ST. VINCENT CHARITY HOSPITAL

A partnership of
The Sisters of Charity of St. Augustine Health System and UniversityHospitals HealthSystem

February 14, 2006

Center for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS – 130-P6
P.O. Box 8010
Baltimore, MD 21244

To Whom It May Concern:

In accordance with "summary" of the rate year 2007 Medicare proposed rule for the Inpatient Psychiatric Facility Prospective Payment System:

1. Re: "Facility-Level Adjustments": Giving the "rural adjustment" is clearly necessary, but ignores the fact that **inner-city** adjustments should also be made. The difficulties of inner-city are one of non-paying high volume in contrast to the more likely rural under use and low volume costs. Clearly, inner-city style inpatient psychiatric facilities must have a 20% positive adjustment at least.

2. Re: "Facility-Level Adjustments": The facilities with emergency departments should not be penalized because they have an inpatient psychiatric facility. My particular hospital has a **psychiatric emergency department** – the only one, possibly in the Midwest? The extra costs of maintaining a psychiatric emergency department and the inpatient psychiatric facility should not be penalized when both settings do their job well for the patient's best interest – efficiently, effectively and timely. There should be no penalty when an inpatient psychiatric facility receives a transfer from acute care medical-surgical units of the same hospital. To penalize transfers is totally unfair—each facility whether it be an emergency department, surgical unit, medical unit, psychiatric unit is doing their jobs, and should be appropriately paid for doing so.

3. Re: "Other Adjustments and Policies": A same day transfer, discharge or death should not penalize any provider's evaluation and treatment efforts. The work is done. It ought to be paid for.

4. Re: "Other Adjustments and Policies": The idea of not paying for "recreational therapy" seems to be counter-productive. These patients are very sick and need every treatment modality available. To begin procedures which remove genuinely helpful treatment approaches is counter-productive. You may save a few bucks on the short-term, but you'll end up paying for it more so later.

5. Please accept these responses in a positive spirit in which they are given.

Sincerely,

Samuel A. Nigro, M.D.
Interim Director
Department of Psychiatry
(216) 592-2850 Phone
(216) 592-2852 Fax

SAN/rj

cc: Jeffrey Jeney, President and CEO, St. Vincent Charity Hospital
David Stewart, Vice President, Hospital Finance, St. Vincent Charity Hospital
Michele Laffin, RN, MSN, Administrative Director, Behavioral Health, St. Vincent Charity Hospital
Debra Krause, RN, Assistant Nurse Manager, Inpatient Psychiatric Units, St. Vincent Charity Hospital

UPMC | University of Pittsburgh Medical Center

200 Lothrop Street
Pittsburgh, PA 15213-2582

February 28, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

ATTENTION: CMS-1306-P

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

Dear Sir or Madam:

On behalf of the University of Pittsburgh Medical Center (UPMC) we are submitting one original and two copies of our comments regarding the Center for Medicare and Medicaid Services (CMS) proposed rule (71 FR 3616-3752, 01/23/2006) "Medicare Program; Proposed Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY2007)"

The following is a summary of UPMC concerns and issues contained in Section IV of the proposed rule:

IV. "OTHER ADJUSTMENTS AND POLICIES".

1. **Therapeutic Recreation in Inpatient Psychiatric Facilities (IPFs)** (Page 3645)

Proposed Rule: In this year's proposed rule CMS indicated that they believe it is no longer appropriate to include references to specific therapies in §412.27. As such CMS is proposing to remove recreational therapy from §412.27(b). CMS also indicates that although it is proposing to remove the specific reference to recreation therapy, they want to emphasize that recreation therapy is, and would continue to be, an accepted therapeutic intervention in psychiatric treatment.

Response: We do not support your position of eliminating the therapeutic recreation therapies references in §412.27(b). The regulation reference indicates:

In order to be excluded from the prospective payment system as specified in §412.1(a)(1), and paid under the prospective payment system as specified in §412.1(a)(2), a psychiatric unit must meet the following requirements:

(a) Admit only patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately only in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in the Fourth Edition, Text Revision of the American Psychiatric Association's Diagnostic and Statistical Manual, or in Chapter Five ("Mental Disorders") of the International Classification of Diseases, Ninth Revision, Clinical Modification.

(b) Furnish, through the use of qualified personnel, psychological services, social work services, psychiatric nursing, occupational therapy, **and recreational therapy.**

(c) Maintain medical records that permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the unit, and that meet the following requirements:

As the text of the (b) section above indicates, the reference to "recreational therapy" is no more specific than the general service and treatment references of occupational therapy or social work services. As such we do not support your claim that recreational therapy is too specific and should be eliminated as only general treatment requirements are appropriate.

In addition we believe the elimination of "recreational therapy" would make it impossible for an unknowledgeable reader to know that Medicare has historically recognized that various forms of recreational therapy have been acceptable adjunctive treatment in psychiatric facilities. Unless the "recreational therapy" reference in section (b) remains, the only other option would be for CMS to add a new section reference such as (d) to clearly indicate for future readers that Medicare has historically recognized "recreational therapy" as an acceptable therapeutic intervention in current and future psychiatric treatment (as clearly indicated in the CMS pre-amble on page 3646.)

We urge CMS to STOP its proposed elimination of the "recreational therapy" reference in section §412.27(b) or to clearly state elsewhere in §412.27 that Medicare has historically recognized "recreational therapy" as an acceptable therapeutic intervention and will do so in current and future psychiatric treatment, as stated in the preamble of (71 FR 3616-3752, 01/23/2006) .

2. Same Day Transfers (Page 3646)

CMS Concern: CMS has concerns with same day transfers from an IPF.

Example: It appears that many of these same day transfer patients are first seen in a hospital's emergency department (ED), are admitted to the hospital's psychiatric unit and, later the same day, determined to be too medically compromised to be

managed in the psychiatric unit. This scenario may occur because the patient presents at the ED and is admitted to the psychiatric unit in the middle of the night, and when the patient's admission to the unit is reviewed by a psychiatrist the next morning, the physician determines that the patient should be discharged for acute care.

CMS further indicates that under TEFRA, a hospital receives its cost up to the hospital's TEFRA limit. The TEFRA limit is based on the hospital's average cost per discharge in a base period. When an admission and discharge occur on the same day, the hospital's cost is unlikely to exceed the TEFRA limit, so the hospital receives its cost for the day. These same day transfers also improve the hospital's payment under TEFRA by slightly reducing its cost per discharge. We are also concerned that when the transfer occurs in the same hospital, this practice circumvents bundling rules under the IPPS, in that it unbundles the ED charges from the IPPS claim and allocates the ED costs to the psychiatric unit even though the patient may have been inappropriately admitted to the unit.

Three Payment Options Proposed by CMS:

Option 1: We could treat these days as covered days under the IPF PPS. However, under the IPF PPS, a 19 percent adjustment to the base rate is applied to day 1 of the stay to reflect the additional administrative and clinical costs associated with admission and the day 1 adjustment is increased to 31 percent when the IPF has a qualifying ED. The IPF may also receive, for example, a teaching adjustment or rural adjustment, for these partial days of care. Several of the claims in our analysis indicate a stay of 2 hours. We are concerned that this approach would overpay IPFs and encourage inappropriate admissions and transfers.

Option 2: Another option would be to make no PPS payment, but continue making TEFRA payments during the IPF PPS transition period. For example, for cost reporting periods beginning in 2006, IPFs will receive a blended payment consisting of 50 percent PPS and 50 percent TEFRA. Therefore, under this approach we would allow some payment for these days for cost reporting periods in 2006 and 2007, but once the IPF PPS transition period is over, the IPFs would receive no payment for these days. We think this approach would encourage changes in admission practices in order to avoid the need to transfer patients. However, once the IPF PPS transition is over, there would be no payment mechanism to pay IPFs for stays in which there is a circumstance, not reasonably foreseeable by the admitting IPF such as a serious change in health status on the day of admission.

Option 3: We could treat these same day transfer cases as covered days under the IPF PPS but limit payment to the Federal per diem base rate or some other payment amount, for example, half the Federal per diem base rate. This approach would limit payment to IPFs in order to provide an incentive for IPFs to make medical clearance determinations as early in the IPF stay as possible. However, we are concerned that

this approach would not lead to changes in admission practices to avoid inappropriate admissions and the need for subsequent transfers.

Response: At this time we support Option 1. Under this option Medicare recognizes IPF same day transfers as a covered Medicare day of care for both the transferring facility and the receiving facility. A day of Medicare utilization is charged only for the admission to the second provider. The transferring facility "will be paid a one day per diem".

This payment approach has been historically recognized by Medicare as shown in section §2205.1 of the Provider Reimbursement Manual Part I. (See below). The only exception identified has been maternity patients as discussed in (PRM, Part I, section §2205.2.)

(PRM, Part I) §2205.1 Days of Admission and Discharge

The day of admission is the day when a person is admitted to a provider for bed occupancy for purposes of receiving inpatient services and counts as a day of inpatient routine care. Except when the day of admission and discharge (or death) are the same, the day of discharge is not counted as a day of inpatient routine care. (However, charges for ancillary services on the day of discharge are included in charges for covered services.) If admission and discharge occur on the same day, the day is considered a day of admission and counts as a day of inpatient routine care. If a patient admitted and discharged on the same day was located only in an ancillary area during the stay, an inpatient day is counted in the routine care area to which the patient was assigned (subject to §2205.2 regarding maternity patients). When a patient is admitted and then transferred from one participating provider to another participating provider before midnight of the same day, a day (except for utilization purposes) is counted at both providers. A day of Medicare utilization is charged only for the admission to the second provider.

This payment methodology for "Same Day Transfers" was again adopted for suspended IPF PPS same day transfer claims from January 1, 2005. (Per Provider Notice 06-037).

While the proposed rule did indicate that some unnecessary IPF same day transfers were identified in their review, no claim volumes were cited as to indicate that this is anything but an occasional occurrence. As such we believe the IPF PPS rules should continue to follow the same day transfer rules historically followed, which is option 1.

Conclusion

We appreciate the opportunity to submit this comment on your proposed changes to the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) for fiscal year 2007 and hope that these comments are considered before any final rules are published.

Sincerely,

Paul Stimmel

Paul Stimmel
Senior Analyst, Special Projects

CC: D. Bobrzynski
E. Karlovich
C. Lewandowski
T. Nigra

American Hospital Association

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March 8, 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 American Hospital Association's (AHA) 4,800 member hospitals, health care systems and other health care organizations, and our 33,000 individual members, 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.

Timing of the Rule
While the proposed rule was delivered to the Federal Register on Friday, January 13, the rule was not posted to the Centers for Medicare & Medicaid Services (CMS) Web site until Wednesday, January 18 and not published in the *Federal Register* until Thursday, January 23. As we stated previously, we believe that the 60-day comment period begins the day the rule is published in the *Federal Register*, as specified in §1871 of the Social Security Act which states: "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" [emphasis added]. If CMS chooses to start the comment period based on the date of display, it must ensure, at the very least, that the display copy is promptly posted to its Web site to provide interested parties sufficient time to review the rule and draft comments before the comment period ends.

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

As noted in prior 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 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 AHA 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 redesignated 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 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 AHA 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, the AHA and state hospital associations 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 the AHA 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 AHA 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 or Danielle Lloyd, senior associate director for policy, at (202) 626-2340 or dlloyd@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

MHA

Massachusetts Hospital
Association

March 10, 2006

Centers for Medicare & Medicaid Services
Attention: CMS–1306–P
P.O. Box 8010
Baltimore, MD 21244.

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

The Massachusetts Hospital Association, on behalf of our member hospitals and psychiatric units, appreciate this opportunity to submit comments on the rate year (RY) 2007 inpatient psychiatric facilities (IPF) prospective payment system (PPS) proposed rule.

FACILITY-LEVEL ADJUSTMENTS - Wage Index Adjustment
For the IPF PPS, CMS proposes fully implementing the new labor market definitions and incorporating the OMB revised standards for Core-Based Statistical Areas (CBSA) for RY 2007. MHA believes that the proposal to immediately implement the CBSA-based wage adjustment factors without the same transition, adjustments and reclassification opportunities provided in the IPPS for general hospitals, is unfair to IPF distinct part units that must compete for scarce skilled workers with the IPPS general hospitals. Without these adjustments Inpatient Psychiatric Facilities will be compromised in their ability attract the personnel to provide appropriate levels of care. There is no justification that a distinct part unit should have an entirely different wage index applied to their payments as that of the general acute hospital, which they are part of, wage index applied under the applicable IPPS rate year. These distinct part units will have a severe competitive disadvantage in recruiting and retaining workers in the psychiatric units compared to the other acute hospital units that are paid a higher wage. All of these units will be similarly impacted by the revised wage areas and should therefore have the same IPPS wage index applied to their units as well. If the stated goal of immediately adopting the CBSA designations is to provide consistency and stability in the Medicare program payment process, then the rule must also recognize that the IPF distinct part unit obviously operates in the same labor market as the acute care hospital they are attached to, and should therefore be afforded the opportunity to account for the variation in hospital labor costs.

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. In these 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 at this time. 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 payers including our state's Medicaid Mental health carve out company, 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 therefore urge CMS to analyze the preliminary 2005 claims data and adjust the calculations for the behavioral offset to maintain IPF spending at 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. While MHA supports the move to a standard post acute "RPL" market basket, we are very concerned about the methodology used. Specifically, CMS is making this change at a time when the various PPS rules for LTCH and IPF facilites have not been completely phased in and the data reflects only two to three years worth of data. As a result, CMS had to piece together data from each of the three provider types by filling in perceived gaps or inadequacies in the data by substituting acute hospital 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, as that does not eflect the type of care and services provided in an LTCH, IRF or IPF. 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.

OTHER ADJUSTMENTS AND POLICIES - Physician Recertification

MHA supports the proposal of making the physician certification requirements consistent between the inpatient acute-care facility units and the inpatient psychiatric facilities. However, we believe the propsal of moving the recertification to day 12 is not consistent with other payer types. Many private payers utilize a recertification on day 18, recognizing that this process will ensure administrative simplification. Further, 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 on day 18 for all provider types. We also suggest that CMS clarify that facilities may further choose to recertify earlier for consistency across their units or payer types, if they so choose.

Should you have any further questions on the issues we have raised above, please do not hesitate to contact me at &781) 272-8000, ext. 173.

Sincerely,

James T. Kirkpatrick
Vice President, Health Care Finance and Managed Care Advocacy

Hardy Wilson Memorial Hospital

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A Proud Past.. A Promising Future

March 10, 2006

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

ATTENTION: CMS-1306-P

Greetings:

We are pleased to submit the following comments on various aspects of the proposed Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Payment Update for Rate Year Beginning July 1, 2006 (RY 2007) published in the Federal Register dated January 23, 2006. We believe that this proposed rule will have a material detrimental effect on our facility and other similarly situated facilities. When discussing IPFs in this letter, we are referring exclusively to a psychiatric unit as a distinct part unit of an acute care hospital. As instructed in the proposed rule, we will outline our concerns related to the areas listed.

FACILITY-LEVEL ADJUSTMENTS

CMS has proposed to change wage indexes for IPFs to be based upon Core Based Statistical Areas (CBSA) rather than Metropolitan Statistical Areas (MSA). We have fundamental problems with this change that relate to consistency. Throughout the proposed update, CMS has emphasized multiple times that they do not intend to make any changes to the regression analysis that will ultimately determine the IPF PPS rates until they have gathered and analyzed 1 year of PPS claims and cost report data. Also, CMS has indicated in this proposed update that the regression analysis will not likely be updated until 2008. However, changing the wage indexes would fundamentally alter the comparability of the cost data that CMS wants to obtain. As a reminder, CMS originally derived IPF PPS per diem costs based on MSA wage indexes unadjusted for geographic reclassification. On one hand, if CMS is not allowing the IPF the geographic reclassifications that apply to the acute care hospital, they must continue MSA wage indexes to maintain the consistency in the regression analysis. On the other hand, if changes to the wage indexes to reflect CBSAs are enacted, CMS is deviating from the regression analysis inconsistent with all other characteristics of the IPF PPS.

To illustrate this inconsistency, CMS has stated that it is not proposing to change the rural adjustment factor add-on of 17% because they do not intend to change the regression analysis. They state that after they obtain enough data, they "can compare rural and urban IPFs to determine how much more costly rural facilities are on a per diem basis under the IPF PPS." Yet, if the CBSA wage indexes are applied, some facilities {*including ours*} will not have comparable data because they will have been changed from rural to urban (and vice-versa) and will thus not receive the 17% add-on, consistent with its first rate year of IPF PPS. Changing facilities from one classification to another without any recourse (such as federal wage reclassifications by the Medicare Geographic Classification Review Board (MGCRB)) will ensure that CMS does not receive comparable data on numerous facilities.

This lack of recourse for similarly situated acute care hospitals and their IPFs illustrates another inconsistency. Unlike acute care hospitals that are allowed by regulation to change from urban to rural status if any of four criteria are met, the IPF of the same hospital has no such avenue for change. Two of the criteria include the facility being located in a rural census tract of a MSA (as determined by Goldsmith Modification by Office of

Rural Health Policy) or being designated as rural by their state. As such, they cannot qualify for the rural add-on, despite evidence that the Hospital is rural and is able to meet the any of the four criteria.

Furthermore, we are concerned about CMS perception that the effects on facilities moving from rural to urban will be immaterial. While on the surface this move would appear to benefit a formerly rural IPF via a higher urban wage index, the effects of a higher urban wage index are materially offset by the loss of the 17% rural add-on that is applied to the entire rate. These adjustments alone will reduce our facility's IPF PPS reimbursement by {*3*}% of reimbursable costs or $\${60,000}$. For some facilities not subject to the PPS transition period, the effects will be immediate and material, contrary to CMS belief that the transition period will mitigate the effects of this material change. Even for those facilities going through the transition period, the CBSA change will consistently reduce a hospital distinct part unit's reimbursement by over 6% in the 50/50 transition year.

Another inconsistency of this proposed update relates to the IPF PPS transition period. Because most facilities are currently approaching or are already in their second transition year (50% cost-based/50% PPS), CMS has stated its belief that the effects of the CBSA changes will be mitigated. They use this as the reason that they will not propose a transition period for wage indexes. Yet, CMS has proposed just such a transition for home health agency (HHAs) and rehabilitation facility (Rehab) PPS methodologies that are affected by the same CBSA changes. This illustrates the inconsistent treatment between provider types, and some hospitals may very well have all of these distinct parts.

Critical access hospitals receive a variation on the same inconsistent treatment. These facilities have already been deemed rural if they were located in a rural census tract of a MSA (as determined by Goldsmith Modification by Office of Rural Health Policy). Or these facilities could have been designated as rural by their state. Yet, the hospital is not deemed rural for purposes of the wage index or receiving the 17% rural add-on, inconsistent with the Medicare program's treatment of the hospital's remaining acute care beds as rural.

CMS has stated that the change to CBSAs would "ensure that the IPF PPS wage index adjustment most appropriately accounts for and reflects the relative hospital wage levels in the geographic area of the hospital as compared to the national average hospital wage level." However, this statement is contradicted if the hospital's inpatient and outpatient wage index has already been geographically reclassified by the MGCRB. Because CMS will still not recognize federal geographic reclassifications that apply to IPFs, wage indexes are applied inconsistently within the same hospital, even though labor markets and shortages are identical. With few exceptions, the IPF is competing for the same employees as the acute care floor.

Another inconsistency is the CMS refusal to allow out-commuting/out-migration adjustment add-on that was allowed for certain acute care hospitals' impatient and outpatient wage indexes. Since the IPF is part of the hospital, it is illogical to assume that IPF employees and acute care employees are not commuting from outside the same immediate area of the hospital.

Finally, CMS has indicated that its wage index policies are appropriate for the IPF because there are "clear distinctions" between the payment systems and wage index issues. Yet, most hospitals will reply that the wage issues they encounter daily for acute care and the IPF are similar if not virtually the same. Regardless of whether the wage index adjustment has been a "stable feature" of acute care hospitals' PPS for over 10 years, the IPF is being asked to accept different treatment than the remainder of its acute care host hospital.

PATIENT-LEVEL ADJUSTMENTS

We are concerned about CMS statement that under the revised regulations, IPFs that are distinct part units of acute care hospitals "may only admit patients who have a principal diagnosis in the DSM-IV-TR or Chapter Five of the ICD-9-CM. While not a new provision, the clarification and emphasis is inconsistent with coding rules, also known as "code first", for which the neurological or physical condition must be coded as the principal diagnosis instead of most dementia diagnoses or transient mental disorders (primarily delirium). This emphasis also appears to be inconsistent with ICD-9 codes that map into DRGs 012 or 023 that are accepted

as part of the IPF PPS—neither of which are mental disorders as defined in the ICD-9 coding manual. This emphasis is also inconsistent with the types of elderly patient conditions that are commonly treated in a geriatric unit of a hospital. Based upon the "code first" instructions, we believe that we have been appropriately listing principal diagnoses in the order proscribed by CMS instructions and the ICD-9 coding manual, but do not wish to run afoul of CMS regulations. As such, this regulation appears to be in conflict with earlier CMS instructions for IPF PPS related to "code first".

BACKGROUND

As a critical access hospital, we cannot let discussion of IPF PPS pass without addressing the intent of the critical access regulations. It is our belief that the Medicare Modernization Act of 2003 was never intended to on one hand allow CAHs to have IPFs, but on the other hand subject the new IPF to a completely different system of reimbursement than the host acute care hospital. Not allowing an IPF to be cost-reimbursed can even create reimbursement inconsistency within an IPF. For example, a unit providing outpatient services would be cost-reimbursed for those services while the same unit's inpatient services would be subject to IPF PPS. For consistency purposes, the IPF should be cost-reimbursed just as the majority of the beds and all outpatient services at a CAH are cost-reimbursed.

CONCLUSION

We thank you for the opportunity to comment and provide our perspective on these rule changes that will materially alter our IPF. As you will note, we are very concerned about the potential implications of the proposed rule if implemented as proposed. We hope you find our comments useful and constructive.

Sincerely,

Chief Executive Officer

CHC

COMMONWEALTH HEALTH CORPORATION

John Desmarais
President and
Chief Executive Officer

Connie Smith
Chief Operating Officer

Jean Cherry
Executive Vice President

Ron Sowell
Executive Vice President

March 13, 2006

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

ATTENTION: CMS-1306-P

Greetings:

We are pleased to submit the following comments on various aspects of the proposed Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Payment Update for Rate Year Beginning July 1, 2006 (RY 2007) published in the Federal Register dated January 23, 2006. We believe that this proposed rule will have a material detrimental effect on our facility and other similarly situated facilities. When discussing IPFs in this letter, we are referring exclusively to a psychiatric unit as a distinct part unit of an acute care hospital. As instructed in the proposed rule, we will outline our concerns related to the areas listed.

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CMS has proposed to change wage indexes for IPFs to be based upon Core Based Statistical Areas (CBSA) rather than Metropolitan Statistical Areas (MSA). We have fundamental problems with this change that relate to consistency. Throughout the proposed update, CMS has emphasized multiple times that they do not intend to make any changes to the regression analysis that will ultimately determine the IPF PPS rates until they have gathered and analyzed 1 year of PPS claims and cost report data. Also, CMS has indicated in this proposed update that the regression analysis will not likely be updated until 2008. However, changing the wage indexes would fundamentally alter the comparability of the cost data that CMS wants to obtain. As a reminder, CMS originally derived IPF PPS per diem costs based on MSA wage indexes unadjusted for geographic reclassification. On one hand, if CMS is not allowing the IPF the geographic reclassifications that apply to the acute care hospital, they must continue MSA wage indexes to maintain the consistency in the regression analysis. On the other hand, if changes to the wage indexes to reflect CBSAs are enacted, CMS is deviating from the regression analysis inconsistent with all other characteristics of the IPF PPS.

To illustrate this inconsistency, CMS has stated that it is not proposing to change the rural adjustment factor add-on of 17% because they do not intend to change the regression analysis. They state that after they obtain enough data, they "can compare rural and urban IPFs to determine how much more costly rural facilities are on a per diem basis under the IPF PPS." Yet, if the CBSA wage indexes are applied, some facilities, including ours, will not have comparable data because they will have been changed from rural to urban (and vice-versa) and will thus not receive the 17% add-on, consistent with its first rate year of IPF PPS. Changing facilities from one classification to another without any recourse (such as federal wage reclassifications by the Medicare Geographic Classification Review Board (MGCRB)) will ensure that CMS does not receive comparable data on numerous facilities.

This lack of recourse for similarly situated acute care hospitals and their IPFs illustrates another inconsistency. Unlike acute care hospitals that are allowed by regulation to change from urban to rural status if any of four criteria are met, the IPF of the same hospital has no such avenue for change. Two of the criteria include the facility being located in a rural census tract of a MSA (as determined by Goldsmith Modification by Office of Rural Health Policy) or being designated as rural by their state. As such, they cannot qualify for the rural add-on, despite evidence that the Hospital is rural and is able to meet the any of the four criteria.

Furthermore, we are concerned about CMS perception that the effects on facilities moving from rural to urban will be immaterial. While on the surface this move would appear to benefit a formerly rural IPF via a higher urban wage index, the effects of a higher urban wage index are materially offset by the loss of the 17% rural add-on that is applied to the entire rate. These adjustments alone will reduce our facility's IPF PPS reimbursement by 10% of reimbursable costs or $106,000. For some facilities not subject to the PPS transition period, the effects will be immediate and material, contrary to CMS belief that the transition period will mitigate the effects of this material change. Even for those facilities going through the transition period, the CBSA change will consistently reduce a hospital distinct part unit's reimbursement by over 6% in the 50/50 transition year.

Another inconsistency of this proposed update relates to the IPF PPS transition period. Because most facilities are currently approaching or are already in their second transition year (50% cost-based/50% PPS), CMS has stated its belief that the effects of the CBSA changes will be mitigated. They use this as the reason that they will not propose a transition period for wage indexes. Yet, CMS has proposed just such a transition for home health agency (HHAs) and rehabilitation facility (Rehab) PPS methodologies that are affected by the same CBSA changes. This illustrates the inconsistent treatment between provider types, and some hospitals may very well have all of these distinct parts.

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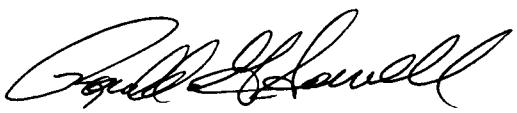

Ron G. Sowell
Executive Vice President and Chief Financial Officer

Greenville
Regional Hospital
Caring for those you love.

March 13, 2006

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

ATTENTION: CMS-1306-P

Greetings:

Greenville Regional Hospital is a non-profit, acute care, 42-bed facility located approximately 50 miles east of St. Louis. The hospital offers comprehensive medical services that include a 10-bed, Geriatric Behavioral Health Unit. The unit serves patients in a wide, geographic area covering approximately 50 miles.

We are pleased to submit the following comments on various aspects of the proposed Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Payment Update for Rate Year Beginning July 1, 2006 (RY 2007) published in the Federal Register dated January 23, 2006. We believe that this proposed rule will have a material detrimental effect on our facility and other similarly situated facilities. When discussing IPFs in this letter, we are referring exclusively to a psychiatric unit as a distinct part unit of an acute care hospital. As instructed in the proposed rule, we will outline our concerns related to the areas listed.

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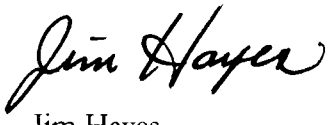
DSM-IV-TR or Chapter Five of the ICD-9-CM. While not a new provision, the clarification and emphasis is inconsistent with coding rules, also known as "code first", for which the neurological or physical condition must be coded as the principal diagnosis instead of most dementia diagnoses or transient mental disorders (primarily delirium). This emphasis also appears to be inconsistent with ICD-9 codes that map into DRGs 012 or 023 that are accepted as part of the IPF PPS—neither of which are mental disorders as defined in the ICD-9 coding manual. This emphasis is also inconsistent with the types of elderly patient conditions that are commonly treated in a geriatric unit of a hospital. Based upon the "code first" instructions, we believe that we have been appropriately listing principal diagnoses in the order proscribed by CMS instructions and the ICD-9 coding manual, but do not wish to run afoul of CMS regulations. As such, this regulation appears to be in conflict with earlier CMS instructions for IPF PPS related to "code first".

CONCLUSION

The proposed reductions in funding will significantly impact the financial viability of the medical services offered within our Geriatric Behavioral Health Unit. The reduction or elimination of these services could occur if these decreases in reimbursement are implemented.

We thank you for the opportunity to comment and provide our perspective on these rule changes that will materially alter our IPF. As you will note, we are very concerned about the potential implications of the proposed rule if implemented as proposed. We hope you find our comments useful and constructive.

Sincerely,



Jim Hayes
President and CEO
Chief Executive Officer

The following comments are in reference to file code CMS-1306-P

Issue Identifier: TABLE 11. –FY 2006 DIAGNOSIS CODES AND ADJUSTMENT FACTORS FOR COMORBIDITY CATEGORIES

We recommend that the following items be changed or added to Table 11, that was published on page 3632 of the Federal Register/Vol. 71, No. 14/Monday, January 23, 2006/Proposed Rules.

Also, please see the attached Microsoft Excel file (Table for CMS-1306-P) to view a table containing the analysis of charges that are referred to within this comment.

Comorbidity category Severe Protein-calorie malnutrition:

Recommendation: Add ICD-9-CM code 263.9 Unspecified protein-calorie malnutrition.

Rationale: In FY 2005 our Med/Psych Units had a total of 528 Medicare discharges with DRGs that are included under the Medicare Program Inpatient Psychiatric Facilities Prospective Payment System. These 528 cases had total charges of $14,259,141, average charges per case of $27,006 and average length of stay of 15 days. Cases with ICD-9-CM code 263.9 had significantly higher average charges of $36,619 ($9,613 per case higher than the total cases) and a significantly higher average length of stay of 19 days (4 days per case higher than the total cases).

Comorbidity category Infectious Disease:

Recommendation: Add ICD-9-CM code 008.45 Intestinal infections due to Clostridium difficile and V09.0 MRSA infections.

Rationale: Cases with ICD-9-CM code 008.45 had significantly higher average charges of $40,531 ($13,525 per case higher than the total cases) and a significantly higher average length of stay of 23 days (8 days per case higher than the total cases).

Cases with ICD-9-CM code V09.0 had significantly higher average charges of $52,373 ($25,367 per case higher than the total cases) and a significantly higher average length of stay of 28 days (13 days per case higher than the total cases).

Comorbidity category Cardiac Conditions:

Recommendation: Develop ICD-9-CM codes for CHF exacerbation and rheumatic heart failure exacerbation and add them to this comorbidity category.

Rationale: It is believed that exacerbations of CHF or rheumatic heart failure are much more resource consumptive than stable CHF.

Recommendation: Add ICD-9-CM code 427.89 Other specified cardiac dysrhythmias (such as bradycardia).

Rationale: Cases with ICD-9-CM code 427.89 had significantly higher average charges of $29,156 ($2,150 per case higher than the total cases) and a significantly higher average length of stay of 17 days (2 days per case higher than the total cases).

Comorbidity category Chronic Obstructive Pulmonary Disease:

Recommendation: Change the category name to "Respiratory Conditions".

Rationale: COPD is too narrow a description for all of the codes currently contained in this comorbidity category. For example, the codes 510.0 Empyema with fistula, 518.83 Chronic respiratory failure, 518.84 Acute and Chronic respiratory failure and V46.1 category for Respirator (Ventilator) status and management are not within the ICD-9-CM section of COPD (490-496) and would be better classified to a broader title that would encompass all of the codes in this comorbidity category.

Recommendation: Add ICD-9-CM codes 491.22 Obstructive chronic bronchitis with acute bronchitis, 493.01 Extrinsic asthma with status asthmaticus, 493.02 Extrinsic asthma with acute exacerbation, 493.11 Intrinsic asthma with status asthmaticus, 493.12 Intrinsic asthma with acute exacerbation, 493.21 Chronic obstructive asthma with status asthmaticus, 493.22 Chronic obstructive asthma with acute exacerbation, 493.91 Asthma, unspecified with status asthmaticus and 493.92 Asthma, unspecified with acute exacerbation.

Rationale: It is believed these conditions would be managed/treated the same and therefore have the same resource consumption as Obstructive chronic bronchitis with acute exacerbation (491.21), which is currently included in this comorbidity category.

Recommendation: Add ICD-9-CM codes 482.0 Pneumonia due to Klebsiella pneumoniae, 482.41 Pneumonia due to Staph Aureus and 486 Pneumonia, organism unspecified.

Rationale: Cases with these ICD-9-CM codes had significantly higher average charges of $33,653 ($6,647 per case higher than the total cases) and a significantly higher average length of stay of 18 days (3 days per case higher than the total cases).

Recommendation: Add ICD-9-CM code 507.0 Aspiration pneumonia.

Rationale: Cases with ICD-9-CM code 507.0 had significantly higher average charges of $29,424 ($2,418 per case higher than the total cases) and a significantly higher average length of stay of 17 days (2 days per case higher than the total cases).

Recommendation: Add ICD-9-CM code 518.81 Acute respiratory failure.

Rationale: Cases with ICD-9-CM code 518.81 had significantly higher average charges of $35,582 ($8,576 per case higher than the total cases) and a significantly higher average length of stay of 17 days (2 days per case higher than the total cases).

We recommend that additional comorbidity categories be added with the following ICD-9-CM codes:

Recommendation: Add a comorbidity category "Embolism or Thrombosis" and include ICD-9-CM codes 415.19 Other pulmonary embolism and infarction, 451.19 Phlebitis and thrombophlebitis of lower extremities, 452 Portal vein thrombosis, 453.41 and 453.8 Venous embolism and thrombosis of deep vessels of distal lower extremity and of Other specified veins.

Rationale: The case with ICD-9-CM code 415.19 had significantly higher average charges of $107,917 ($80,911 higher than the total cases) and a significantly higher average length of stay of 50 days (35 days per case higher than the total cases).

Cases with ICD-9-CM codes 451.19, 452, 453.41 and 453.8 had significantly higher average charges of $49,915 ($22,909 per case higher than the total cases) and a significantly higher average length of stay of 23 days (8 days per case higher than the total cases).

Recommendation: Add a comorbidity category "Gastrointestinal Bleeding" and include ICD-9-CM codes 531.40 Chronic or unspecified gastric ulcer with hemorrhage without mention of obstruction, 532.40 Chronic or unspecified duodenal ulcer with hemorrhage without mention of obstruction, 562.13 Diverticulitis of colon with hemorrhage and 578.9 Hemorrhage of GI tract, unspecified.

Rationale: Cases with these ICD-9-CM codes had significantly higher average charges of $38,724 ($11,718 per case higher than the total cases) and a significantly higher average length of stay of 19 days (4 days per case higher than the total cases).

Recommendation: Add a comorbidity category "Genitourinary Conditions" and include ICD-9-CM codes 599.0 UTI, site not specified and 599.7 Hematuria.

Rationale: Cases with ICD-9-CM code 599.0 had significantly higher average charges of $32,292 ($5,286 per case higher than the total cases) and a significantly higher average length of stay of 18 days (3 days per case higher than the total cases).

Cases with ICD-9-CM code 599.7 had significantly higher average charges of $29,610 ($2,604 per case higher than the total cases) and a higher average length of stay of 16 days (1 day per case higher than the total cases).

Recommendation: Add a comorbidity category "Skin and Subcutaneous Tissue Conditions" and include ICD-9-CM codes 681.10, 681.11, 682.0, 682.3, 682.4, 682.6 and 682.7 – Cellulitis or Abscess unspecified, of toe, of face, of upper arm and forearm, of hand except fingers and thumb, of leg except foot and of foot except toes and 707.03, 707.05-707.07, 707.09 Decubitus ulcer of lower back, buttock, ankle, heel, and other site.

Rationale: Cases with the above ICD-9-CM codes for cellulitis/abscess had significantly higher average charges of $33,424 ($6,418 per case higher than the total cases) and a significantly higher average length of stay of 19 days (4 days per case higher than the total cases).

Cases with the above ICD-9-CM codes for decubitus ulcers had significantly higher average charges of $37,502 ($10,496 per case higher than the total cases) and a significantly higher average length of stay of 20 days (5 days per case higher than the total cases).

Recommendation: Add a comorbidity category "Neurological Conditions" and include ICD-9-CM codes 332.0 Parkinson's disease, 780.39 Other convulsions and 781.2 Abnormality of gait (gait disorder).

Rationale: Cases with ICD-9-CM code 332.0 had significantly higher average charges of $28,158 ($1,152 per case higher than the total cases) and a higher average length of stay of 16 days (1 day per case higher than the total cases).

Cases with ICD-9-CM code 780.39 had significantly higher average charges of $30,622 ($3,616 per case higher than the total cases) and a significantly higher average length of stay of 17 days (2 days per case higher than the total cases).

Cases with ICD-9-CM code 781.2 had significantly higher average charges of $32,263 ($5,257 per case higher than the total cases) and a significantly higher average length of stay of 17 days (2 days per case higher than the total cases).

Recommendation: Add a comorbidity category "Blood Transfusions" and include ICD-9-CM procedure code 99.04 Transfusion of packed cells.

Rationale: Cases with ICD-9-CM procedure code 99.04 had significantly higher average charges of $37,083 ($10,077 per case higher than the total cases) and a higher average length of stay of 18 days (3 days per case higher than the total cases).

Respectfully Submitted,

David Harnett, M.D.
System Medical Director, Behavioral Health Services
Hallmark Health

Diane M. Jean, RHIA, CCS
Documentation Specialist
Hallmark Health
djean@hallmarkhealth.org

Hallmark Health
585 Lebanon Street
Melrose, MA 02176

Analysis of Hallmark Health Med/Psych FY 05 Charges for Medicare Inpatient Psych PPS Cases

DIAGNOSES	ICD-9-CM CODES	TOTAL # CASES	TOTAL CHARGES	AVERAGE CHRGS/CASE	AVG LOS	$ DIFF FM TOTL	% CHNG IN $	# DIFF FM TOTL
ALL PSYCH PPS FY 05		**528**	**$14,259,141**	**$27,006**	**15**			
MALNUTRITION	263.9	10	$366,187	$36,619	19	$9,613	36%	4
C. DIFF	008.45	32	$1,296,985	$40,531	23	$13,525	50%	8
MRSA RESISTANCE	V09.0	10	$523,731	$52,373	28	$25,367	94%	13
BRADYCARDIA	427.89	5	$145,778	$29,156	17	$2,150	8%	2
PNEUMONIAS	482.0, 482.41, 486	45	$1,514,386	$33,653	18	$6,647	25%	3
ASP PNA	507.0	19	$559,057	$29,424	17	$2,418	9%	2
ACUTE RESP FAILURE	518.81	1	$35,582	$35,582	17	$8,576	32%	2
PULMONARY EMBOLUS	415.19	1	$107,917	$107,917	50	$80,911	300%	35
DVT	451.19, 452, 453.41, 453.8	6	$299,487	$49,915	23	$22,909	85%	8
GI BLEEDING	531.40, 532.40, 562.13, 578.9	10	$387,241	$38,724	19	$11,718	43%	4
UTI	599.0	142	$4,585,479	$32,292	18	$5,286	20%	3
HEMATURIA	599.7	15	$444,150	$29,610	16	$2,604	10%	1
CELLULITIS	681.10, 681.11, 682.0 682.3, 682.4, 682.6, 682.7	25	$835,611	$33,424	19	$6,418	24%	4
DECUBITI	707.03, 707.05-707.07, 707.09	11	$412,524	$37,502	20	$10,496	39%	5
PARKINSON'S DISEASE	332.0	24	$675,790	$28,158	16	$1,152	4%	1
SEIZURE	780.39	22	$673,686	$30,622	17	$3,616	13%	2
GAIT DISTURBANCE	781.2	17	$548,464	$32,263	17	$5,257	19%	2
TRANSFUSION OF PRBCs	Procedure 99.04	8	$296,660	$37,083	18	$10,077	37%	3

SISTERS OF MERCY
HEALTH SYSTEM

March 13, 2006

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

Attention: **CMS-1306-P**

Dear Administrator McClellan:

Sisters of Mercy Health System (Mercy) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled *"Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007)"* 71 Fed. Reg. No. 14 (January 23, 2006). Mercy is a 19-hospital system operating in Missouri, Kansas, Oklahoma, and Arkansas. Throughout Mercy, we operate three distinct part inpatient psychiatric facilities (IPFs).

Mercy is appreciative that CMS is proposing on average a 4.2% IPF PPS rate increase for the 2007 rate year. With Medicare representing Mercy's largest payer of care provided in our IPFs, increases in Medicare payment rates are vital to our commitment to provide effective and efficient quality healthcare.

The primary focus of this letter is to comment on the proposed changes to the regulations for the following issues:

I. UPDATE ON PER DIEM BASE RATE
II. OUTLIER CALCULATION
III. REVISED LABOR MARKET AREAS UNDER IPF PPS

I. UPDATE ON PER DIEM BASE RATE

The proposed regulations state that the Agency is "presently unable to create a separate market basket specifically for psychiatric hospitals due to the small number of facilities

and the limited data that are provided." The regulations, as proposed, suggests to create a RPL (inpatient rehabilitation facility - IRF, inpatient psychiatric facility - IPF and long-term care facility -LTCH) market basket due to this lack of available information and because the three component types are considered similar. However, once the RPL is calculated, it is proposed that CMS split IRFs and LTCHs from IPFs in determining how the RPL is applied. If the three disciplines are enough alike to combine into the RPL, then why would they need to be looked at separately?

The Agency proposes to limit the sample of hospitals with a Medicare average length of stay (LOS) within comparable range of the total facility average LOS. In the RPL calculation, IRFs and LTCHs with Medicare average LOS within 15% of the total facility average LOS for the hospital are included within the tolerance level. However, for IPFs, the tolerance level is facilities with an average LOS within 50% of the total facility average LOS. It would appear that this methodology would take into the calculation a disproportionate share of facilities with a longer LOS. As the proposed regulations state, costs decrease further into a patient's stay, thereby we assume that IPFs have an incompatible cost per discharge when grouped with the lower lengths of stay in the IRFs and LTCHs.

II. OUTLIER CALCULATION

Within the draft regulations, CMS is proposing to increase the outlier threshold from $5,700 to $6,200. The Agency claims to use the same process used in FY 05 to simulate outlier payments equaling 2% of total payments. However, CMS is making no changes to any of the major adjustments, such as patient age, variable per diem, DRGs or comorbidities because they want a year's worth of data under PPS. It would appear that data must exist to restate the outlier threshold without any IPF PPS data or that CMS is picking and choosing the factors to adjust. We suggest to be equitable and fair, all factors within the IPF PPS calculations be adjusted or none be adjusted.

In the calculation of outlier payments, CMS has proposed a ceiling on the IPF's Cost to Charge Ratio (CCR) but has not made a provision for a national CCR minimum or floor. We understand that using the national median CCR in place of an IPF's CCR could overstate the IPF's costs. We ask to protect IPFs with fluctuating charges and costs that an exception to the computed CCR be allowed to be filed with the IPF's Fiscal Intermediary if needed. This provision would help to assure an updated CCR would be used when the CCR on file is out dated.

III. REVISED LABOR MARKET AREAS UNDER IPF PPS

CMS has proposed that CBSA wage index not be transitioned in as done for IPPS because their analyses show that an insignificant number of providers will be materially affected by using the CBSA wage index approach. The phase-in provision was made available to hospitals going to the CBSA wage indices. We question how the impact to hospitals necessitated a phase in, but for IPFs, the impact is considered immaterial. Even though most IPFs will be in their second year of transition to PPS within RY 07, we

request that IPFs be allowed to choose a phase-in of CBSA wage indices if the facility desires to do so.

The Agency has adopted a hold harmless provision for "out-migration" adjustment, yet there is not provision proposed under IPF PPS. If CMS recognizes that our facilities' acute, rehab and OP nurses and other employees are commuting, then how can it be assumed that the employees of the IPF are not commuters themselves? Our population distribution and employment markets for health care providers are the same regardless of the positions filled.

As with the phase-in of CBSA wage indices, we request that IPFs be given the option to elect a phase in of Urban to Rural wage index instead of the rural facility adjustment.

Thank you for this opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above.

If you have questions concerning these comments, please feel free to contact Kyle Lee, Regional Director of Reimbursement at (417) 820-8640.

Sincerely,

James Jaacks,
Sr. Vice President and Chief Financial Officer
Sisters of Mercy Health System

cc: Randy Combs
Ron Trulove
Kyle Lee

Vinson&Elkins

Dennis M. Barry dbarry@velaw.com
Tel 202.639.6791 **Fax** 202.639.6604

March 14, 2006

Via Hand Delivery

Mr. Mark McClellan, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
Attention: CMS-1306-P
200 Independence Avenue, SW
Room 445G
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, January 23, 2006 Federal Register
Facilities In Areas Reclassified from Rural to Urban

Dear Dr. McClellan:

On behalf of Carilion New River Valley Medical Center ("CNRV"), a nonprofit hospital that operates an inpatient psychiatric unit in Christiansburg, Virginia, we appreciate the opportunity to provide input on the proposed rule for the rate year 2007 Medicare Inpatient Psychiatric Facility Prospective Payment System ("IPF PPS"), published in the January 23, 2006 Federal Register. We have significant concerns regarding some of the proposals and hope that you will take our comments into consideration.

FACILITY-LEVEL ADJUSTMENTS

A. Impact of Wage Index Proposals on CNRV

We are concerned that the proposed IPF PPS rule will have serious negative payment consequences for CNRV. Under the current rule, CNRV is designated as a rural hospital for purposes of IPF PPS and has a wage index of 0.8479. Under the proposed standards, CNRV would be redesignated as urban and would be located in the Blacksburg-Christiansburg-Radford Metropolitan Statistical Area. Despite being reclassified from rural to urban, CNRV would see a reduction of more than 5 percent in its wage index from 0.8479 to 0.7954.

While the 5 percent reduction to its wage index is significant in itself, under the proposal, CNRV would also lose the 17 percent rural adjustment if it is designated as an urban hospital.

Taking into account the phase-in to the federal rates, over the course of the first rate year (July 1, 2006 to June 31, 2007), CNRV would experience an overall reduction in its Medicare IPF payments of approximately 7 percent. During the second year, assuming no changes, CNRV would experience an 11 percent reduction in Medicare payments for its IPF from what those payments would be under the current rules. In the third year, payments would be about 15 percent below payment levels under the current rules.

We have prepared a calculation to demonstrate the serious effects the of wage index proposal on CNRV's payment under PPS. The following calculation shows CNRV's per diem rate under the current rules and under the proposed rules.[1] As shown by the chart below, CNRV will experience a drop in the PPS portion of its payments of more than 16 percent if the proposed rule is implemented.

	Current Rule	Proposed Rule
Federal per diem base rate	$575.95	$594.66
Labor share	$416.10	$451.48
Non-labor share	$159.85	$143.18
Wage Index	0.8479	0.7954
Rural adjustment	1.17	0.0
CNRV's per diem rate	$599.81	$502.28
Percent change	**0.0%**	**-16.26%**

We believe that CMS' proposal could detrimentally impact beneficiaries' access to psychiatric services in the Blacksburg-Christiansburg-Radford area. CNRV is the only psychiatric unit within a 30 mile radius of the unit. Rural facilities such as CNRV are critical in order to ensure beneficiaries' access to psychiatric services in rural areas. With estimated

[1] The calculation does not reflect any of the patient-specific adjustments, such as the age and per diem adjustments. The percentage reduction, however, should be consistent.

payments under the proposed rules dropping significantly while costs increase, it is unclear how long CNRV and similarly situated hospitals will be financially able to continue to operate the unit.[2] Thus, we request that CMS reconsider its proposals in light of our comments.

While CMS addressed the potential payment consequences of a hospital going from urban to rural under the proposed rules, CMS did not address the consequences of a rural hospital becoming urban. Specifically, CMS noted that while urban hospitals that become rural may have a reduction in their wage index, this reduction will be mitigated by the 17 percent payment adjustment these hospitals will receive.

However, CMS did not address the more serious consequences to a rural hospital, such as CNRV, that becomes urban under the proposal. These hospitals will lose the 17 percent rural payment adjustment. In some cases, the loss of the 17 percent adjustment will be partially offset by an increase in the IPF's wage index that occurs when the facility is reclassified as urban under the CBSA standards, but even in those cases, the IPF will suffer a significant reduction in PPS payments. CNRV will be particularly hard hit by the proposal because it will lose *both* the 17 percent rural adjustment *and* concurrently experience a 5 percent *reduction* to its wage index.[3]

We believe that the impact to CNRV is particularly significant in light of calculations made by CMS in the Regulatory Impact Analysis ("RIA") for the proposed rule. According to the RIA, *every* type of IPF will actually see an *increase* in payments under the proposed rules, with the sole exception of psychiatric units with less than 12 beds (and even they would see only a 0.2% reduction in payment). Under the proposed rule, if implemented, CMS projects that rural hospitals would see a 3.0% increase in payments. Urban hospitals would see a 4.3% increase in payments under the proposal. Nonprofit hospitals would see a 6.1% jump in payments. Urban nonprofit IPFs would see a 6.2% increase in payments while rural nonprofit hospitals would see a 3.9% increase. Finally, IPFs located in the Mid-Atlantic region would have a 7.3% increase in payments. Overall, CMS estimates that IPFs would receive a 4.2% payment increase under the proposals. 71 Fed Reg. 3616, 3650 (Jan. 23, 2006).

In contrast, CNRV, as detailed above, would experience a 7% *reduction* in payment. Based upon CMS' calculations as detailed in the RIA, we believe that CNRV will be unfairly disadvantaged by the proposed rules as compared to other psychiatric units and hospitals. As

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[2] CNRV is a 96-bed hospital. Its acute care operations are too small and generate too little revenue to enable extensive subsidization of its psychiatric unit.

[3] This reduction occurs because, unlike inpatient hospital PPS, CMS has not applied the rural wage index as a floor to the wage index data used to adjust IPF rates.

noted above, under CMS' proposals, all but one category of psychiatric units and hospitals will see gains in payment under the rules. More specifically, the categories into which CNRV falls would see gains in payment of anywhere from 3% to 7.3%. We believe that a 7% overall reduction in payment to CNRV, especially in light of the projected gains to all but one category of IPF, significantly and unfairly disadvantages CNRV.

A dramatic swing in payment of this nature, a 7 percent decline in overall Medicare payment, and an 11 percent variation from the national average, is exactly the sort of change that a prospective payment system is not supposed to have. The goal of prospective payment is to offer reasonable predictability and consistency in payment. Hospitals such as CRNV should be held harmless from reductions in payment.

B. Character of Facility and of Area Have Not Changed

The 17 percent rural adjustment should not be driven solely by the CBSA standards and the hospital's geographic classification. The 17 percent rural adjustment was computed based on the results of CMS' regression analysis, which was based on 2002 data indicating that hospitals in rural areas have, on average, per diem costs that are 17 percent higher than those in urban areas. While CNRV's psychiatric unit did not exist until 2004, all of CNRV's patients were transferred from a nearby affiliated hospital that closed in 2004. Data from that facility were used as part of CMS' study that was used to compute the 17 percent rural payment adjustment. The patient population characteristics and operating conditions at CNRV are similar to those at the affiliated hospital from which all of CNRV's patients were transferred and have not changed significantly since the unit was opened.

The character of the area comprising the Blacksburg-Christiansburg-Radford MSA did not change significantly between the 1990 and 2000 censuses. In fact, the population of the area making up the Blacksburg-Christiansburg-Radford MSA grew only half as fast as the state of Virginia as a whole. Under the CBSA standards, the Blacksburg-Christiansburg-Radford, Virginia MSA is made up of Giles County, Pulaski County, Montgomery County, and Radford City. According to the 1990 census, the total population of this area was 140,715. According to 2000 census data, the total population of the area had increased to 151,272, an increase of 7.5% over the ten year period. In contrast, the population of the state of Virginia increased 14.4%, an increase nearly twice that of the Blacksburg-Christiansburg-Radford MSA. Furthermore, the U.S. Census estimates that the population of this area has actually *decreased* to 150,870 since the 2000 census.[4]

We believe that nothing in the character of this area or in the character of CNRV has changed that justifies the loss of CNRV's rural adjustment. The population of the area has

[4] All census data was obtained from the U.S. Census bureau website at www.census.gov.

grown at a much slower pace than that of Virginia as a whole; indeed, since 2000, the area has actually *lost* residents. In addition, the operating conditions of CNRV have not changed significantly since the implementation of IPF PPS.

C. Suggested Changes to the Proposed Rule

Where data from hospitals currently receiving the rural adjustment was used to compute that adjustment, we believe that these hospitals should continue to receive the rural adjustment. These are the very hospitals that CMS found had average per diem costs 17 percent higher than those in other more urban areas. The average per diem costs for CNRV and other similarly situated IPFs will not decrease merely because of being reclassified under the CBSA standards. In addition, the character of the area where CNRV is located has not changed significantly. We request that CMS reconsider its position with respect to those hospitals that will lose the rural adjustment under the proposals and request a grandfathering provision that will allow those hospitals currently receiving the rural payment adjustment to continue to receive the adjustment.

At a minimum, we believe that CMS should implement a hold harmless provision for rural hospitals that lose the rural adjustment by virtue of becoming urban under the new rules. We believe that these hospitals should continue to receive the rural adjustment for rate years 2007, 2008, and 2009, and that during this period, their payments should not drop below what they would have been had the IPF remained rural. CMS noted in the proposal that it was not proposing a hold harmless provision for urban hospitals that become urban, because reductions in these hospitals' wage indexes would likely be offset by the 17 percent rural payment adjustment. The same logic does not apply to the opposite situation, i.e., where a rural hospital becomes urban under CBSA standards. A hospital that is redesignated from rural to urban will lose the 17 percent rural adjustment. Any increase in these hospitals' wage indexes will not offset the much larger 17 percent loss. As noted above, some hospitals such as CNRV will actually see their wage indexes decline even though they are redesignated as urban.

CMS has proposed hold harmless provisions in other similar situations where providers would be disproportionately harmed by the loss of their rural adjustment. Under the PPS for inpatient rehabilitation facilities, CMS implemented a three-year hold harmless policy "to mitigate the significant payment implications, particularly large negative impacts" for "those IRFs that meet the definition in § 412.602 as rural in FY 2005 and will become urban under the FY 2006 CBSA-based designations." 70 Fed. Reg. 47880, 47924 (Aug. 15, 2005). CMS noted there that while a majority of rural IRFs redesignated as urban would experience a 5 to 10 percent increase in their wage indexes, "the loss of the rural adjustment

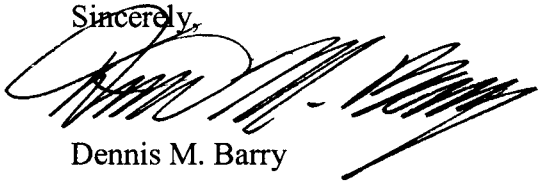
would be such a large negative impact on the rural IRFs that it may potentially cause undue hardship for these rural facilities."

At the time CMS implemented its hold harmless policy for IRFs, the rural adjustment was 19.14 percent, similar to the current rural adjustment for IPFs. *Id.* at 47924. CMS adopted a three-year hold harmless policy to allow rural IRFs redesignated as urban under the CBSA standards time to adjust to the loss of their rural adjustment. CMS recognized that no hold harmless policy was necessary for urban hospital that become rural under the CBSA standards, because any loss in these hospitals' wage indexes would be more than offset by the rural adjustment. According to CMS, "the purpose of the hold harmless policy is to mitigate the significant payment implications for existing rural IRFs that may need time to adjust to the loss of their FY 2005 rural payment adjustment that experience a reduction in payments solely because of such redesignation." *Id.*

We also request that CMS consider implementing a blended wage index for those rural hospitals, such as CNRV, that experience significant reductions in their wage index. As CMS has noted, reductions to an urban hospital's wage index would be more than offset by the rural adjustment these hospitals would gain. The same is not true for those hospitals that are redesignated from rural to urban under the CBSA standards. While some hospitals may experience gains in their wage index, some, including CNRV, will suffer a loss of more than 5 percent. This 5 percent loss will not be offset by gains from other adjustments. Indeed, these hospitals will also lose the 17 percent rural adjustment. We therefore request that CMS consider implementing a blended wage index that will allow these hospitals time to adjust to the potentially large decreases in their wage indexes. CMS implemented a one year blended wage index when it switched to the CBSA standards under IRF PPS. *Id.* at 47922-23. We request that CMS adopt a similar policy to minimize the effects on some rural hospitals, such as CNRV, that experience a 5 percent or more reduction in their wage indexes when they are redesignated as urban.

Thank you for considering our comments.

Sincerely,



Dennis M. Barry

DMB:las

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Wayne MEMORIAL HOSPITAL Always in Touch

March 10, 2006

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

Dear Sir or Madam:

We are aware that the Centers for Medicare and Medicaid Services have published proposed regulations updating the prospective payment rates for Medicare inpatient hospital services provided by inpatient psychiatric facilities (IPFs). With this letter please find enclosed one original and two copies of our comments on the proposed regulations.

We have reviewed these comments in light of the impact on our hospital and utilized an outside consulting firm to assist us in evaluating these very complex regulations. We believe our comments will improve the regulations, creating a more balanced and fair reimbursement system for our hospital.

Respectfully submitted,

J. William Paugh
President & CEO

P.O. BOX 8001 • 2700 WAYNE MEMORIAL DRIVE
GOLDSBORO, NC 27533 • 919.736.1110

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, Osteoarthritis, and Arthropathies
14) 724.0 – 724.9 - Disorders of the Back
15) 780.50 – 780.59 - Sleep Disturbances
16) V45.81 – V45.89 - Other Post surgical Status

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

March 14, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 455-G
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:

In response to the proposed rule for the inpatient psychiatric facility (IPF) prospective payment system (PPS) update for rate year (RY) 2007, the California Hospital Association (CHA) respectfully submits comments on behalf of its nearly 500 hospital and health system members. In addition to these comments, CHA supports the comments and recommendations of the American Hospital Association.

Timing of the Rule

While the proposed rule was delivered to the *Federal Register* on Friday, January 13, the rule was not posted to the Centers for Medicare & Medicaid Services (CMS) website until Wednesday, January 18 and not published in the *Federal Register* until Monday, January 23. As CHA has stated previously, we believe that the 60-day comment period begins the day the rule is published in the *Federal Register*, as specified in §1871 of the Social Security Act, which states: "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" [emphasis added]. If CMS chooses to start the comment period based on the date of display, it must ensure, at the very least, that the display copy is promptly posted to its website to provide interested parties sufficient time to review the rule and draft comments before the comment period ends.

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 PPS. 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 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

As noted in prior comments to CMS, CHA believes an error was made in the calculation of the baseline against which budget neutrality is measured. Under the Balanced Budget Act of 1997, 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. Using the capped payments inappropriately reduces the allowed aggregate spending under the PPS each year. CHA recommends that CMS use what would have been spent, absent the expired temporary caps inflated forward using the market basket rate, to establish the baseline.

UPDATE ON PER-DIEM BASE RATE

Market Basket

Since all rehabilitation, psychiatric and long-term care facilities are now paid under a PPS, CMS proposes to implement a rehabilitation, psychiatric and long-term care (RPL) market basket index, a measure of inflation based on 2002 data for the RY 2007 PPS-based portion of payments. The proposed RPL would update the PPS portion of payments, while the inpatient-excluded hospital market basket, which also includes children's and cancer hospitals, would update the TEFRA portion of payments.

CHA generally supports the proposed implementation of the 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. We do, however, have some reservations about the methodology used in constructing the RPL.

By its own admission, CMS is presently unable to create a separate market basket specifically for psychiatric hospitals due to the small number of facilities and the limited data that are provided (for instance, approximately 4 percent of psychiatric facilities reported contract labor cost data for 2002). As a result, 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. To 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, CHA believes that CMS should work with providers to improve the areas of the cost report where CMS lacks confidence so data from the inpatient PPS is not necessary.

CHA further believes 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

While CMS is not proposing significant changes to the patient-level payment adjustments in RY 2007, CHA does have the following comments on the proposed changes to the comorbidities adjustments.

Comorbidities Adjustments

Tracheostomy Comorbidity Category

CHA recommends adding code V55.0 to the tracheostomy comorbidity category, which includes code V44.0, tracheostomy status. If treatment is 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 cites this as an example.

Chronic Renal Failure Comorbidity Category

CHA recommends 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 who 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, it 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.

CHA recommends 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
CHA recommends 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.

CHA recommends 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, CHA has 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, CHA recommends 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 that 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 redesignated 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. CHA urges CMS to recompute the threshold calculations using the 2005 claims data in advance of the final rule to ensure that the 2 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, it should maintain the threshold at its current level. In addition, CHA recommends that CMS 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.

CHA members tell us that day 12 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. CHA recommends that CMS clarify that facilities may choose to recertify earlier for consistency across their units or payor types, if they so choose.

Same Day Transfers

CHA 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. CHA 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. CHA would be happy to participate in future dialogues about this issue.

CHA does, 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

CHA urges CMS to release an impact file with the final rule in the form of a downloadable Excel file. While CMS' release of a limited data set is appreciated, most providers are unable to purchase and analyze such an extensive file. A more limited file that will assist our members 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.

Thank you for the opportunity to provide comments on this proposed rule. If you have any questions or would like to discuss our comments, please contact Margot Holloway at (202) 488-4688 or mholloway@calhospital.org, or Sheree Kruckenberg at (916) 552-7576 or skruckenberg@calhospital.org.

Sincerely,

Margot Holloway
Vice President, Federal Regulatory Affairs

Sheree Kruckenberg
Vice President, Behavioral Health and Governance

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Federation of American Hospitals®

MAR 14 2006
4:30

FEDERATION OF AMERICAN HOSPITALS
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March 14, 2006

MAIL:
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-1306-P
P.O. Box 8010
Baltimore, MD 21244

RE: File Code CMS-1306-P

Dear Dr. McClellan:

The Federation of American Hospitals ("FAH") is the national representative of investor-owned or managed hospitals and health systems. Our members include general community and teaching hospitals in urban and rural areas as well as the nation's largest freestanding inpatient behavioral healthcare facility systems. We appreciate the opportunity to comment on Rate Year 2007 Inpatient Psychiatric Facilities PPS Payment Update ("IPF PPS").

PROVIDER IMPACT FILES

The FAH requests that CMS make the IPF PPS provider specific impact files publicly available. These files should be comparable to those provided as part of the annual Medicare inpatient DRG and outpatient prospective payment system updates. Industry representatives and providers can review the impact files and then provide fully informed feedback and comment on the annual IPF PPS proposed update. In addition, this disclosure of information to the public may assist in the identification of any material errors or misstatements prior to the publication of the final IPF PPS annual update.

DELAY IN PATIENT LEVEL ADJUSTMENT FACTORS

The FAH supports the CMS decision to delay updating patient-level adjustment factors used in the development and design of initial IPF IPPS implementing final rule in 2004.

801 Pennsylvania Ave., NW, Suite 245 • Washington, DC 20004-2604 • 202-624-1500 • Fax: 202-737-6832

A delay in this update will allow CMS to use more comprehensive and accurate patient level coding data.

BUDGET NEUTRAL BASE RATE

MARKET BASKET

The FAH understands that CMS is presently unable to create a separate market basket for psychiatric hospitals due to the small number of facilities. We agree with the decision to remove cancer and children's hospitals from the market basket and create a new rehabilitation, psychiatric, and long-term care hospital (RPL) market basket. However, we are concerned that all entities in the category have gone to prospective payment relatively recently. As such, the data used to make a number of decisions (such as the labor share and market basket update) will be based on limited data from three provider types who are all going through a PPS phase-in or have only recently achieved full implementation.

Recommendation:

The FAH encourages CMS to review the underlying market basket data possibly annually or at least every two years because provider cost structures may change during this transition to full PPS, and adjustments (such as trim points) may need to be made to ensure a more accurate IPF payment system. As these PPS systems mature, CMS should consider reviewing the market basket on an interval period greater than two years.

BEHAVIORAL OFFSET

The proposed rule continues to maintain the behavioral offset which is intended to protect budget neutrality should higher costs be incurred by Medicare because of changes in provider practice patterns as a result of movement to prospective payment. Practice areas of concern highlighted by CMS are coding for comorbid medical conditions and changes in length of stay. The FAH continues to have concerns that CMS has overestimated the magnitude of behavioral change based on assumptions that will not be borne out when the IPF PPS data become fully available. In the proposed rule, CMS presents no data in the proposed rule to support or refute its original underlying assumptions regarding its behavioral offset.

Recommendation:

The FAH requests CMS to analyze 2005 claims data as soon as possible and to make necessary adjustments in the behavioral offset in order to maintain its statutory mandate of budget neutrality. This change, if warranted as determined by an analysis of the claims data, will result in the establishment of a more accurate IPF PPS federal rate.

FACILITY-LEVEL ADJUSTMENTS:

As determined in the regulatory impact analysis of the proposed rule, the rule will have substantial impact on hospitals classified as "located in rural areas." This impact is driven primarily by new classification of certain IPF rural hospitals under Metropolitan Statistical Areas (MSAs) to Core-Based Statistical Areas (CBSAs). With reclassification, some formerly rural hospitals will now be ineligible for the 17% facility adjustment if they are reclassified as urban. 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. Because of the proposed increase in the labor share (from 72.027% to 75.923%), facilities who will now be classified as urban are particularly disadvantaged.

We understand CMS's position that the transition period for the IPF PPS system as a whole helps mitigate some of the impact of this change. However, the reason for the 17% rural adjustment was to support the financial stability of rural facilities in order to ensure continued access to essential inpatient psychiatric services. These facilities are essential to maintaining an infrastructure that provides treatment for patients in rural areas. Changing to CBSAs does not diminish the financial vulnerability of these facilities.

Recommendation:
To be consistent with CMS prior practice in these wage index matters, e.g. Inpatient Rehabilitation Facility PPS, the FAH recommends that the final rule include a three year hold harmless provision. This provision would provide for a more gradual transition for facilities that would otherwise have their reimbursement levels significantly reduced due to a change in their classification from rural to urban status.

OTHER ADJUSTMENTS AND POLICIES

FIXED DOLLAR LOSS AMOUNT

The FAH notes CMS' intention to change the fixed dollar loss threshold amount from $5,700 to $6,200 based on its review of available data and the desire to meet the 2 percent outlier spending target.

Recommendation:
The FAH recognizes outlier claims data is limited at this time. The FAH encourages CMS to further review and provide detailed disclosure of outlier payment expenditures in order to ensure that the amount is consistent with the 2 percent target and to adjust the fixed dollar threshold accordingly.

PHYSICIAN CERTIFICATION AND RECERTIFICATION

The proposed rule suggests changing the day of physician recertification from the current day 18 following admission to day 12 following admission in order to make it consistent with the requirements in medical and surgical units in general hospitals. The reason given in the proposed rule is to eliminate confusion for acute care hospitals.

Recommendation:

1. The FAH recommends the requirement for recertification remain at day 18. This requirement, as specified in section 424.14 (d) (2) of the CFR, has been in place since the time of the initial statute and is established practice in freestanding psychiatric hospitals. The reason given in the proposed rule for the change does not appear to be compelling enough to drive this change. Excluded psychiatric units in general hospitals could always choose to adopt a more stringent recertification timeframe if that met their need for consistency with other units in the hospital.

2. The FAH requests the language required for the certification and recertification remain consistent with CFR 424.14 (b) (c) language (*inpatient psychiatric hospital services furnished since the previous certification or recertification were, and continue to be medically necessary for either (a) treatment which could reasonably be expected to improve the patient's condition or (b) diagnostic study, or equivalent services).* Fiscal intermediaries (FIs) have incorporated that language into the Local Coverage Determinations (LCD) for Psychiatric Inpatient Hospitalization. Changing the language at this time would add to provider burden and put them at risk for payment denial if this specific language was not included. CMS Publication 100-01, *Medicare General Information, Eligibility, and Entitlement Manual,* Chapter 4, Section 10.5 states:

> "There is no requirement that the certification or recertification be entered on any specific form or handled in any specific way...If all the required information is included in progress notes, the physician's statement could indicate that the individual's medical record contains the information required and that continued hospitalization is medically necessary."

The FAH believes the payment rule should remain consistent with these existing Medicare published requirements.

SAME DAY TRANSFERS

CMS requests comment on several alternative methods for addressing payment for same day transfers under IPF PPS. We acknowledge the importance of making a data-driven decision about same day transfers but suggest that it is impossible to do so in the absence of at least one year of IPF PPS claims and cost report data. This is a very complex issue and we are not able to make a permanent recommendation on the three options presented in the proposed rule without further data and study.

The FAH does support the Section 2205.1 of the *Provider Reimbursement Manual* instruction to fiscal intermediaries to count a day if the day of admission and the day of discharge are the same. In this instruction, when a patient is admitted and then transferred from one participating provider to another before midnight of the same day, a day is counted at both providers for cost reporting purposes, but a day of Medicare utilization is charged only for the admission to the second provider. This distinction is very important for psychiatric admissions because IPF stays in Institutions for Mental Diseases (IMDs) are limited to the 190-day lifetime limit.

Recommendation:

The FAH recommends the continuation of current CMS policy outlined in Change Request 4264 (February 2, 2006) in which same-day-transfers are paid at the IPF PPS per-diem rate. Further, when sufficient data becomes available to fully evaluate same day IPF transfers, CMS should then query input from the IPF industry before making any changes to its current same day transfer payment policy.

* * * * *

FAH appreciates the opportunity to comment on Inpatient Psychiatric Facility PPS. Should you have any questions about our comments or need further information, please contact Steve Speil of my staff at (202)624-1529.

Respectfully submitted,

Charles N. Kahn III
President

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March 14, 2006

Association of
American Medical Colleges
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Jordan J. Cohen, M.D.
President

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Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

sent electronically to:
http://www.cms.hhs.gov/eRulemaking

Attention: CMS–1306–P

Dear Dr. McClellan:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) proposed rule entitled *"Medicare Program; Inpatient Psychiatric Facilities (IPF) Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007); Proposed Rule"* 71 Fed. Reg. 3616 (January 23, 2006). The AAMC represents approximately 400 major teaching hospitals and health systems; all 125 accredited U.S. allopathic medical schools; 96 professional and academic societies; and the nation's medical students and residents.

Our comments focus on a) the data that will be used to determine a hospital's IPF resident cap for the purpose of calculating the teaching adjustment, and b) outlier payments.

Resident Caps

Without opining on the current regulations regarding the imposition of resident caps, we support CMS's efforts to ensure that these caps are accurate. Under the current regulations, the base period for determining the IPF's FTE resident cap "is the inpatient psychiatric facility's most recently filed cost report filed with its fiscal intermediary before November 15, 2004." (42 C.F.R. §412.424(d)(1)(iii)(B)(*1*)). According to the preamble, the base period is to be ultimately determined by the "final settlement" of this cost report (see 71 Fed. Reg. at 3640).

According to the preamble, CMS will use the resident count reported on Worksheet S-3, Part 1, lines 14 and 14.01, Column 7 for psychiatric units of acute care hospitals. We are concerned that because of ambiguity regarding the instructions associated with these variables, this count may not accurately reflect the resident count in the hospital's psychiatric unit.

The cost report instructions state that one should "enter the number of intern and full time equivalents (FTEs) in an approved program determined in accordance with 42 CFR 412.105(g) for the indirect medical education adjustment [IME]." For cost reports before November 15, 2004, psychiatric unit resident counts were not eligible to be counted for purposes of the acute inpatient IME adjustment. So, it is unclear why this reference to the IME adjustment was included in the instructions. It is plausible that the IME reference meant for hospitals to count residents according to the IME rules—that is, residents in approved programs and not weighted (weighting occurs in direct graduate medical education resident counts). However, several of our member hospitals have notified us that they interpreted the instructions in other, equally reasonable, ways. For example, a hospital with resident FTEs in its psychiatric unit did not include those counts because psychiatric unit resident counts weren't eligible for IME payments. Another hospital's psychiatric unit resident count reflected the time that psychiatric residents spent in acute care units of the hospital that were eligible for acute care IME payments. In both cases, the resident count reported is inaccurate for purposes of establishing the IPF teaching adjustment resident cap.[1]

The use of "final settled" cost reports may allow hospitals to report accurate counts during the audit process. To the extent that this is not the case, or that certain hospitals' 2004 cost reports have already gone through final settlement, we urge CMS to take actions that will ensure accurate resident counts for purposes of determining the IPF teaching adjustment resident cap.

Outlier Payments

The proposed rule seeks to increase the outlier fixed-loss threshold amount from $5,700 to $6,200. However, the preamble contains no information regarding the methodology for calculating the threshold, nor any detailed evidence supporting proposed increase.

We concur with comments by the American Hospital Association regarding the outlier payment methodology. 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. Finally, we urge CMS to provide a more thorough description of its outlier methodology and calculations in the final rule.

* * * * * * * * * *

[1] The confusion is compounded because the CFR reference is incorrect. Before October 1, 1997, the FTE resident count for the IME adjustment, was determined in accordance with 42 CFR 412.105(g), as stated in the instructions. However, after October 1, 1997, the FTE count for the IME adjustment, has been determined in accordance with 42 CFR 412.105(f); since FY 1998, 42 CFR 412.105(g) has referred to IME and DGME payments associated with managed care enrollees.

If you have questions concerning these comments, please contact Karen Fisher at kfisher@aamc.org, or 202-862-6140 or Diana Mayes, at dmayes@aamc.org, 202-828-0498.

Sincerely,

Jordan J. Cohen, M.D.

cc: Robert Dickler, AAMC
Karen Fisher, AAMC
Diana Mayes, AAMC

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National Association of Psychiatric Health Systems

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March 8, 2006

Electronically to: http://www.cms.hhs.gov/eRulemaking

MAIL:
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-1306-P
P.O. Box 8010
Baltimore, MD 21244

RE: File Code CMS-1306-P

Dear Dr. McClellan,

As an association representing psychiatric hospitals, general hospital psychiatric units, and other behavioral healthcare provider organizations, the National Association of Psychiatric Health Systems (NAPHS) appreciates the opportunity to comment on the "*Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007)*" published in the January 23, 2006, *Federal Register*.

The National Association of Psychiatric Health Systems (NAPHS) advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Our members are behavioral healthcare provider organizations that own or manage more than 600 specialty psychiatric hospitals, general hospital psychiatric and addiction treatment units and behavioral healthcare divisions, residential treatment facilities, youth services organizations, and extensive outpatient networks. The association was founded in 1933.

COMMENTS AND RECOMMENDATIONS

OVERVIEW FOR UPDATING THE IPF PPS

NAPHS supports the decision made in the 2007 proposed rule to delay updating the patient-level adjustment factors used in constructing the 2004 final rule until there is sufficient data based on implementation of the rule. Waiting until, at a minimum, FY 2008 appears to be appropriate.

BUDGET NEUTRAL BASE RATE

BEHAVIORAL OFFSET

The proposed rule maintains the behavioral offset that is intended to protect budget neutrality should higher costs be incurred by Medicare because of changes in provider practice patterns as a result of movement to prospective payment. Practice areas of concern highlighted by CMS are coding for comorbid medical conditions and changes in length of stay. We continue to be concerned (as we were at the time of the publication of the 2004 final rule) that CMS has overestimated the magnitude of behavioral change based on assumptions that will not be borne out in the data. There is no data presented in the proposed rule to support or refute the underlying assumptions. **We ask CMS to analyze 2005 claims data as soon as possible and make adjustment, if indicated, in the behavioral offset to maintain budget neutrality without setting aside unnecessary amounts of money.**

UPDATE ON PER DIEM BASE RATE

MARKET BASKET

We understand that CMS is presently unable to create a separate market basket for psychiatric hospitals due to the small number of facilities. We agree with the decision to remove cancer and children's hospitals from the market basket and create a new rehabilitation, psychiatric, and long-term care hospital (RPL) market basket. However, we are concerned that all entities in the category have gone to prospective payment relatively recently. The data used to make a number of decisions (such as the labor share and market basket update) will be based on limited data from three provider types who are all going through a phase-in or have recently achieved full implementation. **We encourage CMS to review the data annually because cost structures may change and adjustments (such as trim points) may need to be made.**

FACILITY-LEVEL ADJUSTMENTS

RURAL ADJUSTMENT

The proposed rule would have substantial impact on some hospitals classified as located in rural areas. This potentially negative impact is driven primarily by reclassification from the Metropolitan Statistical Areas (MSAs) to Core-Based Statistical Areas (CBSAs). With reclassification, some formerly rural hospitals lose the 17% facility adjustment if they are reclassified as urban. 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.

We understand CMS's position that the transition period for the IPF PPS system as a whole helps mitigate some of the impact of this change. However, the reason for the 17% rural adjustment was to support the financial stability of rural facilities to ensure continued beneficiary access to inpatient psychiatric services. These facilities are essential to maintaining an infrastructure that provides treatment for patients in rural areas. Changing to CBSAs does not diminish the financial vulnerability of these facilities. **We recommend a three-year hold-harmless provision be added to the rule that prevents the per-diem rate under the PPS portion of payments from dropping below what facilities that lose their rural designation would have been paid had they remained designated as rural for RYs 2007, 2008, and 2009.**

OTHER ADJUSTMENTS AND POLICIES

OUTLIER PAYMENTS

We noted CMS's intention to change the fixed dollar loss threshold amount from $5,700 to $6,200 based on review of available data and the desire to meet the 2% outlier spending target. We know the data to date is limited but **we encourage CMS to use the 2005 claims data, as soon as it is available, to verify the threshold calculations to be sure dollars are not left unspent. Until that data is analyzed, we ask CMS to keep the threshold at its current level.**

PHYSICIAN CERTIFICATION AND RECERTIFICATION

The proposed rule suggests changing the day of physician recertification from the current day 18 following admission to day 12 following admission to make it consistent with the requirements in medical and surgical units in general hospitals. The reason given in the proposed rule is to eliminate confusion for acute care hospitals. **We recommend that the requirement for recertification remain at day18.** This requirement, as specified in section 424.14 (d) (2) of the CFR, has been in place since the promulgation of the initial statute and is established practice in psychiatric hospitals. The reason given in the proposed rule for the change does not appear to be compelling enough to drive this change. Distinct part units in general hospitals could choose to adopt a more stringent recertification timeframe if that met their need for consistency with other units in the hospital.

We also request that the language required for the certification and recertification remain consistent with CFR 424.14 (b) (c) language (*inpatient psychiatric hospital services furnished since the previous certification or recertification were, and continue to be medically necessary for either (a) treatment which could reasonably be expected to improve the patient's condition or (b) diagnostic study, or equivalent services).* Fiscal intermediaries (FIs) have incorporated that language into the Local Coverage Determinations (LCD) for Psychiatric Inpatient Hospitalization. Changing the language at this time would add to provider burden and put them at risk for payment denial if this specific language was not included. CMS Publication 100-01, *Medicare General Information, Eligibility, and Entitlement Manual,* Chapter 4, Section 10.5 states: There is no requirement that the certification or recertification be entered on any specific form or handled in any specific way .If all the required information is included in progress notes, the physician's statement could indicate that the individual's medical record contains the information required and that continued hospitalization is medically necessary. We think the payment rule should remain consistent with these requirements.

SAME DAY TRANSFERS

CMS requests comment on several alternative methods for addressing payment for same day transfers under IPF PPS. We acknowledge the importance of making a data-driven decision about same day transfers, but suggest that it is impossible to do so in the absence of at least one year of IPF PPS claims and cost report data. This is a very complex issue, and we are not able to make a recommendation on the three options presented in the proposed rule without further data and study. **When sufficient data is available to fully evaluate same day transfers, CMS should request input from the field before making any changes to current policy.**

We support the way section 2205.1of the *Provider Reimbursement Manual* instructs fiscal intermediaries to count a day if the day of admission and the day of discharge are the same. When a patient is admitted and then transferred from one participating provider to another before midnight of the same day, a day is counted by both providers for cost reporting purposes, but a day of Medicare utilization is charged only for the admission to the second provider. This distinction is very important for psychiatric admissions because IPF stays in IMDs are limited to the 190-day lifetime limit. We support CMS's current policy for 2005 claims that same day transfers be paid the PPS per-diem.

WE LOOK FORWARD TO WORKING WITH CMS AND HHS.
We would be happy to provide additional background or information on any of the issues raised in our comments above. Please do not hesitate to contact me at 202/393-6700, ext. 100, or mark@naphs.org.

We look forward to working with CMS and the Department of Health and Human Services to ensure that payment reform supports quality patient care.

Sincerely,

Mark Covall
Executive Director

THOMAS

March 13, 2006

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

Dear Sir or Madam:

We are aware that the Centers for Medicare and Medicaid Services have published proposed regulations updating the prospective payment rates for Medicare inpatient hospital services provided by inpatient psychiatric facilities (IPFs). With this letter please find enclosed one original and two copies of our comments on the proposed regulations.

We have reviewed these comments in light of the impact on our hospital and utilized an outside consulting firm to assist us in evaluating these very complex regulations. We believe our comments will improve the regulations, creating a more balanced and fair reimbursement system for our hospital.

Respectfully submitted,

Stephen P. Dexter
President

Thomas Memorial Hospital
4605 MacCorkle Avenue, SW ■ South Charleston, WV 25309 ■ 304-766-3600
www.thomaswv.org

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