listing of Chronic Obstructive Pulmonary Disease and Allied Conditions recommended
   12) 599.0 – 599.9 - Other disorders of urethra and urinary tract
   13) 714.0 – 716.9 - Rheumatoid Arthritis and Polyarthropathies, Osteoarthrosis, and Arthropathies
   14) 724.0 – 724.9 - Disorders of the Back
   15) 780.50 – 780.59 - Sleep Disturbances
   16) V45.81 – V45.89 - Other Postsurgical Status

Submitter : Mr. Raymond Sweeney **Date:** 03/13/2006

Organization : Healthcare Association of New York State

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

Attached please find HANYS' comments.

CMS-1306-P-8-Attach-1.DOC

Healthcare Association
of New York State

March 13, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS - 1306-P
P.O. Box 8010
Baltimore, MD 21244

Re: CMS-1306-P—Medicare Program; Rate Year 2007 Prospective Payment System for Inpatient Psychiatric Facilities (January 23, 2006 *Federal Register)*

Dr. Dr. McClellan:

On behalf of our more than 550 member hospitals, health care systems, and continuing care providers, the Healthcare Association of New York State (HANYS) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) proposed rule for rate year 2007.

HANYS has identified several issues that we hope CMS will consider as it prepares the final rule.

FACILITY-LEVEL ADJUSTMENTS:

Hold Harmless Provision:

CMS plans to implement the new Core-based Statistical Area (CBSA) labor markets under the IPF PPS. Some facilities will receive reduced Medicare payments under the new CBSAs; therefore, a transition period similar to that of the Inpatient PPS is needed to protect those provider organizations that will be harmed by the change. In addition, many formerly rural facilities becoming urban under the new CBSAs will experience a large decrease in their payments due to the change in labor market areas. Those facilities will gain urban status and sometimes receive a higher wage index; however, this increase is often not enough to mitigate the 17% rural adjustment that will no longer be applicable.

> **To ensure the financial stability of those facilities that will go from rural to urban status under the new CBSAs, HANYS suggests a "hold harmless" provision similar to that instituted in the**

Inpatient Prospective Payment System. This would provide a three-year relief period to those urban facilities that would receive less in their IPF PPS payments under the new CBSA labor market areas than under the old Metropolitan Statistical Area labor market areas.

Emergency Department Adjustment:

CMS in the 2005 IPF PPS final rule clearly defined a qualifying emergency department (ED) and the requirements that facilities would have to meet to receive the higher emergency department adjustment on day one of a psychiatric stay. As a result, CMS is proposing to amend the ED language to clarify that a comprehensive array of emergency services includes medical as well as psychiatric services to qualify for the ED adjustment.

HANYS recommends that CMS clarify whether those facilities that previously qualified to receive the ED adjustment need to resubmit another application to receive this adjustment in 2007.

OTHER ADJUSTMENTS AND POLICIES

Impact File:

Currently, CMS publishes an impact file for the Inpatient PPS. This file provides a tool for providers and associations to analyze and evaluate the current payment system. This file also assists providers and associations during the comment period on relevant issues.

HANYS encourages CMS to release an IPF PPS impact file with the final rule similar to the file released as part of the Inpatient PPS rulemaking cycle. We also suggest that CMS develop the file using 2007 rates and policies along with the most current claims data to achieve the most accurate assessment of the IPF PPS.

Physician Recertification:

CMS currently requires physicians to certify after 18 days that the patient continues to need daily inpatient psychiatric care furnished directly by, or requiring the supervision of, inpatient psychiatric facility personnel or needs other professional services that as a practical matter can only be provided on an inpatient basis. However, there has been confusion surrounding the participation requirements for inpatient psychiatric facilities versus inpatient acute care hospitals. CMS is proposing to make the physician recertification requirements consistent between the two. Therefore, for purposes of payment under the proposed IPF PPS rule, physicians are required to certify at time of admission or soon thereafter and the first recertification would be required as of the twelfth day of hospitalization. This falls in line with the physician recertification requirements for acute care hospitals.

Recertification is a burden to providers and requiring the recertification every 12 days adds to that hindrance. In addition, the IPF PPS is a variable per diem system that pays a higher rate at the beginning of a stay. This safeguards against providers keeping patients longer; thus an early recertification is not necessary. HANYS recommends that CMS not implement the requirement to recertify on the twelfth day but rather continue the current process.

Thank you for considering our remarks on the proposed rule. If you have any questions about our comments, please feel free to contact Melanie Graham, Principal Analyst, Economics, Finance, and Information at (518) 431-7687 or at mgraham@hanys.org or Cindy Levernois, Director of Behavioral Health, at (518) 431-7744 or at cleverno@hanys.org.

Sincerely,

Raymond Sweeney
Executive Vice President

RS:do

Submitter : **Mr. Timothy Eckels** **Date: 03/13/2006**

Organization : **Trinity Health**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1306-P-9-Attach-1.DOC

March 13, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1500-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1306-P; Proposed changes to Inpatient Psychiatric Facilities (IPFs) and Fiscal Year 2007 Rates; Proposed Rule

Dear Mr. McClellan:

On behalf of Trinity Health's _____ inpatient psychiatric facilities, we appreciate the opportunity to submit comments on the fiscal year (FY) 2007 inpatient psychiatric facilities (IPF) prospective payment system (PPS) proposed rule.

We are particularly concerned about the

Submitter : **Mr. Dwight Fine** **Date: 03/13/2006**

Organization : **Missouri Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Mr. Timothy Eckels** **Date: 03/13/2006**

Organization : **Trinity Health**

Category : **Hospital**

Issue Areas/Comments

GENERAL

GENERAL

Final attachment, earlier attachment (temp comment number 64851)sent today about an hour ago may have been erroneous. Please use this version

CMS-1306-P-11-Attach-1.DOC

Attachment #11

TRINITY HEALTH
Novi, Michigan

27870 Cabot Drive
Novi, MI 48377-2920
ph 248.489.5004

34605 Twelve Mile Road
Farmington Hills, MI 48331-3221
ph 248.489.6000

www.trinity-health.org

March 14, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1306-P, Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007); Proposed Rule.

Dear Dr. McClellan:

On behalf of Trinity Health, which is the fourth largest Catholic Health System in the country with 25 hospitals, 11 inpatient psych facilities and 379 outpatient clinics and facilities, we appreciate this opportunity to submit comments on the rate year (RY) 2007 inpatient psychiatric facilities (IPF) prospective payment system (PPS) proposed rule. While the bulk of the rule proposes routine updates to the new payment system, we have concerns with some of the policies set forth in the rule. Our detailed comments follow.

TEFRA Caps

We believe an error was made in the calculation of the baseline against which budget neutrality is measured. Under the Balanced Budget Act of 1997 (BBA), the temporary caps on facility-specific (TEFRA) payments expired in 2002. Yet, CMS used those capped payments, inflated by the market basket rate for each year until the PPS actually began in 2005, to establish the baseline for budget neutrality purposes. We believe that CMS should have used what would have been spent, absent the expired temporary caps inflated forward using the market basket rate, to establish the baseline. Using the capped payments inappropriately reduced the allowed aggregate spending under the PPS each year.

Wage Index Adjustment

After a yearlong transition, the fiscal year (FY) 2006 inpatient general acute hospital wage index fully incorporates the OMB's revised standards defining Metropolitan Statistical Areas, based on the 2000 Census data, including its new definitions of Core-Based Statistical Areas (CBSA). For the IPF PPS, CMS proposes fully implementing the new labor market definitions for 2007, which will result in some IPFs receiving reduced Medicare payments under the new CBSAs. As a result, we urge

the CMS to provide a transitional phase-in of CBSAs for IPFs similar to that used for IPPS facilities in FY 2005. We believe that this is needed to protect providers that will be negatively impacted by the new labor markets.

While the CMS discusses the effects on some hospitals previously classified as urban now re-designated as rural, it does not discuss the effects on other hospitals that were equally impacted due to shifts in labor market designations. We believe that the CMS should also provide a transition for these hospitals to protect them against extreme losses due to this policy change. Specifically, we recommend that the CMS add a hold-harmless provision that prevents the per-diem rate under the PPS portion of payments for these facilities from dropping below what they would have otherwise received had the Office of Management and Budget's (OMB) revised standard not been implemented.

In addition, CMS is not proposing the addition of the out-migration factor to the wage index that is included for inpatient general acute hospitals. Our facilities have labor rates that are unfavorably impacted by larger regional wage differences. We believe that CMS should also include the out-migration factor for IPF PPS.

OTHER ADJUSTMENTS AND POLICIES

Outlier Payments

CMS proposes raising the outlier fixed-loss threshold amount from $5,700 to $6,200. However, CMS neither presented its methodology for calculating the threshold, nor provided detailed evidence indicating the need to raise the threshold amount in the rule. We urge CMS to re-compute the threshold calculations using the 2005 claims data in advance of the final rule to ensure that the two percent of aggregate spending set aside for outliers does not go unspent. We further recommend that CMS use the same methodology employed under the inpatient PPS to calculate the threshold. If CMS is unable to analyze the 2005 claims data, we believe that it should maintain the threshold at its current level. In addition, we urge CMS to provide a more thorough description of its methodology and calculations in the final rule.

Physician Recertification

During the first year of the PPS, CMS required physician recertification of medical necessity by day 18. However, there has been confusion surrounding the conditions of participation requirements for inpatient acute-care facilities versus inpatient psychiatric facilities. In the rule, CMS proposes making physician certification requirements consistent between the two; thus, physician certification would be required at admission (or shortly thereafter), and recertification would be required on day 12. Subsequent recertification would be required depending on the

recommendation of the hospital utilization review committee, but occur no less frequently than every 30 days.

We believe that day 18 recertification is preferable, as the recertification process is administratively burdensome, and while there may have been some confusion at first, this has dissipated. In addition, the variable per diem adjustment guards against an incentive to keep patients longer, thus an earlier recertification is unnecessary. Given no evidence to the contrary, CMS should maintain the current recertification policy. We suggest CMS clarify that facilities may choose to recertify earlier for consistency across their units or payor types, if they so choose.

Same Day Transfers

Our hospitals advise us that same day transfers result from difficulty in diagnosing mental health disorders and/or substance use in combination with a physical ailment. Frequently, a patient is admitted to the psychiatric unit for a full evaluation, after which it's determined that the patient's medical condition is too complex for treatment in that unit. Such situations are in no way reflective of units trying to skirt billing rules. In fact, facilities are only acting in accordance with physicians' orders to admit patients. Trinity Health supports CMS' current policy for 2005 claims that same day transfers be paid the PPS per diem. We believe that if CMS conducts a thorough examination of the 2005 claims, it will not find this to be a prevalent occurrence. If CMS then decides that it would like to investigate other options for payment, we urge the agency to convene the field through an open-door forum or other such venue to discuss the possibilities. This is a very complex issue, and we do not have enough time during the comment period, nor the appropriate claims data, to adequately assess the options presented by CMS in the rule. However, Trinity Health would be happy to participate in future dialogues about this issue.

We do, however, support CMS' instructions to count a day for cost reporting purposes if the day of admission and the day of discharge are the same; thus, both the hospital transferring the patient and the hospital receiving that patient will count that day for cost reporting purposes. In addition, we agree that only one day should be applied toward a beneficiary's 190-day, lifetime limit. Beneficiaries should not have their covered days inappropriately reduced because of difficulty diagnosing them and placing them in the appropriate care setting.

Emergency Department Adjustment

Although CMS is not proposing any changes to the ED adjustment, we request that CMS clarify whether it is necessary for IPFs to resubmit correspondence to their fiscal intermediaries to indicate that they continue to maintain a qualifying ED and therefore, should be paid based on the higher rate for the first day of the stay. It would seem

that this action should not be necessary by providers unless there has been a change in the qualifying ED.

Impact File
We urge CMS to release an impact file with the final rule in the form of a downloadable Excel file. While Trinity Health appreciates CMS' release of a limited data set, most providers are unable to purchase and analyze such an extensive file. A more limited file that will assist providers in determining the impact of the final rule on them, such as the files released as part of the inpatient PPS rulemaking cycle, is essential for providers and associations to analyze payment rules and provide informed comments. In addition, we urge CMS to construct this file using 2007 rates and policies, with 2005 claims instead of 2002 claims for volume of services, to arrive at a more accurate assessment of the impact.

Trinity Health appreciates the opportunity to submit these comments on the proposed rule regarding the IPF PPS payment update. If you have questions about our remarks, please feel free to contact Timothy Eckels at 248-489-6068 or Paul Sahney at 248-489-6509.

Sincerely,

Timothy Eckels, VP Public Policy
eckelst@trinity-health.org

Paul Sahney, VP Revenue Management
sahneyp@trinity-health.org

Submitter : **Ms. Heather Hulscher** **Date: 03/13/2006**

Organization : **Iowa Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Ms. Mary Whitbread** **Date: 03/14/2006**

Organization : **Henry Ford Health System**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1306-P-13-Attach-1.DOC

Mary Whitbread, Vice President
Reimbursement & Contracting
One Ford Place, 5F
Detroit, MI 48202
Office (313) 874-9533
Fax (313) 876-9220

March 12, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1306-P
Post Office Box 8010
Baltimore, MD 21244

RE: CMS-1306-P, Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006); 2007 Proposed Rule.

Dear Dr. McClellan:

On behalf of Henry Ford Health System (HFHS), we would like to thank you for the opportunity to submit comments on the 2007 inpatient psychiatric facilities prospective payment system proposed rule. Henry Ford Health System currently operates two psychiatric facilities: Kingswood Hospital, a 100 bed psychiatric hospital, and a 56 bed psychiatric unit operating at Henry Ford Wyandotte Hospital. While the main focus of the rule is routine updates to the payment system, we do have concerns on how some of the proposed policies will affect our two facilities. Our detailed comments follow:

BUDGET NEUTRAL BASE RATE

Behavioral Offset

The proposed rule includes a reduction factor for anticipated changes in coding and length of stay that may occur as a result of the transition to a per diem based prospective payment system. However, CMS fails to supply evidence that adjustments of this magnitude are warranted. For the reasons identified below, HFHS believes the assumptions made by CMS, for both 2006 and 2007 are inappropriate and overstate the impact of changes in hospital behavior.

First, accurate coding is already a high priority at both Henry Ford Wyandotte Hospital, which operates our distinct-part units (DPU) and Kingswood Hospital, our freestanding psychiatric facility. At Wyandotte Hospital, the staff who assign the appropriate codes to psychiatric patients' records also perform coding services for many other patients for whom payment is based on the diagnosis related group (DRG) to which they are assigned, and the co-morbidities recorded for them. Therefore, coding practices in acute care hospitals with DPUs should not undergo any major changes.

Second, the system includes a variable per diem adjustment that reduces payments based on length of stay, minimizing hospital's incentive to keep patients for additional days of care. The decreased

payment, coupled with strong utilization review by many payors, makes it less likely that IPF stays will increase. Hospitals would likely incur more cost by keeping a patient longer in order to receive a lower Medicare per diem payment.

Third, because the prospective payment system is currently being phased in, and only 50 percent of the payment made for a patient's stay in the second year will be based on the IPF PPS, the incentive for behavior change is diminished.

For the reasons noted above, we urge CMS to analyze the preliminary 2005 claims data and adjust the 2007 proposed payment levels for actual experience to maintain IPF spending at the appropriate levels.

UPDATE ON PER-DIEM BASE RATE

Market Basket

CMS proposes to implement a rehabilitation, psychiatric and long-term care hospital – or "RPL" – market basket index, a measure of inflation based on 2002 data for the 2007 PPS-based portion of IPF payments. Historically, the CMS has utilized the inpatient-excluded hospital market basket, which also includes cancer and children's hospitals.

In general, Henry Ford Health System supports the shift to an "RPL" market basket and agrees that the cost structures of children's and cancer hospitals generally differ than those of other inpatient PPS-exempt hospital types subject to the PPS and therefore should be excluded. However, we have some reservations about the methodology used in constructing the "RPL." For instance, due to lack of data, CMS had to piece together data from each of the three provider types by using disparate length-of-stay trimming methodologies to create a sufficient data pool. CMS also had to fill in data inadequacies by substituting inpatient PPS data where necessary. As a result, we believe CMS should work with providers to improve the areas of the cost report where CMS lacks confidence to alleviate the need for using inpatient PPS data. We also believe that CMS should regularly re-analyze the market basket, especially since these providers only recently converted to PPS and their cost structures may be changing. This would also help ensure that the labor-related portion adjusted for the area wage index is as accurate as possible. A periodic analysis would also allow CMS to continue evaluating the possibility of provider-specific market basket indices.

PATIENT-LEVEL ADJUSTMENTS

Comorbidities Adjustments:

Tracheostomy Comorbidity Category

HFHS supports the recommendation of adding code V55.0 to the tracheostomy comorbidity category which includes code V44.0, tracheostomy status. If treatment were being provided to the tracheostomy such as toilet or cleansing, the correct code would be V55.0, rather than V44.0. Page 54 of the December 1, 2005 version of the *Official Guidelines for Coding and Reporting* specifically cited this as an example.

Chronic Renal Failure Comorbidity Category

HFHS supports the recommendation that code 404.03 – hypertensive heart disease and renal disease, malignant, with heart failure and renal failure – should qualify for both the cardiac conditions and chronic renal failure comorbidity adjustments. This is similar to a diabetic patient that has both uncontrolled

diabetes and chronic renal failure (codes 250.42 and 585.9) or uncontrolled diabetes and gangrene (codes 250.42 and 785.4). Coding rules allow for both these conditions to be coded separately, and each one qualifies for a different comorbidity.

If ICD-9-CM conventions and the *Official Guidelines for Coding and Reporting* (Section I, C, 7, a, 4) would not require a combination code (404.03) for hypertensive heart and kidney disease, these conditions would be reported using the following codes:

- Malignant hypertensive heart disease with heart failure (code 402.01), which currently is included in the cardiac conditions comorbidity category with an adjustment factor of 1.11; and
- Chronic renal failure (code 585.6-585.9 or, as of October 1, 2005, changed to chronic kidney disease), which currently is included in the chronic renal failure comorbidity with an adjustment factor of 1.11.

When the stage of chronic kidney disease (CKD) is unknown – or if the documentation only refers to chronic renal failure, or chronic kidney disease, or chronic renal insufficiency – only code 404.03 would be assigned and only the cardiac conditions adjustment applied. However, when CKD is documented as stage III to V, or as end-stage renal disease, they would correctly get an adjustment for the cardiac condition and the renal failure because two codes would be reported: 404.03, plus a code from 585.3 to 585.6.

Henry Ford Health System urges CMS to be sensitive to ICD-9-CM combination codes in constructing variables for any future regression analyses to avoid any potential coding conflicts.

Digestive and Urinary Artificial Openings Comorbidity Category

HFHS supports the recommendation of adding codes V55.1 to V55.6 to the artificial openings, digestive and urinary comorbidity category. The rationale for adding these codes is similar to our comment under tracheostomy. Codes V44.1 to V44.6 listed in this comorbidity are status codes. The ICD-9-CM instructions have an exclusion note under V44 for artificial openings requiring attention or management to be coded using category V55.

Obstetrical Psychiatric Diagnoses

Claims that do not contain a principal diagnosis from Chapter 5 of the ICD-9-CM or DSM, or are listed in the code first table, do not receive the DRG adjustment.

HFHS supports the recommendation that processing logic be developed to allow a DRG adjustment for mental health conditions in obstetrical (OB) patients. We recommend that the processing system look for cases with a principal diagnosis of 648.30 to 648.34 or 648.40 to 648.44, and then search the secondary diagnosis for Chapter 5 codes (290 to 319) to assign a DRG adjustment.

The *Official Guidelines for Coding and Reporting* require that the OB code be listed first, followed by the appropriate mental health disorder or drug dependence code – Chapter 11 (OB) codes have sequencing priority over codes from other chapters (Guideline I, C, 11, a, 1).

For example, if a pregnant patient is admitted for continuous cocaine dependence, the principal diagnosis would be reported 648.32 with a secondary diagnosis of 304.21. A patient admitted for a postpartum panic attack would be coded with a principal diagnosis of 648.44 and secondary diagnosis of 300.01.

OTHER ADJUSTMENTS AND POLICIES

Outlier Payments

The CMS proposes to increase the outlier fixed-loss threshold amount by approximately 9 percent, from the current $5,700 to $6,200. However, CMS neither presented its methodology for calculating the threshold, nor provided detailed evidence indicating the need to raise the threshold amount in the rule. In advance of the final rule, HFHS urges CMS to recompute the threshold calculations using the 2005 claims data to ensure that the two percent of aggregate spending set aside for outliers does not go unspent. We further recommend that CMS utilize the same methodology employed under the inpatient PPS for calculating the IPF outlier threshold. If CMS is unable to analyze the 2005 claims data, we believes that the agency should maintain the threshold at its current level. In addition, we urge CMS to provide a detailed description of the methodology and calculations in the final rule.

Physician Recertification

During the first year of the prospective payment system, CMS required physician recertification of medical necessity by day 18. However, there has been confusion surrounding the conditions of participation requirements for inpatient acute-care facilities versus inpatient psychiatric facilities. In the rule, CMS proposes making physician certification requirements consistent between the two; thus, physician certification would be required upon admission (or shortly thereafter), and recertification would be required on day 12. Subsequent recertification would be required depending on the recommendation of the hospital utilization review committee, but occur no less frequently than every 30 days.

HFHS prefers the 18 day recertification, as the recertification process is administratively burdensome. Requiring the recertification every 12 days will further increase the burden. In addition, the IPF PPS is a variable per diem system that pays a higher rate at the beginning of a stay, which safeguards against providers keeping patients longer. Thus, an early recertification is not necessary. HFHS urges CMS to maintain the current recertification policy. We also suggest that CMS clarify that facilities may opt to recertify earlier if they choose for consistency across their units or payor types.

Impact File

HFHS also urges CMS to publish, preferably in an Excel format, an impact file with the final rule similar to the file published as part of the IPPS rulemaking cycle. This would help serve as an excellent tool for us in analyzing and evaluating the current payment system. In addition, we also suggest that CMS develop the file using 2007 rates and policies along with the most current claims data in order to achieve the most accurate assessment of the IPF PPS.

Henry Ford Health System appreciates the opportunity to submit these comments on the proposed rule regarding the IPF PPS payment update. If you have questions regarding the above comments or require additional information, please contact me at (313) 874-9525 or via email, mwhitbr1@hfhs.org.

Sincerely,

Mary Whitbread
Vice President, Reimbursement & Contracting
Henry Ford Health System

Submitter : Mr. Anthony Santangelo **Date:** 03/14/2006

Organization : Partners Healthcare System

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1306-P-14-Attach-1.DOC

Electronically

March 14, 2006

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 443-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attention: CMS-1306-P

Dear Dr. McClellan:

Partners HealthCare System, Inc. is pleased to comment on the Proposed Rule for the Medicare Program; Inpatient Psychiatric Facilities Prospective Payment Systems Payment Update for Rate Year Beginning July 1, 2006 (RY2007), on behalf of the following institutions:

Institution	Provider Number
Faulkner Hospital	22S119
Massachusetts General Hospital	22S071
McLean Hospital	224007
Northshore Medical Center	22S035
Newton-Wellesley Hospital	22S101

Overview

We would first like to thank CMS for the smooth transition to the 1st year under the Inpatient Psychiatric Facility – Prospective Payment System (IPF-PPS). The RY2006 final rule was published in November 2004, and because all of the Partners' psychiatric facilities have an October 1st fiscal year start date, we had the benefit of an 11-month lead-time to make internal adaptations to meet the requirements of the PPS. We ask that CMS to provide similar implementation period to ensure smooth transition of future changes related to PPS.

We also agree with the proposed policy of no recalibration of PPS factors until a full-year PPS data is available. We share CMS' belief that PPS updates have profound impact on

providers and need to be evaluated carefully with the most recent and reliable data. We will continue to provide comments to and work closely with CMS on the future updates.

Implementation of the Proposed Revised Labor Market Areas under the IPF PPS

1. Support of the CBSA change

We support the adoption of the revised "core-based statistical areas" (CBSA's) for purposes of determining labor markets for the area wage adjustment. The refinements proposed by OMB are the result of an extensive review over several years of the criteria used to establish these socio-economic areas. This review process provided ample opportunity for the industry and any other interested parties to provide comments. The Boston MSA, as currently defined for the purposes of payments to IPFs, encompasses an area with diverse labor markets, spanning north to include three counties in New Hampshire, west to Worcester and south to Fall River. The wage differentials within this area are dramatic. We strongly believe that CBSA's provide significantly better measures of individual labor markets and fully support their adoption.

2. IPFs should receive the same AWI adjustments as acute hospitals

The proposed rule does not allow for the application of "outmigration" and reclassification wage adjustments to IPF PPS because CMS believes those adjustments apply specifically to the acute hospitals. We believe that IPFs compete in the same labor market as the acute hospitals, thus should receive the same area wage adjustment as the acute hospitals in the same CBSA. Furthermore, the majority of IPFs are units within acute hospitals[1], thus making an even stronger case that they should receive the same area wage index as the medical units of the same hospital.

Under the current proposed rule, the difference in the wage indexes between some hospital-based IPFs and their acute medical units can be drastic. For example, the Northshore Medical Center (Provider # 220035) is located in CBSA 21604, Essex County MA, and currently receives an outmigration adjustment. If the proposed rule is implemented, the psychiatric unit of the Northshore Medical Center will receive an area wage index that is 6.5% lower than the index of adjacent medical and surgical units. This difference in payment policy can place the psychiatric units at a significant disadvantage. CBSAs receiving upward adjustments to their base indices are a common phenomenon across the country. We believe the example outlined above is not an isolated event, therefore, we strongly urge CMS to treat IPFs the same as acute hospitals in the application of AWIs to allow for equal and fair competition in the labor market.

Proposed Update to the Outlier Fixed Dollar Loss Threshold Amount

The proposed rule states that analysis of the latest available data warrants a change to the outlier fixed dollar threshold amount in order to maintain a 2% outlier policy. We

[1] The proposed rule indicates that out of 1,806 IPFs that currently participate in the Medicare program, 78% or 1,399 of them are hospital-based units.

understand a full-year 2005 claims data may not be available for analysis, but we urge CMS to update the dataset, if newer data become available, for the final rule making. We also recommend that a more detailed description of the analysis and the dataset used to be included in the future rulemaking to allow for constructive feedback from the providers.

On behalf of Partners Healthcare, I thank you for the opportunity to comment on this proposed rule. Please feel free to contact Cecelia Wu at (617) 726-9165 or Cwu4@partners.org should you, or your staff, have any questions or would like more information.

Sincerely,

Anthony Santangelo
Corporate Manager of Government Revenue
Partners Healthcare System

Submitter : Ms. Karen Fisher **Date:** 03/14/2006

Organization : Association of American Medical Colleges

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Ms. Kathryn Simpson** **Date: 03/14/2006**

Organization : **Lakeland Regional Medical Center**

Category : **Psychiatric Hospital**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1306-P-16-Attach-1.DOC

Lakeland Regional Medical Center
Mental Health Addictions Recovery Unit
1324 Lakeland Hills Boulevard
Lakeland, Florida 33804
(863)687-1100
www.LRMC.com

March 14, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Room 445-G, Hubert H. Humphrey Services
200 Independence Avenue, S. W.
Washington, DC 20201

RE: CMS-1306-P, Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007); Proposed Rule.

Dear Dr. McClellan:

On behalf of the Mental Health and Addiction Recovery Unit at Lakeland Regional Medical Center, we appreciate the opportunity to submit comments on the rate year (RY) 2007 IPF-PPS proposed rule. Outlined below are our comments regarding the policies in the rule.

PATIENT-LEVEL ADJUSTMENTS

While CMS is not proposing changes to patient level payment adjustments in RY 2007, we have found specific conditions, requiring a significant amount of additional supplies or increasing length of stay. We are requesting consideration to add these conditions to the current co-morbid adjustments.

Co-morbidities Adjustments

Urinary Tract Infections
Specifically, we recommend adding code 599.0 of which we see often in our population of patients admitted with primary diagnosis of dementia, requiring additional care and resources.

Chronic Pulmonary Heart Disease
Supplies utilized for this code (416.0) include frequent respiratory treatments and medications.

V Code Considerations

In 2004, a great number of our patients were displaced from an Assisted Living facility due significant damage from a hurricane. Some patients are homeless or have been evicted, thus a greater length of stay often ensues in order to find an appropriate discharge setting. Consideration of adding V codes including V60.0 – Lack Housing, V63.0 – Unavailability of Medical Facility and V63.2 – Person Waiting for Facility would offset the additional cost incurred in providing services to these patients.

Chronic Renal Failure and Co-morbidity Category

We agree with the AHA's position in that code 404.03 – hypertensive heart disease and renal disease, malignant, with heart failure – should qualify for both the cardiac and chronic renal failure co-morbidity adjustments, as coding rules allow for both these conditions to be coded separately, each qualifies as a co-morbidity.

Obstetrical Psychiatric Diagnoses

We have concern we will not receive appropriate payment when admitting an obstetrical (OB) patient with a mental health diagnosis. Coding rules require the OB code be listed first and claims that do not contain a principal diagnosis from Chapter 5 of the ICD-9-CM do not receive the DRG adjustment. We are requesting CMS develop a system in which these claims can be accurately processed and paid.

UPDATE ON PER-DIEM BASE RATE

Regarding the implementation of a rehabilitation, psychiatric and long-term care hospital (RPL) market basket index measure of inflation. We believe there is insufficient data available to construct the RPL at this time and request CMS work with providers to collect accurate information. Providers are currently analyzing the impact of PPS, this data should be utilized to develop this measure.

OTHER POLICIES

Physician Recertification

CMS has required physician recertification of medical necessity by day 18 for the first year of PPS. In order to be consistent with acute-care facilities, CMS proposes to change the re-certification to day 12. We would like to continue our current practice of day 18 re-certification, since most patients are discharged before day 18, therefore not requiring the recertification and to change the process now would be unnecessarily burdensome.

Data

We request a limited downloadable file to assist in determining the impact of the final rule for our facility. Additionally, we request CMS utilize 2007 rates and policies with

2005 claims instead of 2002 claims for a more accurate reflection of the effect to our facility.

The Mental Health and Addiction Recovery Unit at Lakeland Regional Medical Center appreciates the opportunity to submit these comments regarding the proposed rule for the IPF PPS payment update.
If you have questions about our remarks, please feel free to contact me at (863)284-1997 or Katie.Simpson@lrmc.com.

Most Sincerely,

Kathryn A Simpson, MPH, MSW
Team Leader

Submitter : Dr. JAMES SCULLY **Date:** 03/14/2006

Organization : AMERICAN PSYCHIATRIC ASSOCIATION

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1306-P-17-Attach-1.DOC

American Psychiatric Association

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E-mail apa@psych.org
Internet www.psych.org

March 20, 2006

Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare & Medicaid Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Proposed Rule: "Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007)." [CMS-1306-P]

Dear Administrator McClellan:

The American Psychiatric Association (APA), the national medical specialty society representing more than 37,000 psychiatric physicians, appreciates the opportunity to submit these comments. They concern the proposed rule for Medicare payment for inpatient psychiatric facilities (IPFs) under the Prospective Payment System (PPS) for rate year 2007. Relevant regulations of interest are 42 C.F.R. 412 and 424. This proposed rule was published in the Federal Register on January 23, 2006, with the title, "Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007)."[1] APA has certain concerns as to this proposed rule, detailed below.

The proposed rule changes apply to IPF discharges during the rate year July 1, 2006, through June 30, 2007. CMS proposes to adopt the new Office of Management and Budget (OMB) labor market area definitions for the purpose of geographic classification and the wage index. The federal per diem base rate for patients in IPFs is subject to a number of adjustments, i.e., for emergency departments, DRGs, co-morbidities, age, rural location, cost of living, and facility teaching status.

TIMING FOR COMMENTS

As specified in Section 1871 of the Social Security Act, "The Secretary shall provide for notice of the proposed regulation in the *Federal Register* and a period of not less than 60 days for public comment thereon." The 60-day comment period begins the

[1] CMS Proposed Rule: "Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007);" CMS-1306-P [Federal Register January 23, 2006 (Volume 70, No. 14)].

day the rule is published in the *Federal Register,* which is January 23, 2006. That would make comments due later than that of March 14th, as stated in the proposed rule.

TEFRA CAPS

Under the Balanced Budget Act of 1997 (BBA), temporary caps on facility-specific (TEFRA) payments expired in 2002. CMS used those capped payments to establish the baseline for budget neutrality.[2] The capped payments were inflated annually by the market basket rate, until the PPS began in 2005. CMS should ensure that its data is sufficient and that its methodology accurately projects an adequate baseline.

BASE RATE

The proposed rule updates the inpatient psychiatric PPS base payment rate from $575.95 (rate year 2006) to $594.66 (labor share $451.48; non-labor share $143.18) effective for discharges in rate year (RY) July 1, 2006, through June 30, 2007.[3] The new base rate includes an adjustment for CMS' coding error that assigned non-teaching status to teaching facilities, causing total IPF PPS payments to be underestimated. The actual proposed increase in the payment rate is 3.2 percent. Is this increase appropriately calculated and sufficient? CMS will not recalculate the federal per diem base rate until fiscal year 2008, after analyzing one year of IPF PPS claims and cost report data, but will update that rate each spring. APA supports ongoing re-evaluation of data for the base rate.

MARKET BASKET INDEX

The rule uses a new market basket (RPL) that reflects operating and capital cost structures with rehabilitation (IRF), long-term care hospitals (LTCH), and psychiatric hospitals and units (IPF), now all under PPS.[4] While the commonality is PPS, there may be substantial differentials in a number of cost factors across these facility types. CMS is not creating a separate market basket for psychiatric hospitals, due to a small number of facilities and limited data. Grouping PPS facilities into one market basket benefits IPFs where composite non-IPF costs are proportionately higher than IPF costs taken alone. To the extent that non-IPFs' other costs are higher than those of IPFs, the grouping effect may further raise per diem payments for IPFs. The opposite effect on IPFs can also occur by inclusion in this market basket, should non-IPF costs be proportionately lower than IPF costs. Is CMS' justification for using this market basket appropriately data driven?

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[2] CMS Proposed Rule: "Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007);" CMS-1306-P [Federal Register January 23, 2006 (Volume 70, No. 14)], at 3620.

[3] CMS Proposed Rule: "Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007);" CMS-1306-P [Federal Register January 23, 2006 (Volume 70, No. 14)], at 3620.

[4] CMS Proposed Rule: "Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007);" CMS-1306-P [Federal Register January 23, 2006 (Volume 70, No. 14)], at 3621.

Because there has not yet been long-term experience in these market basket facilities with the PPS, data for CMS decisions on essential factors like labor share and market basket updates are still limited. Cost-structures may still be in flux, due to the recent change to PPS for some facilities. For this reason, it is important for CMS to conduct an annual review of the pertinent data, to ensure accurate decision-making for adjustments.

LABOR SHARE

The proposed rule increases the labor share of the base rate from 72.528% to 75.923% for RY 2007.[5] Labor share includes wages and salaries, employee benefits, professional fees, all other labor-intensive services, and the labor-related share of capital costs. The increase in the labor share is a function of the proposed change in the market basket to PPS-only entities. Hospitals with a wage index greater than or equal to 1.000 would benefit. CMS should ensure that the labor share is calculated appropriately, based on recent and comprehensive data for the facilities in the market basket.

GEOGRAPHIC LABOR MARKET AND DESIGNATIONS WAGE INDEX ADJUSTMENT

The Office of Management and Budget (OMB) revised its standards defining Metropolitan Statistical Areas, based on the 2000 Census data, including its new definitions of Core-Based Statistical Areas (CBSA).[6] For patient discharges on or after July 1, 2006, CMS wants to apply labor market definitions based on CBSAs for determining the wage index adjustment.[7] This method is consistent with the labor market areas used for DRG hospitals. APA is concerned that these labor market areas accurately reflect actual labor market differentials, which may not always be the case.

These changes resulted in some hospitals being reclassified as rural (from urban) and others as urban (from rural). When certain rural hospitals under MSAs are reclassified as urban CBSAs, they can lose the 17% facility adjustment, afforded to rural facilities to support patient access in typically under-served areas.[8] This is a substantial loss for facilities already operating on marginal or near-marginal status and may result in the failure of some, altogether. Those previously "rural" areas most affected by the reclassification are least likely to be able to withstand the loss of community psychiatric services. This reclassification can result in an overall gain for some facilities and a loss

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[5] CMS Proposed Rule: "Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007);" CMS-1306-P [Federal Register January 23, 2006 (Volume 70, No. 14)], at 3627.

[6] CMS Proposed Rule: "Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007);" CMS-1306-P [Federal Register January 23, 2006 (Volume 70, No. 14)], at 3634.

[7] CMS Proposed Rule: "Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007);" CMS-1306-P [Federal Register January 23, 2006 (Volume 70, No. 14)], at 3635.

[8] CMS Proposed Rule: "Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007);" CMS-1306-P [Federal Register January 23, 2006 (Volume 70, No. 14)], at 3638.

for others. Even though some of the difference may be made up through the increased area wage index, this does not close the gap for many facilities. APA urges CMS to find a method by which a change in geographic designation does not adversely affect a facility's payments. To allow adjustment, facilities should not be allowed to lose financially for a period of three years, as a result of re-designation.

BEHAVIORAL OFFSET

CMS intends to use an offset to account for changes in the ways that personnel may perform coding, i.e., for co-morbidities, and for length-of-stay (LOS) changes that may occur as a result of practice patterns during facilities' transition to a per-diem prospective payment system.[9] CMS should analyze preliminary claims data from 2005 to determine whether its assumptions are correct, as to whether the variable per diem adjustment incentives for shorter LOSs work, as predicted. CMS should also adjust calculations for the behavioral offset to maintain appropriate IPF spending. APA requests assurances that CMS is not unnecessarily setting aside money for behavioral offsets.

EMERGENCY DEPARTMENT ADJUSTMENT

CMS' "Correction. . . " deleted references to "24/7 Full-service emergency department" and replaced this with "Qualifying ED," with respect to the ED adjustment. Patients discharged from a hospital and admitted to the same hospital's psychiatric unit, a new source of admission code "D" has been assigned, effective April 1, 2006, to preclude the ED adjustment.[10] CMS intends that a facility must provide a comprehensive array of medical, as well as psychiatric services, to qualify for the ED adjustment.[11] What criteria will CMS use to determine what constitutes a "comprehensive" array of medical as well as psychiatric services and are these appropriate to ensure high-quality care for psychiatric patients? IPFs should not have to go through the process of submitting documentation to qualify for an ED adjustment each rate year, as it is overly burdensome to do so. APA supports CMS' intent to clarify that a comprehensive array of emergency services includes psychiatric services as well as medical ones, by its proposal to amend § 412.424(d)(1)(V)(A).[12]

PHYSICIAN CERTIFICATION AND RECERTIFICATION

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[9] CMS Proposed Rule: "Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007);" CMS-1306-P [Federal Register January 23, 2006 (Volume 70, No. 14)], at 3620.

[10] CMS Proposed Rule: "Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007);" CMS-1306-P [Federal Register January 23, 2006 (Volume 70, No. 14)], at 3642.

[11] CMS Proposed Rule: "Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007);" CMS-1306-P [Federal Register January 23, 2006 (Volume 70, No. 14)], at 3646.

[12] CMS Proposed Rule: "Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007);" CMS-1306-P [Federal Register January 23, 2006 (Volume 70, No. 14)], at 3641.

CMS proposes to revise § 424.14(d) to have all distinct-part units of acute care hospitals, all critical access hospitals, and all psychiatric hospitals to do initial physician certification at admission or reasonably thereafter with the first recertification to be on the 12th hospital day and subsequent recertification no less than every 30 days (to be set at intervals by the hospital's UR committee).[13] Current PPS requires recertification by day 18. Recertification means that the patient continues to need, on a daily basis, active treatment by or requiring supervision of IPF personnel. If data shows that the average lengths of stay (LOS) for IPF patients is less than or equal to 12 days, then recertification at day 12 presents an unnecessary burden upon the physician because it will be required just as the patient is statistically likely to leave shortly, anyway. Whether these intervals are appropriate depends upon the data upon which CMS relies for LOS and that data should be current and carefully considered. In the absence of compelling data by CMS that warrants imposition of the burden on physicians to recertify patients at day 12, recertification should remain required at day 18, not day 12. CMS has not shown that there is any particular clinical significance to tying recertification to day 12.

SAME DAY TRANSFERS

When a transfer or discharge occurs on the same day as an admission to an IPF, the IPF PPS PRICER does not recognize any covered IPF days and the IPF claims are suspended.[14] APA is cognizant that this type of transfer can be related to the difficulties attendant to caring for patients with co-existing psychiatric and physical disorders. CMS should adopt payment methods that fairly reimburse IPFs without inadvertently overpaying for the same patient. However, in the absence of a minimum of one year IPF PPS claims and cost report data, it is unclear what the most appropriate payment method would be. In addition, APA supports CMS' solution articulated in CMS Transmittal 832, as to how to handle same-day transfer claims that were suspended since January 1, 2005. APA sees no reason not to continue using this method to deal with such claims, in answer to CMS' query on the subject in the proposed rule.

PATIENT-LEVEL ADJUSTMENT FACTORS

CMS would wait, under the proposed rule, until there has been further implementation of the PPS system, in order to obtain more data from which to update patient-level adjustment factors. APA supports CMS' goal of having sufficient data for this process.

DRG ADJUSTMENT

The proposed rule updates the ICD diagnosis codes that are classified to one of the 15 DRGs that are provided a DRG adjustment in the IPF PPS. While some diagnosis codes have been added to DRGs, CMS proposes that the DRG adjustment factors

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[13] CMS Proposed Rule: "Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007);" CMS-1306-P [Federal Register January 23, 2006 (Volume 70, No. 14)], at 3645.

[14] CMS Proposed Rule: "Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007);" CMS-1306-P [Federal Register January 23, 2006 (Volume 70, No. 14)], at 3646-47.

currently being paid to IPFs would remain the same for discharges during the July 1, 2006 - June 30, 2007, payment year. Do data suggest that other DRGs be added to those for which an adjustment is given? CMS should examine the data on an ongoing basis to make this determination.

FIXED DOLLAR LOSS THRESHOLD AND OUTLIER PAYMENTS

The proposed rule seeks to increase the fixed dollar threshold amount for outlier payments from $5,700 to $6,200 to keep the overall outlier payment at 2% of total payments, as per diem rates increase. How can CMS accurately determine that 2% of total payments a reasonably sufficient outlier parameter for IPFs and that the $6,200 threshold was appropriate? APA is concerned that CMS may lack sufficient evidence to support raising this threshold. It would be helpful to know in detail CMS rationale and methodology for doing so. Increasing the threshold means IPFs will lose an additional $500 per outlier patient before an outlier payment is made. That will have a substantial effect on some IPFs that operate on thin margins. The per diem rate increases will offset this loss to a varying degree, depending upon the facility. Has CMS adequately considered charge/cost inflation?

CMS should determine whether there is legal authority to carry over the fixed loss set-aside fund from one fiscal year to the next, to benefit IPFs when economic circumstances change. We urge CMS to compute the threshold calculations using the 2005 claims data before it develops the final rule, to ensure that the two percent set-aside for outliers is available to facilities to spend.

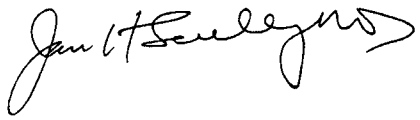
ECT PAYMENTS

CMS proposes to pay the median cost for an ECT treatment established in the calendar year 2006 OPPS update. After adjustments, the ECT payments increase from $247.96 to $254.86. Has CMS ensured that this adequately reflects costs to provide ECT treatments and cost inflation?

CONCLUSION

APA urges CMS to continue to improve Medicare inpatient psychiatric facility payments with updated information and methodology that provides an equitable result for IPFs. APA would also like to encourage CMS to advocate for and work with Congress to obtain increased funding for the IPF PPS. This would provide CMS with more flexibility in creating appropriate and fair payment methods for psychiatric services. Thank you for allowing APA the opportunity to communicate its concerns.

Sincerely,



James H. Scully Jr., M.D.
Medical Director and C.E.O., American Psychiatric Association

Submitter :

Date: 03/14/2006

Organization : **Georgia Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

i.e. See Attachment

CMS-1306-P-18-Attach-1.DOC

March 14, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1306-P, Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007); Proposed Rule.

Dear Dr. McClellan:

On behalf of the Georgia Hospital Association (GHA) and our 180 member hospitals, we appreciate the opportunity to submit comments on the rate year (RY) 2007 inpatient psychiatric facilities (IPF) prospective payment system (PPS) proposed rule. While the bulk of the rule proposes routine updates to the new payment system, we have concerns with some of the policies set forth in the rule.

BUDGET NEUTRAL BASE RATE

Behavioral Offset

In the proposed rule, CMS again includes an offset to account for changes in coding and length of stay that may occur as a result of the transition to a per diem-based prospective payment system. However, CMS does not indicate whether an analysis was conducted to determine if continuing an adjustment of such magnitude is warranted. We believe the assumptions CMS made, for both this rate year and last, overestimate the likely impact of changes in hospitals' behavior for several reasons.

First, accurate coding is already a high priority in distinct-part units and some freestanding facilities. In distinct-part units, those assigning the appropriate codes to psychiatric patients' records already code for many other patients for whom payment is based on the diagnosis related group (DRG) to which they are assigned, and the co-morbidities recorded for them. Therefore, coding practices in general hospitals with distinct-part units, which care for 50 percent of psychiatric patients, should not undergo any major changes.

Second, the system includes a variable per diem adjustment that reduces payments based on length of stay, minimizing hospitals' incentive to keep patients for additional days of care. This

decreased payment, coupled with strong utilization review by many payors, makes it less likely that stays will increase.
Third, because the PPS is being phased in, and only 50 percent of the payment made for a patient's stay in the second year will be based on the IPF PPS, the incentive for behavior change is diminished.

We urge CMS to analyze the preliminary 2005 claims data and adjust the calculations for the behavioral offset to maintain IPF spending at appropriate levels.

TEFRA Caps
We believe an error was made in the calculation of the baseline against which budget neutrality is measured. Under the Balanced Budget Act of 1997 (BBA), the temporary caps on facility-specific (TEFRA) payments expired in 2002. Yet, CMS used those capped payments, inflated by the market basket rate for each year until the PPS actually began in 2005, to establish the baseline for budget neutrality purposes. We believe that CMS should have used what would have been spent, absent the expired temporary caps inflated forward using the market basket rate, to establish the baseline. Using the capped payments inappropriately reduced the allowed aggregate spending under the PPS each year.

UPDATE ON PER-DIEM BASE RATE

Market Basket
CMS proposes to implement a rehabilitation, psychiatric and long-term care hospital – or "RPL" – market basket index, a measure of inflation based on 2002 data for the RY 2007 PPS-based portion of payments. CMS historically has used the inpatient-excluded hospital market basket, which also includes cancer and children's hospitals.

GHA generally supports the shift to an "RPL" market basket. We agree that the cost structures of children's and cancer hospitals likely are different than those of other inpatient PPS exempt hospital types now under prospective payment, and should be removed. However, we have some reservations about the methodology used in constructing the "RPL." For instance, CMS had to piece together data from each of the three provider types by using disparate length-of-stay trimming methodologies to create a sufficient data pool. CMS also has had to fill in perceived gaps or inadequacies in the data by substituting inpatient PPS data where necessary. Thus, we believe that CMS should work with providers to improve the areas of the cost report where CMS lacks confidence so that data from the inpatient PPS is not necessary. We further believe that CMS should regularly re-analyze the market basket in an effort to refine it, particularly since these providers only recently converted to prospective payment and their cost structures may be changing. This also will ensure that the labor-related share to which the wage index applies is as accurate as possible, which is of particular importance given that this portion of the payment can be adjusted either positively or negatively depending on the provider. In addition, a regular analysis will allow CMS to continue to consider the possibility of provider specific market basket indices.

PATIENT-LEVEL ADJUSTMENTS

CMS is not proposing significant changes to the patient level payment adjustments in RY 2007, as it plans to wait until at least one year's worth of claims and cost-report data are available. However, we do have comments on the proposed changes to the comorbidities adjustments.

Comorbidities Adjustments

Tracheostomy Comorbidity Category

We recommend adding code V55.0 to the tracheostomy comorbidity category which includes code V44.0, tracheostomy status. If treatment were being provided to the tracheostomy such as toilet or cleansing, the correct code would be V55.0, rather than V44.0. Page 54 of the December 1, 2005 version of the *Official Guidelines for Coding and Reporting* specifically cited this as an example.

Chronic Renal Failure Comorbidity Category

We recommend that code 404.03 – hypertensive heart disease and renal disease, malignant, with heart failure and renal failure – should qualify for both the cardiac conditions and chronic renal failure comorbidity adjustments. This is similar to a diabetic patient that has both uncontrolled diabetes and chronic renal failure (codes 250.42 and 585.9) or uncontrolled diabetes and gangrene (codes 250.42 and 785.4). Coding rules allow for both these conditions to be coded separately, and each one qualifies for a different comorbidity.

If ICD-9-CM conventions and the *Official Guidelines for Coding and Reporting* (Section I, C, 7, a, 4) would not require a combination code (404.03) for hypertensive heart and kidney disease, these conditions would be reported using the following codes:

- Malignant hypertensive heart disease with heart failure (code 402.01), which currently is included in the cardiac conditions comorbidity category with an adjustment factor of 1.11; and
- Chronic renal failure (code 585.6-585.9 or, as of October 1, 2005, changed to chronic kidney disease), which currently is included in the chronic renal failure comorbidity with an adjustment factor of 1.11.

When the stage of chronic kidney disease (CKD) is unknown – or if the documentation only refers to chronic renal failure, or chronic kidney disease, or chronic renal insufficiency – only code 404.03 would be assigned and only the cardiac conditions adjustment applied. However, when CKD is documented as stage III to V, or as end-stage renal disease, they would correctly get an adjustment for the cardiac condition and the renal failure because two codes would be reported: 404.03, plus a code from 585.3 to 585.6.

We recommend that CMS be sensitive to ICD-9-CM combination codes in constructing variables for any future regression analyses to avoid any potential coding conflicts.

Digestive and Urinary Artificial Openings Comorbidity Category
We recommend adding codes V55.1 to V55.6 to the artificial openings, digestive and urinary comorbidity category. The rationale for adding these codes is similar to our comment under tracheostomy. Codes V44.1 to V44.6 listed in this comorbidity are status codes. The ICD-9-CM instructions have an exclusion note under V44 for artificial openings requiring attention or management to be coded using category V55.

Obstetrical Psychiatric Diagnoses
Claims that do not contain a principal diagnosis from Chapter 5 of the ICD-9-CM or DSM, or are listed in the code first table, do not receive the DRG adjustment.

We recommend that processing logic be developed to allow a DRG adjustment for mental health conditions in obstetrical (OB) patients. We recommend that the processing system look for cases with a principal diagnosis of 648.30 to 648.34 or 648.40 to 648.44, and then search the secondary diagnosis for Chapter 5 codes (290 to 319) to assign a DRG adjustment.

The *Official Guidelines for Coding and Reporting* require that the OB code be listed first, followed by the appropriate mental health disorder or drug dependence code – Chapter 11 (OB) codes have sequencing priority over codes from other chapters (Guideline I, C, 11, a, 1).

For example, if a pregnant patient is admitted for continuous cocaine dependence, the principal diagnosis would be reported 648.32 with a secondary diagnosis of 304.21. A patient admitted for a postpartum panic attack would be coded with a principal diagnosis of 648.44 and secondary diagnosis of 300.01.

FACILITY-LEVEL ADJUSTMENTS

CMS does not propose any significant changes to the facility-level payment adjustments until one year's worth of claims data are available. However, we have some concerns regarding the wage index adjustment.

Wage Index Adjustment
After a yearlong transition, the fiscal year (FY) 2006 inpatient general acute hospital wage index fully incorporates the Office of Management and Budget's revised standards defining Metropolitan Statistical Areas, based on the 2000 Census data, including its new definitions of Core-Based Statistical Areas (CBSA). For the IPF PPS, CMS proposes fully implementing the new labor market definitions for RY 2007.

While CMS discusses the effects on some hospitals previously classified as urban now re-designated as rural, it does not discuss the effects on some hospitals previously classified as rural being re-designated as urban. These facilities will lose the 17 percent rural adjustment, which in the vast majority of cases is not offset by the corresponding increase in their wage index. We believe that CMS should provide a transition for these hospitals to protect them against extreme losses due to this policy change. Specifically, we recommend that CMS add a hold-harmless provision that prevents the per-diem rate under the PPS portion of payments for

these facilities from dropping below what they would have otherwise received had they remained designated as rural for RYs 2007, 2008 and 2009. CMS commonly provides a hold harmless provision for providers who are disproportionately harmed by policy changes related to labor market area changes. Under the inpatient PPS, for instance, hospitals that were urban and became rural based on CBSA changes were given a three-year hold harmless period due to the disproportionately negative affect. Almost 50 rural facilities will experience a decrease in their per diem rates after being re-designated as urban under the new CBSAs. These facilities provide crucial access to psychiatric services and cannot withstand up to a 16.3 percent decrease in their per diem rates.

OTHER ADJUSTMENTS AND POLICIES

Outlier Payments

CMS proposes raising the outlier fixed-loss threshold amount from $5,700 to $6,200. However, CMS neither presented its methodology for calculating the threshold, nor provided detailed evidence indicating the need to raise the threshold amount in the rule. We urge CMS to recompute the threshold calculations using the 2005 claims data in advance of the final rule to ensure that the two percent of aggregate spending set aside for outliers does not go unspent. We further recommend that CMS use the same methodology employed under the inpatient PPS to calculate the threshold. If CMS is unable to analyze the 2005 claims data, we believe that it should maintain the threshold at its current level. In addition, we urge CMS to provide a more thorough description of its methodology and calculations in the final rule.

Physician Recertification

During the first year of the PPS, CMS required physician recertification of medical necessity by day 18. However, there has been confusion surrounding the conditions of participation requirements for inpatient acute-care facilities versus inpatient psychiatric facilities. In the rule, CMS proposes making physician certification requirements consistent between the two; thus, physician certification would be required at admission (or shortly thereafter), and recertification would be required on day 12. Subsequent recertification would be required depending on the recommendation of the hospital utilization review committee, but occur no less frequently than every 30 days.

Our members tell us that day 18 recertification is preferable, as the recertification process is administratively burdensome, and while there may have been some confusion at first, this has dissipated. In addition, the variable per diem adjustment guards against an incentive to keep patients longer, thus an earlier recertification is unnecessary. Given no evidence to the contrary, CMS should maintain the current recertification policy. We suggest CMS clarify that facilities may choose to recertify earlier for consistency across their units or payor types, if they so choose.

Same Day Transfers

Our members advise us that same day transfers result from difficulty in diagnosing mental health disorders and/or substance use in combination with a physical ailment. Frequently, a patient is admitted to the psychiatric unit for a full evaluation, after which it's determined that

the patient's medical condition is too complex for treatment in that unit. Such situations are in no way reflective of units trying to skirt billing rules. In fact, facilities are only acting in accordance with physicians' orders to admit patients. We support CMS' current policy for 2005 claims that same day transfers be paid the PPS per diem. We believe that if CMS conducts a thorough examination of the 2005 claims, it will not find this to be a prevalent occurrence. If CMS then decides that it would like to investigate other options for payment, we urge the agency to convene the field through an open-door forum or other such venue to discuss the possibilities. This is a very complex issue, and we do not have enough time during the comment period, nor the appropriate claims data, to adequately assess the options presented by CMS in the rule. However, our association would be happy to participate in future dialogues about this issue.

We do, however, support CMS' instructions to count a day for cost reporting purposes if the day of admission and the day of discharge are the same; thus, both the hospital transferring the patient and the hospital receiving that patient will count that day for cost reporting purposes. In addition, we agree that only one day should be applied toward a beneficiary's 190-day, lifetime limit. Beneficiaries should not have their covered days inappropriately reduced because of difficulty diagnosing them and placing them in the appropriate care setting.

Data

We urge CMS to release an impact file with the final rule in the form of a downloadable Excel file. While GHA appreciates CMS' release of a limited data set, most providers are unable to purchase and analyze such an extensive file. A more limited file that will assist providers in determining the impact of the final rule on them, such as the files released as part of the inpatient PPS rulemaking cycle, is essential for providers and associations to analyze payment rules and provide informed comments. In addition, we urge CMS to construct this file using 2007 rates and policies, with 2005 claims instead of 2002 claims for volume of services, to arrive at a more accurate assessment of the impact.

The GHA appreciates the opportunity to submit these comments on the proposed rule regarding the IPF PPS payment update. If you have questions about our remarks, please feel free to contact Karen Waters, VP Professional Services at 770 249-4540 or kwaters@gha.org.

Sincerely,

Joseph Parker
President

Submitter : Ms. PATRICIA ANDERSEN **Date:** 03/14/2006

Organization : OKLAHOMA HOSPITAL ASSOCIATIN

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHED LETTER

CMS-1306-P-19-Attach-1.DOC

March 14, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1306-P, Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007); Proposed Rule.

Dear Dr. McClellan:

On behalf of the Oklahoma Hospital Association's (OHA) member hospitals which include over 20 free-standing and distinct part unit psychiatric facilities, we appreciate this opportunity to submit comments on the rate year (RY) 2007 inpatient psychiatric facilities (IPF) prospective payment system (PPS) proposed rule. The rule primarily addresses what CMS views as updates to the relatively new prospective payment system for psychiatric facilities. We and our members submit the following comments and concerns which we trust you will consider prior to moving the rule from "proposed" to final.

BUDGET NEUTRAL BASE RATE

Behavioral Offset

In the proposed rule fro RY 2007, CMS again includes an offset to account for changes in coding and length of stay that may occur as a result of the transition to a per diem-based prospective
payment system. We objected to the magnitude of this "neutrality" adjustment last year and further object for the coming year. If an adjustment were appropriate for the prior year, it should not need to be further adjusted for the coming year. Further, CMS does not indicate whether an analysis was conducted to determine if continuing an adjustment of such magnitude is warranted. We believe the assumptions CMS made, for both this rate year and last, overestimate the likely impact of changes in hospitals' behavior for several reasons.

1. Accurate coding is already a high priority in distinct-part units and some freestanding facilities. In distinct-part units, those assigning the appropriate codes to psychiatric patients' records already code for many other patients for whom payment is based on the diagnosis related group (DRG) to which they are assigned, and the co-morbidities recorded for them. Therefore, coding practices in general hospitals with distinct-part units, which care for 50 percent of psychiatric patients, should not undergo any major changes.

2. The system includes a variable per diem adjustment that reduces payments based on length of stay, minimizing hospitals' incentive to keep patients for additional days of care. This decreased payment, coupled with strong utilization review by many payers, makes it less likely that stays will increase.

3. Because the PPS is being phased in, and only 50 percent of the payment made for a patient's stay in the second year will be based on the IPF PPS, the incentive for behavior change is diminished.

Therefore, we urge CMS to analyze the preliminary 2005 claims data and adjust the calculations for the behavioral offset to maintain IPF spending at appropriate levels.

TEFRA Caps
We believe an error was made in the calculation of the baseline against which budget neutrality is measured. Under the Balanced Budget Act of 1997 (BBA), the temporary caps on facility-specific (TEFRA) payments expired in 2002. **Yet, CMS used those capped payments**, inflated by the market basket rate for each year until the PPS actually began in 2005, to establish the baseline for budget neutrality purposes. We believe that CMS should have used what would have been spent, absent the expired temporary caps inflated forward using the market basket rate, to establish the baseline. Using the capped payments inappropriately reduced the allowed aggregate spending under the PPS each year.

UPDATE ON PER-DIEM BASE RATE

Market Basket
CMS proposes to implement a rehabilitation, psychiatric and long-term care hospital – or "RPL" – market basket index, a measure of inflation based on 2002 data for the RY 2007 PPS-based portion of payments. CMS historically has used the inpatient-excluded hospital market basket, which also includes cancer and children's hospitals.

The OHA generally supports the shift to an "RPL" market basket. We agree that the cost structures of children's and cancer hospitals likely are different than those of other inpatient PPS-exempt hospital types now under prospective payment, and should be removed. However, we have some reservations about the methodology used in constructing the "RPL." These concerns include the following:

1. CMS had to piece together data from each of the three provider types by using disparate length-of-stay trimming methodologies to create a sufficient data pool.

2. CMS also has had to fill in perceived gaps or inadequacies in the data by substituting inpatient PPS data where necessary.

Therefore, we recommend the following:

1. CMS work with providers to improve the areas of the cost report where CMS lacks confidence so that data from the inpatient PPS is not necessary.

2. CMS regularly re-analyze the market basket in an effort to refine it, particularly since these providers only recently converted to prospective payment and their cost structures may be changing.

The above changes ensure that the labor-related share to which the wage index applies is as accurate as possible, which is of particular importance given that this portion of the payment can be adjusted either positively or negatively depending on the provider. In

addition, a regular analysis will allow CMS to continue to consider the possibility of provider-specific market basket indices.

PATIENT-LEVEL ADJUSTMENTS

CMS is not proposing significant changes to the patient level payment adjustments in RY 2007, as it plans to wait until at least one year's worth of claims and cost-report data are available. However, we agree with the concerns expressed by the American Hospital Association regarding needed changes to the comorbidities adjustments as expressed in their letter to you dated March 8, 2006.

FACILITY-LEVEL ADJUSTMENTS

CMS does not propose any significant changes to the facility-level payment adjustments until one year's worth of claims data are available. However, we have some concerns regarding the wage index adjustment.

Wage Index Adjustment—Holdharmless for Newly Designate Rural Facilities
After a yearlong transition, the fiscal year (FY) 2006 inpatient general acute hospital wage index fully incorporates the Office of Management and Budget's revised standards defining Metropolitan Statistical Areas, based on the 2000 Census data, including its new definitions of Core-Based Statistical Areas (CBSA). For the IPF PPS, CMS proposes fully implementing the new labor market definitions for RY 2007.

While CMS discusses the effects on some hospitals previously classified as urban now re-designated as rural, it does not discuss the effects on some hospitals previously classified as rural being re-designated as urban. These facilities will lose the 17 percent rural adjustment, which in the vast majority of cases is not offset by the corresponding increase in their wage index. We believe that CMS should provide a transition for these hospitals to protect them against extreme losses due to this policy change.

Specifically, we recommend that CMS add a hold-harmless provision that prevents the per-diem rate under the PPS portion of payments for these facilities from dropping below what they would have otherwise received had they remained designated as rural for RYs 2007, 2008 and 2009. CMS commonly provides a hold harmless provision for providers who are disproportionately harmed by policy changes related to labor market area changes. Under the inpatient PPS, for instance, hospitals that were urban and became rural based on CBSA changes were given a three-year hold harmless period due to the disproportionately negative affect.

OTHER ADJUSTMENTS AND POLICIES

Outlier Payments
CMS proposes raising the outlier fixed-loss threshold amount from $5,700 to $6,200. However, CMS neither presented its methodology for calculating the threshold, nor

provided detailed evidence indicating the need to raise the threshold amount in the rule. We urge CMS to recompute the threshold calculations using the 2005 claims data in advance of the final rule to ensure that the two percent of aggregate spending set aside for outliers does not go unspent. We further recommend that CMS use the same methodology employed under the inpatient PPS to calculate the threshold. If CMS is unable to analyze the 2005 claims data, we believe that it should maintain the threshold at its current level. In addition, we urge CMS to provide a more thorough description of its methodology and calculations in the final rule.

Physician Recertification

During the first year of the PPS, CMS required physician recertification of medical necessity by day 18. There has been confusion surrounding the conditions of participation requirements for inpatient acute-care facilities versus inpatient psychiatric facilities. In the proposed rule, CMS proposes making physician certification requirements consistent between the two; thus, physician certification would be required at admission (or shortly thereafter), and recertification would be required on day 12. Subsequent recertification would be required depending on the recommendation of the hospital utilization review committee, but occur no less frequently than every 30 days.

Because the recertification process is administratively burdensome and the initial confusion has been greatly reduced, we recommend retaining the 18 day recertification timeline. In addition, the variable per diem adjustment guards against an incentive to keep patients longer, thus an earlier recertification is unnecessary. Given no evidence to the contrary, CMS should maintain the current recertification policy. CMS may clarify that facilities may choose to recertify earlier for consistency across their units or payer types, if they so choose.

Same Day Transfers

Our membership advises us that same day transfers result from difficulty in diagnosing mental health disorders and/or substance use in combination with a physical ailment. Frequently, a patient is admitted to the psychiatric unit for a full evaluation, after which it's determined that the patient's medical condition is too complex for treatment in that unit. Such situations are in no way reflective of units trying to skirt billing rules. In fact, facilities are only acting in accordance with physicians' orders to admit patients. The OHA supports CMS' current policy for 2005 claims that same day transfers be paid the PPS per diem. We believe that if CMS conducts a thorough examination of the 2005 claims, it will not find this to be a prevalent occurrence. If CMS then decides that it would like to investigate other options for payment, we urge the agency to convene the field through an open-door forum or other such venue to discuss the possibilities. This is a very complex issue requiring significant data and time to properly analyze and adequately assess the options presented by CMS in the rule. However, the OHA, other state hospital associations and the AHA would be happy to participate in future dialogues about this issue.

OHA does support CMS' instructions to count a day for cost reporting purposes if the day of admission and the day of discharge are the same; thus, both the hospital transferring the patient and the hospital receiving that patient will count that day for cost reporting purposes. In addition, we agree that only one day should be applied toward a beneficiary's 190-day, lifetime limit. Beneficiaries should not have their covered days inappropriately reduced because of difficulty diagnosing them and placing them in the appropriate care setting.

Data

We urge CMS to release an impact file with the final rule in the form of a downloadable Excel file. While the OHA appreciates CMS' release of a limited data set, most providers are unable to purchase and analyze such an extensive file. A more limited file that will assist providers in determining the impact of the final rule on them, such as the files released as part of the inpatient PPS rulemaking cycle, is essential for providers and associations to analyze payment rules and provide informed comments. In addition, we urge CMS to construct this file using 2007 rates and policies, with 2005 claims instead of 2002 claims for volume of services, to arrive at a more accurate assessment of the impact.

The OHA appreciates the opportunity to submit these comments on the proposed rule regarding the IPF PPS payment update. If you have questions about our remarks, please feel free to contact me at 405-427-9537 or pandersen@okoha.com

Sincerely,

Patricia Andersen

Patricia Andersen, CPA
CFO & VP-Finance & Strategic Information
Oklahoma Hospital Association

Submitter : Mrs. Karen Heller **Date:** 03/14/2006

Organization : Greater New York Hospital Association

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1306-P-20-Attach-1.PDF

Attachment #20

GREATER NEW YORK HOSPITAL ASSOCIATION
GNYHA
Greater New York Hospital Association
555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

March
Fourteen
2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 443-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Subject: Medicare Program; Inpatient Psychiatric Facility Prospective Payment System Payment Update for Rate Year 2007, Beginning July 1, 2006; Proposed Rule; *Federal Register*, Vol. 71, No. 14, January 23, 2006, pp. 3616–3752. [CMS–1306–P]

Dear Dr. McClellan:

On behalf of the approximately 75 not-for-profit and public inpatient psychiatric facilities that are members of the Greater New York Hospital Association (GNYHA), I greatly appreciate the opportunity to comment upon the Centers for Medicare & Medicaid Services' (CMS's) proposed rule for the rate year (RY) 2007 Inpatient Psychiatric Facility Prospective Payment System (IPF PPS).

RY 2007 represents the second year in the transition to the IPF PPS, and CMS has not proposed to make significant changes, with one exception. The Agency is proposing to replace the Metropolitan Statistical Areas (MSAs) with Core-Based Statistical Areas (CBSAs) as the basis upon which the area wage adjustments are made. This was not a surprise to us, since CMS has made this change in many other prospective payment systems. And our opposition to this change will not be a surprise to CMS, since we have vigorously resisted it on the grounds that the CBSAs were not developed to represent hospital labor markets and, thus, result in inappropriate boundaries in many parts of the United States, including the metropolitan New York area.

In the context of the IPF PPS, however, we particularly oppose the timing of the labor market change. The IPF PPS was based upon a regression model that was carefully constructed to vary payments in accordance with expected cost variation. In other words, the model was optimized

for payment accuracy. Changing a significant variable outside of the context of a full revision of the regression model immediately disturbs the balance of the PPS and diminishes payment accuracy. Therefore, in general, we believe that CMS should not make significant changes to the PPS in an ad hoc way, but should accumulate such changes and make them together in the context of periodic updates to the regression model. Since we were influential in the development of the IPF PPS, we admit to a special concern about its integrity, but our recommendation extends to all of the empirically-based payment systems. Moreover, since CMS is expected to undertake a full revision of the IPF PPS within the next few years, there is a specific opportunity to change the labor markets in the proper way. There is no reason to distort the payment system so soon after it has begun. Therefore, our principal recommendation is that CMS postpone changing the labor market definitions until it can do so in the context of revising the IPF PPS regression model.

However, if CMS is unwilling to postpone implementation of the CBSAs in the IPF PPS, then we advise the Agency to provide a transition to the CBSAs in the form of a blend of MSA- and CBSA-based wage indices in RY 2007. The Agency provided such a transition in the acute inpatient PPS, the outpatient PPS, the inpatient rehabilitation facility PPS, and the skilled nursing facility PPS, but did not propose a wage index blend for the IPF PPS because the new system itself is still under transition. While this is so, we believe that the severe fiscal impact of the labor market change on hospitals losing their rural adjustment nonetheless justifies a blend. This effect could be mitigated by holding those hospitals harmless from the loss of their rural status, but we believe that approach would be inappropriate because it would then overpay those facilities and further harm disadvantaged urban hospitals by requiring a negative budget neutrality adjustment to the federal per diem rate. Instead, we believe that CMS should simply continue the transition policy it began with the acute inpatient PPS. Of course all of these distortions could be avoided by postponing the change in the labor markets until the regression model is revised.

We will reiterate these recommendations below, where we present our comments on the wage index and several other issues in the requested order.

UPDATE ON PER DIEM BASE RATE

CMS has proposed updating the IPF PPS based upon the price changes and weights inherent in the rehabilitation, psychiatric, and long-term care (RPL) market basket. The alternative market basket would have been the excluded hospital plus capital market basket, which is based upon the RPL hospitals as well as cancer and children's hospitals. We think the RPL market basket is the appropriate choice because the mix of inputs is similar among these hospitals, which tend to be more labor-intensive than cancer, children's, and other acute care hospitals. Therefore, we endorse CMS's proposal.

On a related matter, we were interested in CMS's comment that it used data from acute care hospitals to develop cost weights for certain categories in the RPL market basket because there were insufficient data in the rehabilitation, psychiatric, and long-term care hospital cost reports. We would greatly appreciate it if CMS would explain in the IPF PPS final rule exactly how it computes cost category weights based on Medicare cost report data. If we understood which data

elements were used and how they were used, we could develop educational programs to improve our member hospitals' reporting.

Recommendations:

- *CMS should proceed to use the RPL market basket to determine the inflation update and the labor-related share of the federal per diem rate in the IPF PPS.*

- *CMS should explain exactly how it develops market basket weights from Medicare cost report data so that programs can be developed to improve the reporting of these data.*

ADJUSTMENT FACTORS—PATIENT-LEVEL ADJUSTMENTS

DRG Adjustment for Obstetrical Cases

In order to receive a DRG adjustment in the IPF PPS, the claim must have a principal diagnosis that falls into one of the following categories:

- The diagnosis would have caused the case to be grouped into a psychiatric DRG under the acute inpatient PPS; or

- The diagnosis is otherwise listed in Chapter 5 of the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM); or

- The diagnosis otherwise appears in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR); or

- The diagnosis appears in the IPF PPS *Code First* table.

We note that psychiatric patients who are also obstetrical patients currently cannot receive a DRG adjustment because they do not fall into any of the foregoing categories. The *Official ICD-9-CM Guidelines for Coding and Reporting* requires that Chapter 11 (obstetrics) codes be listed before codes from other chapters. This is similar to the *Code First* situation, except that in that situation only a select number of Chapter 5 codes are affected, while in the case of obstetrics patients, all psychiatric codes are affected. Because we believe that CMS did not intend to preclude obstetrical cases from receiving a DRG adjustment in IPF PPS, we recommend that CMS correct this problem in the RY 2007 final rule.

Recommendation: CMS should ensure that obstetrical patients with psychiatric illness receive a DRG adjustment in the IPF PPS by developing an algorithm that would accommodate the fact that obstetrical codes have sequencing priority over psychiatric codes.

Comorbidity Adjustment for Renal Failure, Chronic

CMS noted that the diagnosis code for chronic kidney disease has been disaggregated from a single code, 585, to multiple codes 585.1–585.9, which distinguish among various levels of

illness. In response, the Agency said that only new codes 585.3–585.9 would qualify for a comorbidity adjustment in the IPF PPS. This proposal would deny a comorbidity adjustment for codes 585.1 and 585.2, which are chronic kidney disease, Stage I and Stage II, respectively.

We believe that this exclusion is inappropriate because the comorbidity adjustment was derived from all chronic kidney disease cases, including the least severe. If it had been possible to exclude these cases from the regression model that generated the comorbidity adjustments, the adjustment for chronic kidney disease would have been higher than 11%, the level associated with all cases. In other words, CMS's proposal is a form of comorbidity refinement in the absence of actually refining the chronic kidney disease adjustment. It would be reasonable for CMS to refine this adjustment when it revises its regression model, but until then, we believe that cases with codes 585.1 and 585.2 should continue to receive a comorbidity adjustment.

Recommendation: CMS should continue to provide a comorbidity adjustment for all patients with chronic kidney disease until it revises its regression model.

Comorbidity Adjustment for Tracheostomy

The secondary diagnosis codes that yield a comorbidity adjustment for tracheostomy include code V44.0, which is a status code. According to the *Official ICD-9-CM Guidelines for Coding and Reporting*, code V55.0, Attention to artificial opening, tracheostomy, should be used if any treatment is being provided to the patient. Therefore, we believe that this code should qualify a psychiatric patient for a tracheostomy comorbidity adjustment as well.

Recommendation: CMS should add code V55.0, Attention to artificial opening, tracheostomy, to the tracheostomy comorbidity category.

Comorbidity Adjustment for Artificial Openings, Digestive and Urinary

The secondary diagnosis codes that yield a comorbidity adjustment for artificial openings, digestive and urinary, include codes V44.1–V44.6, which are status codes. Again, we believe that the "attention to artificial opening" codes should be added as well because they are required for any artificial openings requiring attention or management.

Recommendation: CMS should add the following codes to the artificial opening, digestive and urinary, comorbidity category:

- *V55.1, Attention to artificial opening, gastrostomy;*
- *V55.2, Attention to artificial opening, ileostomy;*
- *V55.3, Attention to artificial opening, colostomy;*
- *V55.4, Attention to artificial opening, other artificial opening of digestive tract;*
- *V55.5, Attention to artificial opening, cystostomy; and*
- *V55.6, Attention to artificial opening, other artificial opening of urinary tract.*

ADJUSTMENT FACTORS—FACILITY-LEVEL ADJUSTMENTS

Area Wage Adjustment

As it has done in the context of updates to the other prospective payment systems, CMS has proposed to change the definition of the labor markets upon which the IPF PPS area wage adjustments are based from the MSAs that the Medicare program used for more than 20 years to the new CBSAs. We have consistently opposed this change because it is arbitrary and capricious rather than policy-based and has, thus, resulted in inappropriate hospital labor market boundaries in many parts of the United States, including the metropolitan New York area. Furthermore, the resulting wage indices have a strong interactive effect on the other payment parameters in the IPF PPS, so that changing them without adjusting the other parameters will diminish the accuracy and integrity of the new payment system.

CMS is expected to revise the regression model upon which the IPF PPS is based as early as for RY 2009 or shortly thereafter. Therefore, so as not to distort the new payment system after only one year of implementation, we strongly urge the Agency to postpone changing the labor markets until it can be done in the context of revising the regression model. If the other payment parameters are allowed to adjust to the changing labor markets/wage indices, then the impact of redefining the labor markets will be appropriately mitigated.

This solution is superior to providing a labor market transition, or a hold harmless for particularly hard-hit hospitals, because it preserves payment accuracy for all hospitals and access to services for all Medicare beneficiaries. Nonetheless, if CMS is unwilling to postpone implementation of the CBSAs in the IPF PPS, then we advise the Agency to provide a one-year transition to the CBSAs, just as it did in other prospective payment systems. A transition is preferable to a hold harmless for a subset of hospitals because the latter would exacerbate the payment inequities resulting from the labor market change by requiring a negative budget neutrality adjustment to the federal per diem rate.

Recommendations:

- *In order to preserve payment accuracy and the integrity of the new payment system, we strongly urge CMS to postpone implementing the CBSAs in the IPF PPS until it revises the regression model and, thus, the other payment parameters as well.*

- *If the Agency is unwilling to postpone implementation of the CBSAs, then we recommend implementation of a one-year transition to the mitigate the effect of the change on hospitals losing their rural add-on as well as all other hospitals adversely affected by the labor market change.*

Emergency Department (ED) Adjustment

CMS is proposing to amend § 412.424(d)(1)(V)(A) to clarify the definition of a "dedicated ED." In that context we recommend that CMS also state that once an IPF has submitted documentation to its fiscal intermediary and received approval for the ED adjustment, it does not have to submit

further documentation annually for continued approval. Rather, on a less frequent basis, it can assert that there are no material changes to the original documentation.

Recommendation: CMS should establish a process whereby IPFs that have received approval for the ED adjustment can continue to receive the adjustment without submitting documentation to the fiscal intermediary on an annual basis.

OTHER ADJUSTMENTS AND POLICIES

Interrupted Stays

We observed that CMS did not address payment policy for interrupted stays in the proposed rule, so we assume that the Agency intends to continue to reimburse these stays in the same manner as it is currently doing.

Recommendation: We request that CMS confirm in the final rule that it is not changing its current payment policy for interrupted stays.

Physician Recertification Requirement

CMS has proposed to advance the initial recertification from the 18th day of the patient's stay to the 12th day. Since many patients are discharged after the 12th day but before the 18th day, changing the initial recertification date would impose an increased administrative burden on psychiatric facilities. Given the financial fragility of these facilities, it can be assumed that any increase in administrative activities would come at the expense of patient care activities. Therefore, we believe that CMS should advance the initial recertification date only if it determines that IPFs are increasing their lengths of stay under the new per diem reimbursement methodology. Since there is no evidence that this is occurring, we believe that CMS should not change the initial recertification date for RY 2007.

Recommendation: CMS should not change the timeframe of the initial recertification because there is no empirical evidence at this time that increasing the administrative burden of IPFs is warranted by increased lengths of stay.

Same Day Transfers

Same-day transfers are patients who present to an IPF with psychiatric illness and are evaluated and stabilized, but who do not stay overnight and are instead transferred to another facility for appropriate longer-term treatment. In the RY 2006 final rule, CMS did not promulgate a payment policy for these cases and therefore pended their claims for about a year. On February 2, 2006, CMS issued Transmittal 832 (Change Request 4264) which released the pended claims and reimbursed them as one-day stays. Notwithstanding that decision, CMS requested comments regarding the appropriate payment policy for same-day transfers.

We believe that CMS should either continue to reimburse same-day transfers as one-day stays or derive a partial payment based on an empirical analysis. CMS should not arbitrarily designate a

lower payment level. We would be pleased to conduct such an empirical analysis; however, the version of the Medicare Provider Analysis and Review (MedPAR) file that non-government researchers can access does not contain the date and time of each case, which would be needed to identify same-day transfers. Therefore, we cannot compare the cost of same-day transfers with the cost of one-day stays. Either CMS should conduct its own empirical analysis and review its results with the hospital industry, or the Agency should release a version of MedPAR with the relevant information to qualified researchers.

Recommendation: CMS should continue to reimburse same-day transfers as one-day stays unless it can demonstrate empirically that the cost of the former is sufficiently less than the cost of the latter to justify a partial payment.

FOLLOW UP

We hope our comments have been helpful and, again, we greatly appreciate the opportunity to provide them. If you or your staff have any questions or would like to discuss these issues further, please do not hesitate to contact me at (212) 506-5408/heller@gnyha.org or Christopher Vaz, Ph.D., at (212) 506-5514/vaz@gnyha.org.

Very truly yours,

Karen S. Heller
Senior Vice President and Executive Director, THEORI
The Health Economics and Outcomes Research Institute
At the Greater New York Hospital Association

Submitter : Mr. Michael Breen **Date:** 03/14/2006

Organization : St John Health

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1306-P-21-Attach-1.DOC

March 13, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1306-P
P.O. Box 8010
Baltimore, MD 41244-8012

RE: CMS-1306-P, Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY2007); proposed Rule.

Dear CMS Leadership:

St. John Health is a leading provider of Behavioral Health Services in the state of Michigan providing inpatient psychiatric services at five separate locations in southeast Michigan. Inpatient Psychiatric Facility (IPF) service locations include:

1. St. John Hospital & Medical Center – Detroit, Michigan
2. St. John Detroit Riverview Hospital – Detroit, Michigan
3. Providence Hospital & Medical Centers – Southfield, Michigan
4. St. John Oakland Hospital – Madison Heights, Michigan
5. St. John Macomb Hospital – Warren, Michigan

We appreciate this opportunity to submit comments on the rate year (RY) 2007 inpatient psychiatric facilities (IPF) prospective payment system (PPS) proposed rule. While the bulk of the rule proposes routine updates to the new payment system, we have concerns with some of the policies set forth in the rule. Our detailed comments follow:

BUDGET NEUTRAL BASE RATE

Behavioral Offset

In the proposed rule, CMS includes a reduction factor for anticipated changes in coding and length of stay that may occur as a result of the transition to a per diem-based prospective payment system. However, CMS does not indicate whether an analysis was conducted to

determine if continuing an adjustment of such magnitude is warranted. We believe the assumptions CMS made, for both this rate year and last, overestimate the likely impact of changes in hospitals' behavior for several reasons.

First, coding accuracy is a high priority in distinct-part units. Those assigning the appropriate codes to psychiatric patients' records already code for many other services for whom payment is based on the diagnosis related group (DRG) to which they are assigned, and the co-morbidities recorded for them. Therefore, coding practices in general hospitals with distinct-part units, which care for 50 percent of psychiatric patients, should not undergo any major changes.

Second, the system includes a variable per diem adjustment that reduces payments based on length of stay, minimizing hospitals' incentive to keep patients for additional days of care. This decreased payment, coupled with strong utilization review, makes it less likely that stays will increase.

Third, because the PPS is being phased in, and only 50 percent of the payment made for a patient's stay in the second year will be based on the IPF PPS, the incentive for behavior change is diminished.

We urge CMS to analyze the preliminary 2005 claims data and adjust the calculations for the behavioral offset to maintain IPF spending at appropriate levels.

TEFRA Caps

As noted in the American Hospital Association's comments to CMS, we believe an error was made in the calculation of the baseline against which budget neutrality is measured. Under the Balanced Budget Act of 1997 (BBA), the temporary caps on facility-specific (TEFRA) payments expired in 2002. Yet, CMS used those capped payments, inflated by the market basket rate for each year until the PPS actually began in 2005, to establish the baseline for budget neutrality purposes. We believe that CMS should have used what would have been spent, absent the expired temporary caps inflated forward using the market based rate, to establish the baseline. Using the capped payments inappropriately reduced the allowed aggregate spending under the PPS each year.

UPDATE ON PER-DIEM BASE RATE

Market Basket

CMS proposes to implement a rehabilitation, psychiatric and long-term care hospital – or "RPL" – market basket index, a measure of inflation based on 2002 data for the RY 2007 PPS-based portion on payments. Historically CMS has used the inpatient-excluded hospital market basket, which also includes cancer and children's hospitals.

St. John Health generally supports the shift to an "RPL" market basket. We agree that the cost structures of children's and cancer hospitals are somewhat different that those of other inpatient PPS-exempt hospital types now under prospective payment, and should be excluded. However, we have some reservations about the methodology used in constructing the "RPL". For instance, due to lack of data, the CMS had to piece together data form each of the tree provider types by using disparate length-of-stay trimming methodologies to create a sufficient data pool. In addition, the CMS had to fill in perceived gaps or inadequacies in the data by substituting

inpatient PPS data where necessary. Thus, we believe that CMS should work with providers to improve the areas of the cost report where CMS lacks confidence so that data from the inpatient PPS is not necessary. We further believe that CMS should regularly re-analyze the market basket in an effort to refine it, particularly since providers only recently converted to prospective payment and their cost structures may be changing. This also will ensure that the labor-related share to which the wage index applies is as accurate as possible, which is of particular importance given that this portion of the payment can be adjusted either positively or negatively depending on the provider. In addition, a regular analysis will allow CMS to continue to consider the possibility of provider-specific market basket indices.

PATIENT-LEVEL ADJUSTMENTS

CMS is not proposing significant changes to the patient level payment adjustments in RY 2007, as it plans to wait until at least one year's worth of claims and cost-report data are available. However, we do have comments on the proposed changes to the comorbidities adjustments.

Comorbidities Adjustments

Tracheostomy Comorbidity Category

We recommend adding code V55.0 to the tracheostomy comorbidity category, which includes code V44.0, tracheostomy status. If treatment were being provided to the tracheostomy such as toilet or cleansing, the correct code would be V55.0, rather than V44.0. Page 54 of the December 1, 2005 version of the Official Guidelines for Coding and Reporting specifically cited this as an example.

Chronic Renal Failure Comorbidity Category

We recommend that code 404.03 – hypertensive heart disease and renal disease, malignant, with heart failure and renal failure – should qualify for both the cardiac conditions and chronic renal failure comorbidit5y adjustments. This is similar to a diabetic patient that has both uncontrolled diabetes and chronic renal failure (codes 250.42 and 585.9) or uncontrolled diabetes and gangrene (codes 205.42 and 785.4). Coding rules allow for both these conditions to be coded separately, and each one qualifies for a different comorbidity.

If ICD-9-CM conventions and the Official Guidelines for Coding and Reporting (Section I, C, 7, a, 4) would not require a combination code (404.03) for hypertensive heart and kidney disease, these conditions would be reported using the following codes:

- Malignant hypertensive heart disease with hear failure (code 402.01), which currently is included in the cardiac conditions comorbidity category with an adjustment factor of 1.11; and
- Chronic renal failure (code 585.6-585.9 or, as of October 1, 2005, changed to chronic kidney disease), which currently is included in the chronic renal failure comorbidity with an adjustment factor of 1.11.

When the stage of chronic kidney disease (CKD) is unknown – or it the documentation only refers to chronic renal failure, or chronic kidney disease, or chronic renal insufficiency – only code 404.03 would be assigned and only the cardiac conditions adjustment applied. However, when CKD is documented as stage III to V, or as end-stage renal disease, they would correctly get an adjustment for the cardiac condition and the renal failure because two codes would be reported: 404.03, plus a code from 585.3 to 585.6.

We recommend that CMS be sensitive to ICD-9-CM combination codes in constructing variables for any future regression analyses to avoid any potential coding conflicts.

Digestive and Urinary Artificial Openings Comorbidity Category
We recommend adding codes V55.1 to V55.6 to the artificial openings, digestive and urinary comorbidity category. The rationale for adding these codes is similar to our comment under tracheostomy. Codes V44.1 to V44.6 listed in this comorbidity are status codes. The ICD-9-CM instructions have an exclusion note under V44 for artificial openings requiring attention or management to be coded using category V55.

Obstetrical Psychiatric Diagnoses
Claims that do not contain a principal diagnosis from Chapter 5 of the ICD-9-CM or DSM, or are listed in the code first table, do not receive the DRG adjustment.

We recommend that processing logic be developed to allow a DRG adjustment for mental health conditions in obstetrical (OB) patients. We recommend that the processing system look for cases with a principal diagnosis of 648.30 to 648.34 or 648.40 to 648.44, and then search the secondary diagnosis for Chapter 5 codes (290 to 319) to assign a DRG adjustment.

The *Official Guidelines for Coding and Reporting* require that the OB code be listed first, followed by the appropriate mental health disorder or drug dependence code – Chapter 11 (OB) codes have sequencing priority over codes from other chapters (Guideline I, C, 11, a, 1).

For example, if a pregnant patient is admitted for continuous cocaine dependence, the principal diagnosis would be reported 648.32 with a secondary diagnosis of 304.21. A patient admitted for a postpartum panic attack would be coded with a principal diagnosis of 648.44 and secondary diagnosis of 300.01.

FACILITY-LEVEL ADJUSTMENTS

The CMS does not propose any significant revisions to the facility-level payment adjustments until one year's worth of claims data are available. However, we have some concerns regarding the Emergency Department and wage index adjustments.

Emergency Department Adjustment

To account for the costs associated with maintaining a full service emergency department (ED), the CMS provides a facility-specific adjustment to the federal per diem base rate. The CMS was concerned about creating an incentive for psychiatric units in acute care hospitals to admit all psychiatric patients through the ED. As an alternative, the CMS decided to provide a facility-level adjustment for psychiatric hospitals, acute care hospitals with a distinct part psych unit, and CAHs with a distinct part psychiatric unit that maintain qualifying EDs. The adjustment is provided only to hospitals or CAHs with EDs that are staffed and equipped to furnish a comprehensive array of emergency services and that meet the definition of a "dedicated emergency department". The ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay, resulting in IPFs that have qualifying EDs receiving a higher variable per diem adjustment for the first day of each stay. In order to receive the Ed adjustment, the CMS required IPFs to notify their fiscal intermediaries that they met the criteria and were eligible for the ED adjustment.

Although the CMS is not proposing any changes to the ED adjustment, St. John Health requests that the CMS clarify whether it is necessary for IPFs to submit correspondence to their fiscal intermediary to indicate that they do have a qualifying ED and therefore, should be paid based on the higher rate for the first day of the stay. It would seem that this action would not be necessary by providers unless there has been a change since the prior year.

Wage Index Adjustment
After a yearlong transition, the fiscal year (FY) 2006 inpatient general acute hospital wage index fully incorporates the Office of Management and Budget's revised standards defining Metropolitan Statistical Areas, based on the 2000 Census data, including its new definitions of Core-Based Statistical Areas (CBSA). For the IPF PPS, CMS proposes fully implementing the new labor market definitions for 2007, which will result in some IPFs receiving reduced Medicare payments under the new CBSAs. As a result, St. John Health urges the CMS to provide a transitional phase-in of CBSAs for IPFs similar to that used for IPPS facilities in FY 2005. We believe that this is needed to protect providers that will be negatively impacted by the new labor markets.

OTHER ADJUSTMENTS AND POLICIES

Outlier Payments
The CMS proposes to increase the outlier fixed-loss threshold amount by approximately 9 percent, from the current $5,700 to $6,200. However, the CMS neither presented its methodology for calculating the threshold, nor provided detailed evidence indicating the need to raise the threshold amount in the rule. In advance of the final rule, St. John Health urges the CMS to recompute the threshold calculations using the 2005 claims data to ensure that the two percent of aggregate spending set aside for outliers does not go unspent. We further recommend that the CMS utilize the same methodology employed under the inpatient PPS for calculating the IPF outlier threshold. If the CMS is unable to analyze the 2005 claims data, we believe that the agency should maintain the threshold at its current level. In addition, we urge the CMS to provide a detailed description of the methodology and calculations in the final rule.

Physician Recertification
During the first year of the PPS, the CMS required physician recertification of medical necessity by day 18. However, there has been confusion surrounding the conditions of participation requirements for inpatient acute-care facilities versus inpatient psychiatric facilities. In the rule, the CMS proposes making physician certification requirements consistent between the two; thus, physician certification would be required upon admission (or shortly thereafter), and recertification would be required on day 12. Subsequent recertification would be required depending on the recommendation of the hospital utilization review committee, but occur no less frequently than every 30 days.

Our care teams have indicated that day 18 recertification is preferable, as the recertification process is administratively burdensome. While there may have been confusion initially, this has dissipated. The recertification is a burden to providers and requiring the recertification every 12 days will further increase the burden. In addition, the IPF PPS is a variable per diem system that pays a higher rate at the beginning of a stay, which safeguards against providers keeping patients longer. Thus, an early recertification is not necessary. St. John Health believes the CMS should

maintain the current recertification policy. We also suggest the CMS clarify that facilities may opt to recertify earlier for consistency across their units or payor types, if they so choose.

Same Day Transfers

Our care teams have advised us that same day transfers result from difficulty in diagnosing mental health disorders and/or substance use in combination with a physical ailment. Frequently, a patient is admitted to the psychiatric unit for a full evaluation, and subsequently, it is determined that the patient's medical condition is too complex for treatment in that unit. Such situations are in no way reflective of units trying to skirt billing rules. In fact, facilities are only acting in accordance with physicians' orders to admit patients. St. John Health is supportive of the CMS' current policy for 2005 claims that same day transfers be paid the PPS per diem. We believe that if the CMS conducts a thorough examination of the 2005 claims, it will not find this to be a prevalent occurrence. If the CMS subsequently decides to investigate other options for payment, we urge the agency to convene the field through an open-door forum or other such venue to discuss the possibilities. This is a very complex issue, and the comment period does not provide adequate time to adequately assess the options presented by the CMS in the rule. However, our national and state hospital associations would welcome the opportunity to participate in future dialogues regarding this issue.

We do, however, support CMS' instructions to count a day for cost reporting purposes, if the day of admission and the day of discharge are the same. This results in both the hospital transferring the patient and the hospital receiving that patient counting that day for cost reporting purposes. In addition, we agree that only one day should be applied toward a beneficiary's 190-day, lifetime limit. Beneficiaries should not have their covered days inappropriately reduced due to difficulty diagnosing them and ensuring they are placed in the appropriate care setting.

Impact File

Currently, for the IPPS, the CMS publishes an impact file, which serves as an excellent tool for providers in analyzing and evaluating the current payment system. In addition, the file is very useful to providers and associations during the comment period. St. John Health urges the CMS to release an impact file with the IPF final rule similar to the file released as part of the IPPS rulemaking cycle. In addition, we also suggest that the CMS develop the file using 2007 rates and policies along with the most current claims data in order to achieve the most accurate assessment of the IPF PPS.

St. John Health appreciates the opportunity to submit these comments on the proposed rule regarding the IPF PPS payment update. If you have any questions about our remarks, please feel free to contact my office at (586) 753-0646 or Michael.breen@stjohn.org.

Respectfully Submitted,

Michael F. Breen
V.P. Behavioral Health

Submitter : Mr. David Carlini **Date:** 03/14/2006

Organization : Prince William Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1306-P-22-Attach-1.DOC

March 14, 2006

Mark McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1306-P, Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007); Proposed Rule.

Dear Dr. McClellan:

As a provider of general hospital-based inpatient psychiatric treatment, the Prince William Health System would like to express agreement with the concerns articulated in the recent correspondence from the American Hospital Association dated March 8, 2006.

The letter addresses a number of concerns including base rate calculation methodology and payment adjustments for patient comorbidity as well as payment adjustments for facilities with new labor market definitions relating to the acute hospital wage index. Other concerns included the calculation of the "outlier fixed loss threshold" and proposed rules addressing physician recertification and "same day" transfers between psychiatric and medical programs or facilities.

We are encouraging careful consideration of the concerns raised by the American Hospital Association because of the potential negative impact upon the operational and financial viability of an overall decreasing "pool" of existing acute general hospital-based inpatient psychiatric beds. Be assured the need for these vital inpatient services is growing.

Thank you.

Sincerely,

Vic Khot, MD
President of Medical Staff Organization

Gary Herbek
Chief Operating Officer

Submitter : **Ms. Tina Ford** **Date: 03/14/2006**

Organization : **BESLER Consulting**

Category : **Health Care Industry**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1306-P-23-Attach-1.DOC

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March 14, 2006

Attachment #23

Dr. Mark McClellan
CMS Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-1306-P
P.O. Box 8010
Baltimore, MD 21244

Re: File Code CMS-1306-P

Dear Dr. McClellan:

BESLER Consulting (BESLER) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled *Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007); Proposed Rule*, 71 Federal Register 3616 (January 23, 2006).

While BESLER supports the efforts to ensure that inpatient psychiatric facilities (IPFs) are paid appropriately for acute inpatient psychiatric care, we believe that CMS should revisit the issues listed below to ensure the new payment system meets this goal.

"FACILITY-LEVEL ADJUSTMENTS"

- Wage Index Adjustment - Reclassifications:
  - Section 124 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 gives the Secretary broad authority in developing and making adjustments to the Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS). Therefore, the Secretary should implement all wage index reclassifications that are applicable under IP PPS under the IPF PPS. If an excluded psych unit were to decertify then those psych IP stays under IP PPS would receive the reclassified wage index amount. There doesn't seem to be a difference in the staff between an excluded unit and acute care facility.

- Wage Index Adjustment – "Imputed Rural Floor":
  - Section 124 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 gives the Secretary broad authority in developing and making adjustments to the Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS). Therefore, the Secretary should implement the "imputed" rural floor as applicable under the IP PPS.

Thank you for this opportunity and we look forward to hearing your comments.

Sincerely,

Tina Ford

Tina M. Ford
Senior Manager