CMS-1392-P-602 **Medicare**

Submitter : Mrs. Willa Waters **09/11/2007**

Organization : none
Individual

Category :

Issue Areas/Comments

Specified Covered Outpatient Drugs

Specified Covered Outpatient Drugs

Dear Mr. Weems:
Regarding: CMS-1392-P, Specified Covered Outpatient Drugs

I would like to commend CMS for seeking to improve patient access to care while simultaneously keeping down the related costs and trying to eliminate abuse of services. However, as a patient with Cervical Dystonia (a movement disorder resulting from sustained involuntary muscle spasms), I have serious concerns about CMS□s proposal to reduce the payment rate to hospitals for physician-injected drugs. I receive injections of botulinum toxin to alleviate the debilitating dystonic symptoms. These injections are critically important to my ability to function normally.

I respectfully request that CMS not change the payment formula for physician-injectable drugs for 2008, and instead maintain the current payment formula. Any reduction in reimbursement will lead to fewer injectors in an area where we have too few knowledgeable injectors in the first place. Anyone can inject botulinum toxin. Not just anyone can inject it successfully to relieve the spasms. Also, this change in policy would destroy the uniformity of payments made across settings that ensures there are no economic rewards or penalties to providers, depending on where the injections are given.

Thank you for allowing me to provide these comments.

CMS-1392-P-603 **Medicare**

Submitter : Mr. Matthew Rush **09/11/2007**

Organization : Hayes Green Beach Memorial Hospital
Hospital

Category :

Issue Areas/Comments

Necessary Provider
CAHs

Necessary Provider CAHs

We strongly oppose this proposed rule for the following reasons:

-will restrict ability of CAH's to develop or enhance services that the community needs, when current campus configuration will not allow development on campus;

-significantly reduces CAH's ability to compete on a level playing field with PPS or other for-profit providers who have no restrictions on location of facilities/services;

-limits CAH's ability to recruit/retain physicians by limiting options for upgrading quality of facilities/technology and thereby reduces access to care;

-potentially increases cost of enhancing facilities/services, when off-site renovations/development are more economical than reconfiguring outdated on campus facilities;

-timing of proposed rule implementation is unreasonable, given projects that may be contemplated or now underway that will be put at risk if proposed rule goes into effect;

-most of all, this proposed rule is contrary to the stated CMS stated intention in creating CAH's necessary provider status "to ensure access to essential health services for rural residents".

We believe CMS should rescind this proposed rule immediately, until such time further study of the underlying rationale for the proposed rule can be evaluated and understood by CMS, CAH's, and the communities we serve.

Matthew W. Rush, CHE
President and CEO

Hayes Green Beach Memorial Hospital

CMS-1392-P-604 **Medicare**

Submitter : Mrs. Bridget Campbell **09/11/2007**

Organization : None
Individual

Category :

Issue Areas/Comments

OPPS: Packaged Services

OPPS: Packaged Services

Dear Mr. Weems:
Regarding: CMS-1392-P, OPPS: Packaged Services

I would like to commend CMS for seeking to improve patient access to care while simultaneously keeping down the related costs and trying to eliminate abuse of services. However, as a patient with Cervical Dystonia/Spasmodic Torticollis, (dystonia is a movement disorder resulting from sustained involuntary muscle spasms), I have serious concerns about CMS□s proposal to bundle the payment rate to hospitals for physician-injected drugs. I receive injections of botulinum toxin to alleviate the debilitating dystonic symptoms. Both the guidance service and the botulinum toxin injections I receive are critically important for my ability to function normally and have relief of the pain associated with dystonia.

I respectfully request that CMS not package the payment of these services together but continue to pay for them separately. The proposed change may result in hospitals pressuring doctors not to utilize this equipment and the injections being ineffective because it does not get to the right muscles to have benefit for me. The guidance service is critically important for this treatment to be effective. I believe doing this would be very cruel to dystonic patients like myself.

Thank you for allowing me to provide these comments.
Sincerely,
Bridget Campbell
1741 Jackson Avenue
Pascagoula, MS 39567

CMS-1392-P-605 **Medicare**

Submitter : Mrs. Elizabeth Freeman **09/11/2007**

Organization : None
Individual

Category :

Issue Areas/Comments

OPPS: Packaged Services

OPPS: Packaged Services

I am a patient with Spasmodic Dystonia. I have serious concerns about CMS'S proposal to bundle the payment rate to hospitals for physician injected drugs. I receive botulinum toxim injections every 3 months which are critically important to my ability to function normally and relieve the pain associated with Dystonia.
I respectfully request that CMS not package the payment of these services together but continue to pay for them separately.
The proposed change may result in Hospital's pressuring Doctors not to utilize this equipment and the injections being ineffective because it does not get to the right muscles to have benefit for me. The guidance service is critically important for this treatment to be effective.

Sincerely,
Elizabeth Freeman.

CMS-1392-P-606 **Medicare**

Submitter : Mr. Sean Wendell **09/11/2007**

Organization : Beacon Behavioral Health
Other Health Care Provider

Category :

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1392-P-606-Attach-1.TXT

CMS-1392-P-606-Attach-2.TXT

CMS-1392-P-606-Attach-3.DOC

#606

September 10, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1392-P
Mail Stop: C4-26-05
7500 Security Blvd.
Baltimore, Maryland 21244-1850

Dear Sirs:

Re: Response to Proposed Changes to the CY2008 Hospital Outpatient PPS-CMS-1392-P Partial Hospitalization (APC 0033)

On behalf of Beacon Behavioral Health, Inc., we appreciate the opportunity to submit comments regarding CMS's proposed OPPS rates concerning APC Code 0033 - Partial Hospitalization Programs and 0322, 0323, 0324, 0325 – Outpatient Psychiatric Services

Beacon Behavioral Health is deeply concerned about the direct impact a fourth consecutive rate reduction will have on partial hospitalization and hospital outpatient services. We believe this rate cut will jeopardize the very existence of the partial hospitalization benefit itself.

Beacon Behavioral Health is a member of The Association of Ambulatory Behavioral Healthcare (AABH) and we support their response to this situation which is as follows:

1. **CMS data does not support a PHP per diem rate of $179.88 by its' own methodology of calculation.**

CMS-1392-p, on pp. 255-256, describes the CMS methodology utilized to calculate the current proposed rates. Page 255 states "We use CCRs from the most recently available hospital and CMHC cost reports". Unfortunately, this data is aggressively **stale**. The costs utilized are at least **1 to 3 years old and are used to project rates 2 years forward.** A review of the data utilized for the CY 2008 rates would indicate that as much as 50% of the cost data could be 3 years old from 2004. Page 255 of the report goes on to say that "All of these costs are then arranged from lowest to highest and the middle value of the array would be the median per diem cost". This process guarantees that 50% of the providers will be providing services and be receiving reimbursement below their daily costs. Combining cost data several years old with recent units of service does not accurately reflect the costs the providers endure.

2. CMS does not support a PHP per diem rate of $179.88.

CMS has identified the true Median Cost of APC 325 for group therapy at $66.17. With a minimum of 4 services per day (many programs offer more), CMS would recognize the minimum cost at $264.68 per day. These data are inconsistent with a rate of $179.88 and indicate that a higher payment rate is necessary to prevent providers from running substantial deficits that will risk financial viability.

3. The current methodology is not conducive to this APC code.

Unlike the other 1100+ APC codes which generally represent individual medical procedures, Partial Hospitalization is a complete service industry, that encompasses a complete business setting rather than one simple process such as a Corneal Transplant (0244) or a Transfusion (0110). There is precedent in other CMS OPPS service industries to exclude the services from the APC code listing and treat them independently. Two examples are Home Health and Hospice Care. Home health was just finalized for CY2008 with a set rate and a 3 percent increase if certain quality data standards are met or a 1 percent increase if the standards are not met. Positive performance results in reimbursement rewards. PHP could be treated the same. This would stabilize the rates and generate future rate predictability for these services.

4. The preliminary rate of $179.88 is excessively severe.

The CMS table on p. 257 of CMS-1392-p reflects 4 median per diem costs as determined by CMS. The projected rate of $179.88 is the lowest of the four samples. This would penalize all CMHCs providing four or more units of service per day and all hospitals in either category. All current PHP LCD's of the Fiscal Intermediaries state the CMS requirements that "Partial Hospitalization Programs must **offer** a minimum of 20 hours a week of structured program provided over at least a five-day period." The minimum patient participation is three hours per day of care with a minimum of 12 hours per week." AABH would offer 2 suggestions. First, enforce the minimum service requirement to assure PHPs are **offering** at least 20 hours of structured programming per week. Second, days of service with less than 4 services are being paid within the rules of CMS and Medicare. Programs should not be penalized for following the rules.

In further regard to the Hospital-based PHPs, CMS data indicated that over 66% of paid claims were for 4 or more units of service. The median cost of $218 for hospitals is $40 below the projected reimbursement rates. A decision of this nature would end these services in Hospital-based locations.

5. CMS's calculations for the CY 2008 PHP per diem payment are diluted.

CMS states that per diem costs were computed by summarizing the line item costs on each bill and dividing by the number of days on the bills. This calculation can severely dilute the rate and penalize providers. All programs are strongly encouraged by the fiscal intermediaries to submit all PHP service days on claims, even when the patient receives less than 3 services. Programs must report these days to be able to meet the 57% attendance threshold and avoid potential delays in the claim payment. Yet, programs are only paid their per diem when 3 or more qualified services are presented for a day of service. If only 1 or 2 services are assigned a cost and the day is divided into the aggregate data, the cost per day is significantly compromised and diluted. Even days that are paid but only have 3 services dilute the cost factors on the calculations. With difficult challenges of treating the severe and persistently mentally ill adults, these circumstances occur frequently.

6. The proposed PHP per diem rate also severely compromises Hospital Outpatient Services.

CMS pays hospital facilities for Outpatient Services on a per unit basis **up to** the per diem PHP payment. As previously shown, CMS has identified Group Therapy APC 0325 with a true Median Cost of $66.17. Most patients involved in the Outpatient Services are participating 1-3 days and generally receive 4 or more services on those days. While programs provide 4 services the per diem limit will only allow them to be "paid their cost" for about 2.75 services (3 x $66.17 = $198.51). The program is $18.63 short for the 3rd service and the 4th service is provided for no reimbursement.

7. Cost Report Data frequently does not reflect Bad Debt expense for the entire year.

As the cost report data is proposed surrounding Bad Debt, many "recent" bad debt copays of the last 4-5 months of the fiscal year have not completed the facility's full collection efforts and therefore are not eligible for consideration of bad debt on the cost report. Those that are, can only be recovered up to 55%. These costs are not being considered in the CMS data and severely short change the rate calculations.

8. Data for settled Cost Reports fail to include costs reversed on appeal.

CMS historically has reduced certain providers' cost for purposes of deriving the APC rate based on its observation that "costs for settled cost reports were considerably lower than costs from "as submitted cost reports". (68 Federal Register 48012) While CMS's observation is true, it fails to include in the provider's costs, those costs denied/removed from "as submitted" cost reports, and subsequently reversed on appeal to the Provider Reimbursement Review Board ("PRRB"), subsequently settled pursuant to the PRRB's mediation program, or otherwise settled among the provider and intermediary. During the relevant years at issue, providers of PHP incurred particularly significant cost report denials, but also experienced favorable outcomes on appeal. Because the CMS analysis did not take into consideration what were ultimately the allowable costs, its data are skewed artificially low. The cost data used to derive the APC rate should be revised to account for these costs subsequently allowed.

Based on the above issues, AABH would recommend that CMS take the following course of action:

1. Allow the PHP per diem to remain the same as the CY2007 per diem rate of $234.73.

2. Beacon Behavioral Health encourages CMS to go with AABH to the legislature and support a legislative amendment to:

    - Remove PHP from the APC codes and have independent status using Home Health as an example
    - Establish the current rate of $234.73 as the base per diem rate for services
    - Annually adjust the base rate by a conservative inflation factor such as the CPI
    - Establish quality criteria to judge performance and that influences future rate reimbursement

Thank you, for the opportunity to respond to this critical issue.

Respectfully,

Sean Wendell
CEO
Beacon Behavioral Health

CMS-1392-P-607 **Medicare**

Submitter : Mr. Jim Tavary **09/11/2007**

Organization : Prosser Memorial Hospital Hospital

Category :

Issue Areas/Comments

Necessary Provider CAHs

Necessary Provider CAHs

See attachment.

CMS-1392-P-607-Attach-1.DOC

PROSSER
MEMORIAL HOSPITAL
Working Together for Your Good Health.

#607

September 10, 2007

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue
Washington, DC 20201

Delivered Via On-Line Form: http://www.cms.hhs.gov/eRulemanking

Subject: CMS-1392-P-Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates; Proposed Changes Affecting Necessary Provider Designations of Critical Access Hospitals

Dear Deputy Administrator Kuhn:

I am writing in response to the proposed rule referenced above, specifically in regards to proposals made affecting the Critical Access Hospital (CAH) program. I am the CEO at Prosser Memorial Hospital (PMH) in Prosser, Washington, a CAH hospital since January 2002.

Our hospital became a CAH designated hospital in the true spirit of the founding documents; to assure safety net services in a rural community that fully depends on us for access to care. One of the crucial services offered by PMH, in addition to core hospital services, is primary care medicine provided through a certified rural health clinic (RHC) located some 16 miles from Prosser in a medically underserved area. In fact, we are the only provider of medical services in this community (Benton City) where we are told we serve a critical need that otherwise would not be available to residents there.

Similarly, we are giving thought to opening a second RHC in a small town located west of Prosser. This town is also classified both a MUA and a HPSA and is in dire need of primary care medical services. Again, there is no interest on the part of larger organizations in providing any kind of safety net service there. Medicare recipients there have few choices and often find themselves sacrificing early intervention for more costly care later.

As you know, there is virtually incentive for independent medical practitioners to locate practices in rural communities. The economic challenges associated with small, private practices have driven many physicians from rural areas, leaving hospitals and other health care organizations the difficult task of filling the void. Prosser is an excellent example of the plight of rural communities. During the past 7 years every single private practitioner has either sold their practice and retired or sold their practice and become an employee of a local non-profit medical group. Without the incentives offered through CAH and RHC models, the delivery of medical services in many rural communities would be severely curtailed and, in many cases, lost entirely.

Due to these concerns, I respectfully ask that you withdraw the provisions in this rule pertaining to off-site clinics owned by CAHs. As stated above, such provisions would

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MEMORIAL HOSPITAL
Working Together for Your Good Health.

have a devastating impact on the access to quality health care in my rural community. This is the opposite of the intention of the CAH program, which is to provide the financial stability for small, rural hospitals to serve their communities. Such provisions would eliminate our flexibility to provide the care needed to rural seniors.

Thank you for considering my comments. Please fee free to contact me at your convenience if you have any questions.

Sincerely,

Jim Tavary, CEO

CMS-1392-P-608 **Medicare**

Submitter : Dr. David Hector **09/11/2007**

Organization : Tyler Cardiovascular Consultants
Physician

Category :

Issue Areas/Comments

OPPS Impact

OPPS Impact

I am an interventional cardiologist practicing for the last 24 years. The use of contrast in stress echos has greatly reduced the overall cost of health care by improving the accuracy and reliability of stress echos.

It is my opinion that eliminating the use of contrast events will significantly decrease not only the accuracy but will eventually decrease the high quality of stress echocardiography while increasing the frequency of procedures.

CMS-1392-P-609 **Medicare**

Submitter : Mr. Melvin Fahs **09/11/2007**

Organization : Community Memorial Hospital Hospital

Category :

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1392-P-609-Attach-1.TXT

CMS-1392-P-609-Attach-2.DOC

#609

September 14, 2007

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue
Washington, DC 20201

Subject: CMS-1392-P – Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates; Proposed Changes Affecting Necessary Provider Designations of Critical Access Hospitals

Dear Deputy Administrator Kuhn:

I am writing in response to the proposed rule referenced above, specifically in regards to proposals made affecting the Critical Access Hospital (CAH) program. I am President/CEO of Community Memorial Hospital located in Hicksville, Ohio. We are a rural community in NW Ohio with approximately 4,000 residents.

On January 1, 2001, we were the second hospital in the state of Ohio to receive CAH designation. Without this designation, most likely Hicksville would not have a hospital. Instead, we just opened our new 12 million dollar facility and we continue to grow in volume and services that we can offer our rural community.

We currently operate three clinics that are approximately nine to ten miles from Hicksville and are located in communities much smaller. These clinics are very expensive to operate. Without these clinics, our hospital would not be able to provide physician access to these small and rural communities. We would like to designate these clinics as certified rural health clinics and use a mid-level nurse practitioner to increase access to residents in these rural communities. If we can bring the clinics under certification, it would provide needed increased reimbursement for operations.

Due to these concerns, I respectively ask that you withdraw the provisions in this rule pertaining to off-site clinics owned by CAHs. As stated above, such provisions would have a devastating impact on the access to quality health care in my rural community. This is the opposite of the intention of the CAH program, which is to provide the financial stability for small, rural hospitals to serve their communities. Such provisions would eliminate our flexibility to provide the care needed to rural seniors.

Thank you for considering these comments. Please contact me if you have any questions.

Sincerely,

Melvin H. Fahs, FACHE
President/CEO

CMS-1392-P-610 Medicare

Submitter : Mrs. Donna Arens **09/11/2007**

Organization : Graceville Health Center
Other Health Care Professional

Category :

Issue Areas/Comments

OPPS Impact

OPPS Impact

September 14, 2007

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue
Washington, DC 20201

Delivered Via On-Line Form: http://www.cms.hhs.gov/eRulemaking

Subject: CMS-1392-P □ Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates; Proposed Changes Affecting Necessary Provider Designations of Critical Access Hospitals

Dear Deputy Administrator Kuhn:

I am writing in response to the proposed rule referenced above, specifically in regards to

proposals made affecting the Critical Access Hospital (CAH) program. I am an employee at Graceville Health Center in Graceville, MN.

Graceville Health Center is comprised of several entities including a critical access hospital and two rural health clinics, one in Graceville and the other in Chokio. The decision to obtain CAH designation was made in hopes that our facility would remain viable as well as be available to address health care needs for our immediate and surrounding communities. To better serve our increasing elderly population, consideration has been given to opening other off-site clinics in

neighboring communities. This would allow these individuals better access to the care they need and accommodate family/friends in providing transportation for these patients.

Due to these concerns, I respectively ask that you withdraw the provisions in this rule pertaining to off-site clinics owned by CAHs. As stated above, such provisions would have a devastating impact on the access to quality health care in my rural community. This is the opposite of the intention of the CAH program, which is to provide the financial stability for small, rural hospitals to serve their communities. Such provisions would eliminate our flexibility to provide the care needed to rural seniors.

Thank you for considering these comments. Please contact me if you have any questions.

Sincerely,

Donna Arens, RHIT
Health Information Management

CMS-1392-P-611 **Medicare**

Submitter : Dr. Paul Kreis **09/11/2007**

Organization : Univ. California Davis
Physician

Category :

Issue Areas/Comments

Implantation of Spinal Neurostimulators

Implantation of Spinal Neurostimulators

I am a professor and the medical director of the pain management program at the University of California at Davis. I have been implanting spinal cord stimulators for approximately 10 years. The development of the rechargeable battery system has been very important for several reasons. First, it allows for more effective programming of the unit since power consumption can be liberalized. Second, it greatly increases the time between battery exchanges which involves outpatient surgery. I previously had a number of patients who required battery exchanges every year. Those same patients now will not require a battery exchange for up to 9 years. Third, every time we have to replace a battery, it exposes the patient to the risk of infection, in which case the entire system must be explanted. Please consider the long term cost effectiveness and risk reduction associated with rechargeable systems and take that into account such that reimbursement is appropriate. I feel very strongly given the increased power settings that can be utilized in addition to the much improved battery life that patients should be offered a rechargeable battery system whenever possible. We can only offer this improved technology to our patients if the equipment costs are adequately reimbursed. Thank you for your consideration.
Paul Kreis, MD

CMS-1392-P-612 **Medicare**

Submitter : Dr. Amanda Williams **09/11/2007**

Organization : Akron General Medical Center
Physician

Category :

Issue Areas/Comments

Partial Hospitalization

Partial Hospitalization

I, Amanda Williams, M.D. of Akron General Medical Center and the Center for Akron Psychiatry, Inc. appreciate the opportunity to submit comments. I am deeply concerned about the direct impact a fourth consecutive rate reduction will have on partial hospitalization and hospital outpatient services. I believe this rate cut will jeopardize the very existence of the partial hospitalization benefit itself. Akron General Medical Center is a member of The Association of Ambulatory Behavioral Healthcare (AABH) and we support their response to this situation which is as follows: CMS data does not support a PHP per diem rate of $179.88 by its own methodology of calculation. CMS-1392-p, on pp. 255-256, describes the CMS methodology utilized to calculate the current proposed rates. Page 255 states We use CCRs from the most recently available hospital and CMHC cost reports. Unfortunately, this data is aggressively stale. The costs utilized are at least 1 to 3 years old and are used to project rates 2 years forward. CMS has identified the true Median Cost of APC 325 for group therapy at $66.17. With a minimum of 4 services per day (many programs offer more), CMS would recognize the minimum cost at $264.68 per day. These data are inconsistent with a rate of $179.88 and indicate that a higher payment rate is necessary to prevent providers from running substantial deficits that will risk financial viability.The preliminary rate of $179.88 is excessively severe. The CMS table on p. 257 of CMS-1392-p reflects 4 median per diem costs as determined by CMS. The projected rate of $179.88 is the lowest of the four samples. This would penalize all CMHCs providing four or more units of service per day and all

hospitals in either category. All current PHP LCDs of the Fiscal Intermediaries state the CMS requirements that Partial Hospitalization Programs must offer a minimum of 20 hours a week of structured program provided over at least a five-day period. The minimum patient participation is three hours per day of care with a minimum of 12 hours per week. 3. CMS s calculations for the CY 2008 PHP per diem payment are diluted. The proposed PHP per diem rate also severely compromises Hospital Outpatient Services. CMS pays hospital facilities for Outpatient Services on a per unit basis up to the per diem PHP payment. As previously shown, CMS has identified Group Therapy APC 0325 with a true Median Cost of $66.17. Most patients involved in the Outpatient Services are participating 1-3 days and generally receive 4 or more services on those days. While

programs provide 4 services the per diem limit will only allow them to be □paid their cost□ for about 2.75 services (3 x $66.17 = $198.51). The program is $18.63 short for the 3rd service and the 4th service is provided for no reimbursement. Cost Report Data frequently does not reflect Bad Debt expense for the entire year. Data for settled Cost Reports fail to include costs reversed on appeal. Based on the above issues, AABH would recommend that CMS take the following course of action:

1. Allow the PHP per diem to remain the same as the CY2007 per diem rate of $234.73.
2. Remove PHP from the APC codes and have independent status using Home Health as an example

- Establish the current rate of $234.73 as the base per diem rate for services
- Annually adjust the base rate by a conservative inflation factor such as the CPI
- Establish quality criteria to judge performance and that influences future rate reimbursement

Amanda E. Williams, M.D.
Director, Psychiatry Resident Clinic
Akron General Medical Center
Assistant Professor of Psychiatry, Northeastern Ohio Universities College of Medicine
Diplomate, American Board of Psychiatry and Neurology

CMS-1392-P-613 **Medicare**

Submitter : **09/11/2007**

Organization :
Health Care Provider/Association

Category :

Issue Areas/Comments

GENERAL

GENERAL

see attachement

#613

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

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

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

CMS-1392-P-614 **Medicare**

Submitter : Mr. James Spence **09/11/2007**

Organization : Portage Hospital
Other Technician

Category :

Issue Areas/Comments

OPPS Impact

OPPS Impact

I am a practicing cardiac sonographer at Portage Hospital in Micigan's Upper Peninsula. Our protocols allow me the flexibity of using contrast agents in our outpatient population when I suspect they will significantly improve the image quality and subsequent diagnostic accuracy of the procedure (whether is is a resting, transthoracic echo, or a stress echo). Our Medicare patient population is much larger than other areas of Michigan and the U.S. as a whole. This is the population that requires the use of contrast agents more often than younger individuals. Probably already underutilized, the CMS proposal to eliminate separate payment for contrast agents in hospital outpatient populations will have the effect of further limiting their use. The resulting increase in indeterminant echos will undoubtedly result in either the referral of patients for other procedures that are 2-3 times more expensive with other potential side effects, or they won't get the appropriate test done resulting in poorer patient care. I'm sure neither result is desired by CMS.

I urge you not to eliminate separate payment for contrast agents used in hospital outpatient settings and in so doing allow us to continue offering the most appropriate, and highest quality, echocardiographic service that we, as sonographers, are trained to deliver. Don't tie our hands with a one-size fits all approach to helping our patients by creating a methodology that will decrease diagnostic accuracy and simultaneously increase costs.

Thank you for the opportunity to comment on this proposal.

CMS-1392-P-615 **Medicare**

Submitter : Mr. Paul Altovilla **09/11/2007**

Organization : Diamond Healthcare
Health Care Industry

Category :

Issue Areas/Comments

Partial Hospitalization

Partial Hospitalization

Comments for The Centers for Medicare and Medicaid Services

File Code: CMS-1392-P

Regarding the July 16, 2007 42 CFR Parts 410, 411, 414, 416, 419, 482, and 485
Medicare Program: Proposed Changes to Outpatient Prospective Payment System and CY 2008 Payment Rates

The following comments are provided regarding the proposed regulations published in the Federal Register (FR) on July 16, 2007 to update the hospital outpatient prospective payment system for CY 2008.

1) The proposed payment rate of $179.88 for Partial Hospitalization (PHP) services is low and inadequate considering the scope of services and costs required to render PHP services. The large payment fluctuations ranging from $206.82 to $286.82 and now proposed to $179.88 for PHP services from 2001 to this proposed rate for 2008 indicates that CMS data and analysis regarding median per diem costs for PHP services have been and remain fundamentally flawed. It is recommended that CMS further research and conduct detailed provider-level research to better understand the costs necessary to deliver PHP services in hospital and CMHC

settings.

Psychiatric partial hospitalization is a distinct and organized intensive outpatient treatment of less than 24 hours of daily care, designed to provide patients with profound or disabling mental health conditions an individualized, coordinated, intensive, comprehensive, and multidisciplinary treatment program not provided in a regular outpatient setting. Often PHP treatment must offer a minimum of 20 hours a week of structured program provided over at least a five-day time period. The minimum patient participation is three (3) hours per day of care with a minimum of 12 hours

per week. Active treatment consists of clinically recognized multi-model interventions including physician services, psychiatric evaluation, history and physical, individual/group/family psychotherapy, education and training, and occupational therapy. PHP group sizes vary with acuity of illness of the participants, but the maximum size of therapeutic group should not exceed 10.

Based upon the above criteria, generally PHP programs average approximately 6.00 FTE staff members to include a program director, therapists, nursing, technicians and program assistants totaling approximately $270,000 annually in salaries and wages. Non-salary direct operating expenses include PRN staffing, education, supplies and other operating expenses averaging approximately $55,000 annually. Generally PHP program services are delivered in approximately 2,000 square feet and entail approximately $300,000 in capital related, employee benefits, administration, plant operations, maintenance, cafeteria, medical records, and other dwelling related costs. Given PHP guidelines to include those stated above generally limiting the maximum size of therapeutic groups to 10, a well operated PHP program averages 8.00 patients per day over a 250 day annual period generating 2,000 PHP days per year. Given the above description of typical PHP services at costs of approximately $625,000 annually to deliver 2,000 PHP patient days, the average PHP cost per PHP day is approximately $314.24, representing a cost 74.69% higher than that of the proposed PHP rate of $179.88. It is recommended that CMS further research and conduct provider-level research to more accurately understand the costs necessary to deliver PHP services in hospital and CMHC settings and establish a more accurate rate for PHP services accordingly. It is recommended the rate for PHP services be set at approximately $314.24 per patient day, and no less than the RY 2007 rate of $234.73.

CMS-1392-P-616 **Medicare**

Submitter : Mr. Bruce King **09/11/2007**

Organization : The New London Hospital Association, Inc.
Critical Access Hospital

Category :

Issue Areas/Comments

OPPS Impact

OPPS Impact

See Attachment

CMS-1392-P-616-Attach-1.DOC

#616

Member of DARTMOUTH-HITCHCOCK ALLIANCE

September 14, 2007

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue
Washington, DC 20201

Delivered Via On-Line Form: *http://www.cms.hhs.gov/eRulemaking*

Subject: CMS-1392-P – Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates; Proposed Changes Affecting Necessary Provider Designations of Critical Access Hospitals

Dear Deputy Administrator Kuhn:

I am writing in response to the proposed rule referenced above, specifically in regards to proposals made affecting the Critical Access Hospital (CAH) program. I am the President and CEO at The New London Hospital Association, Inc. in New London, New Hampshire.

In this paragraph explain the situation at your hospital. Please include:

- In April 2003, we were designated as a necessary provider by the State of New Hampshire and applied for and received CAH designation.
- We currently have a rural health center, internal medicine and family practice provider-based clinics.
- As our region grows, we will continue to evaluate the need for additional primary care provider-based practices.
- We believe that limiting future off-site clinics would create hardship for our patient population due to the significant geographical area that these clinics cover, and the challenge for transportation for this population.

Due to these concerns, I respectively ask that you withdraw the provisions in this rule pertaining to off-site clinics owned by CAHs. As stated above, such provisions would have a devastating impact on the access to quality health care in my rural community. This is the opposite of the intention of the CAH program, which is to provide the financial stability for small, rural hospitals to serve their communities. Such provisions would eliminate our flexibility to provide the care needed to rural seniors.

Thank you for considering these comments. Please contact me if you have any questions.

Sincerely,

Bruce P. King
President and CEO

CMS-1392-P-617 **Medicare**

Submitter : Mrs. Juddi Brennan **09/11/2007**

Organization : Sharp Mesa Vista Hospital
Psychiatric Hospital

Category :

Issue Areas/Comments

OPPS: Partial Hospitalization

OPPS: Partial Hospitalization

SHARP MESA VISTA HOSPITAL
7850 Vista Hill Ave.
San Diego, CA 92123

September 11, 2007

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1392-P
Mail Stop: C4-26-05
7500 Security Blvd.
Baltimore, Maryland 21244-1850

Dear Sirs:

Re: Response to Proposed Changes to the CY2008 Hospital Outpatient PPS-CMS-1392-P

Partial Hospitalization (APC 0033)

On behalf of Sharp Mesa Vista Hospital, I appreciate the opportunity to submit comments regarding CMS□s proposed OPPS rates concerning APC Code 0033 - Partial Hospitalization Programs and 0322, 0323, 0324, 0325 □ Outpatient Psychiatric Services

Sharp Mesa Vista Hospital is deeply concerned about the direct impact a fourth consecutive rate reduction will have on partial hospitalization and hospital outpatient services. I believe this rate cut

will jeopardize the very existence of the partial hospitalization benefit itself.

Sharp Mesa Vista Hospital is a member of The Association of Ambulatory Behavioral Healthcare (AABH) and we support their response to this situation which is as follows:

1. CMS data does not support a PHP per diem rate of $179.88 by its own methodology of calculation.

CMS-1392-p, on pp. 255-256, describes the CMS methodology utilized to calculate the current proposed rates. Page 255 states "We use CCRs from the most recently available hospital and CMHC cost reports". Unfortunately, this data is aggressively stale. The costs utilized are at least 1 to 3 years old and are used to project rates 2 years forward. A review of the data utilized for the CY 2008 rates would indicate that as much as 50% of the cost data could be 3 years old from 2004. Page 255 of the report goes on to say that "All of these costs are then arranged from lowest to highest and the middle value of the array would be the median per diem cost". This process guarantees that 50% of the providers will be providing services and be receiving reimbursement below their daily costs. Combining cost data several years old with recent units of service does not accurately reflect the costs the providers endure.

2. CMS does not support a PHP per diem rate of $179.88.

CMS has identified the true Median Cost of APC 325 for group therapy at $66.17. With a minimum of 4 services per day (many programs offer more), CMS would recognize the minimum cost at $264.68 per day. These data are inconsistent with a rate of $179.88 and indicate that a higher payment rate is necessary to prevent providers from running substantial

deficits that will risk financial viability.

3. The current methodology is not conducive to this APC code.

Unlike the other 1100+ APC codes which generally represent individual medical procedures, Partial Hospitalization is a complete service industry, that encompasses a complete business setting rather than one simple process such as a Corneal Transplant (0244) or a Transfusion (0110). There is precedent in other CMS OPPS service industries to exclude the services from the APC code listing and treat them independently. Two examples are Home Health and Hospice Care. Home health was just finalized for CY2008 with a set rate and a 3 percent increase if certain quality data standards are met or a 1 percent increase if the standards are not met. Positive performance results in reimbursement rewards. PHP could be treated the same. This would stabilize the rates and generate future rate predictability for these services.

4. The preliminary rate of $179.88 is excessively severe.

The CMS table on p. 257 of CMS-1392-p reflects 4 median per diem costs as determined by CMS. The projected rate of $179.88 is the lowest of the four samples. This would penalize all CMHCs providing four or more units of service per day and all hospitals in either category. All current PHP LCD's of the Fiscal Intermediaries state the CMS requirements that "Partial Hospitalization

Programs must offer a minimum of 20

CMS-1392-P-618 Medicare

Submitter : Mr. Paul Altovilla **09/11/2007**

Organization : Diamond Healthcare
Health Care Industry

Category :

Issue Areas/Comments

National Unadjusted
Medicare Payment

National Unadjusted Medicare Payment

Comments
for
The Centers for Medicare and Medicaid Services

File Code: CMS-1392-P

Regarding the July 16, 2007
42 CFR Parts 410, 411, 414, 416, 419, 482, and 485
Medicare Program: Proposed Changes to Outpatient Prospective Payment System and CY 2008 Payment Rates

The following comments are provided regarding the proposed regulations published in the Federal Register (FR) on July 16, 2007 to update the hospital outpatient prospective payment system for CY 2008.
2) Please see the attached table concerning the historic rates of OPPS Psychotherapy Services and Medication Management.
Rate Year APC 322 APC 323 APC 324 APC 325
2001 $65.46 $91.75 $92.74 $76.88

2002 $59.05 $88.57 $137.95 $70.25
2003 $69.23 $96.91 $128.35 $74.28
2004 $69.85 $101.97 $133.53 $81.10
2005 $73.60 $100.23 $161.59 $83.62
2006 $73.22 $97.59 $137.58 $79.95
2007 $72.52 $104.90 $132.97 $66.17
P-2008 $79.32 $106.49 $141.61 $64.45
% Change 2006 +8.33% +9.11% +2.93% <19.39%>

As detailed within the table above all psychotherapy APC□s encompassing CPT Codes 90801 through 90806 have been reasonably consistently valued since 2005 and as far back as 2001. The proposed rates for RY 2008 also are valued consistently from RY 2007, with the major exception of Group Psychotherapy, CPT Codes 90853 and 90849 mapping to APC 325. The proposed rate of $64.45 represents a proposed cumulative decrease from RY 2006 of 19.39%.

The APC□s listed above to include APC 325 are often utilized within Hospital Outpatient Psychiatric Treatment Services (OPTS) representing a range of services in a continuum of ambulatory psychiatric services. This range of services provides for the diagnosis and active treatment to individuals with mental disorders using a variety of modalities. Generally patients who need more than eleven (11) hours of psychiatric services per week are considered for PHP services rather than this OPTS level of care. In order for hospitals to maintain this important level of care, at a lesser cost when compared to inpatient psychiatry and partial hospitalization, it is recommended that CMS increase the rate for APC 325 Group Psychotherapy to $85.37 which represents the average (6.79%) increase from RY 2006 to RY 2008 for the remaining psychotherapy APC□s.

CMS-1392-P-619 **Medicare**

Submitter : Michael Carda **09/11/2007**

Organization : Alegent Health
Other Technician

Category :

Issue Areas/Comments

OPPS Impact

OPPS Impact

There are several types of stress tests. Some of the new data states that stress echo with contrast agents in difficult patients has a higher accuracy than the alternative, nuclear stress testing. Stress echocardiography, even with a contrast charge, is less than half the cost of a nuclear stress test, takes less than half of the time of a nuclear strss test, and has results within a few minutes of completion. If you take away the contrast charge, cardiologist's offices will just order nuclear stress testing on everyone thus strapping medicare even more. By saving a few hundred dollars in a contrast charge, the backlash will cost $1000 - $2000 more. I work for a hospital. On in-patients, we eat the cost anyway. I am a staff cadiovascular sonographer with nothing to gain by this. I've worked with cardiologists and they don't do things for free or at discount prices. I'll guarantee you that costs will increase from ordering nuclear stress testing instead.
Thank you for your time,
Michael Carda, RDCS, RVT

CMS-1392-P-620 **Medicare**

Submitter : Mrs. Laurian Osantowski **09/11/2007**

Organization : None
Individual

Category :

Issue Areas/Comments

OPPS: Packaged Services

OPPS: Packaged Services

Dear Mr. Weems:
Regarding: CMS-1392-P, OPPS: Packaged Services
I would like to commend CMS for seeking to improve patient access to care while simultaneously keeping down the related costs and trying to eliminate abuse of services. However, as a patient with cervical dystonia, (dystonia is a movement disorder resulting from sustained involuntary muscle spasms), I have serious concerns about CMS's proposal to bundle the payment rate to hospitals for physician-injected drugs. I receive injections of botulinum toxin to alleviate the debilitating dystonic symptoms. Both the guidance service and the botulinum toxin injections I receive are critically important for my ability to function normally and have relief of the pain associated with dystonia.
I respectfully request that CMS not package the payment of these services together but continue to pay for them separately. The proposed change may result in hospitals pressuring doctors not to utilize this equipment and the injections being ineffective because it does not get to the right muscles to have benefit for me. The guidance service is critically important for this treatment to be effective.
Thank you for allowing me to provide these comments.
Sincerely,

CMS-1392-P-622 **Medicare**

Submitter : Mr. Ben Moore **09/11/2007**

Organization : River Hospital
Critical Access Hospital

Category :

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1392-P-622-Attach-1.DOC

#622

September 14, 2007

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue
Washington, DC 20201

Delivered Via On-Line Form: *http://www.cms.hhs.gov/eRulemaking*

Subject: CMS-1392-P – Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates; Proposed Changes Affecting Necessary Provider Designations of Critical Access Hospitals

Dear Deputy Administrator Kuhn:

I am writing in response to the proposed rule referenced above, specifically in regards to proposals made affecting the Critical Access Hospital (CAH) program. I am the Chief Executive Officer of River Hospital in Alexandria Bay, New York.

We are a recently (2003) designated CAH hospital which opened with a provider based clinic. We are now engaged in a strategic planning process that includes participation of the community. It is evident to us that a result of our planning process will be the establishment of the need for additional provider based clinic sites. Restrictions on our ability to develop new sites will severely hamper the mission of this institution.

Due to these concerns, I respectively ask that you withdraw the provisions in this rule pertaining to off-site clinics owned by CAHs. As stated above, such provisions would have a devastating impact on the access to quality health care in my rural community. This is the opposite of the intention of the CAH program, which is to provide the financial stability for small, rural hospitals to serve their communities. Such provisions would eliminate our flexibility to provide the care needed to rural seniors.

Thank you for considering these comments. Please contact me if you have any questions.

Sincerely,

Ben Moore, III
Chief Executive Officer
River Hospital
4 Fuller Street
Alexandria Bay, NY 13607
(315) 482-1110
bmoore@riverhospital.org

CMS-1392-P-623 **Medicare**

Submitter : Mrs. Jacquelyn Pasadyn **09/11/2007**

Organization : None
Individual

Category :

Issue Areas/Comments

OPPS: Packaged Services

OPPS: Packaged Services

Dear Mr. Weems:
Regarding: CMS-1392-P, Specified Covered Outpatient Drugs

I would like to commend CMS for seeking to improve patient access to care while simultaneously keeping down the related costs and trying to eliminate abuse of services. However, as a patient with (or the form dystonia you have), both types of dystonia (a movement disorder resulting from sustained involuntary muscle spasms), I have serious concerns about CMS□s proposal to reduce the payment rate to hospitals for physician-injected drugs. I receive injections of botulinum toxin to alleviate the debilitating dystonic symptoms. These injections are critically important to my ability to function normally.

I respectfully request that CMS not change the payment formula for physician-injectable drugs for 2008, and instead maintain the current payment formula. Any reduction in reimbursement will lead to fewer injectors in an area where we have too few knowledgeable injectors in the first place. Anyone can inject botulinum toxin. Not just anyone can inject it successfully to relieve the spasms. Also, this change in policy would destroy the uniformity of payments made across settings that ensures there are no economic rewards or penalties to providers, depending on where the injections are given.

Thank you for allowing me to provide these comments.

CMS-1392-P-624 **Medicare**

Submitter : Mrs. Laurian Osantowski **09/11/2007**

Organization : None
Individual

Category :

Issue Areas/Comments

Specified Covered Outpatient Drugs

Specified Covered Outpatient Drugs

Dear Mr. Weems:
Regarding: CMS-1392-P, Specified Covered Outpatient Drugs
I would like to commend CMS for seeking to improve patient access to care while simultaneously keeping down the related costs and trying to eliminate abuse of services. However, as a patient with cervical dystonia, (a movement disorder resulting from sustained involuntary muscle spasms), I have serious concerns about CMS□s proposal to reduce the payment rate to hospitals for physician-injected drugs. I receive injections of botulinum toxin to alleviate the debilitating dystonic symptoms. These injections are critically important to my ability to function normally.
I respectfully request that CMS not change the payment formula for physician-injectable drugs for 2008, and instead maintain the current payment formula. Any reduction in reimbursement will lead to fewer injectors in an area where we have too few knowledgeable injectors in the first place. Anyone can inject botulinum toxin. Not just anyone can inject it successfully to relieve the spasms. Also, this change in policy would destroy the uniformity of payments made across settings that ensures there are no economic rewards or penalties to providers, depending on where the injections are given.
Thank you for allowing me to provide these comments.
Sincerely,

CMS-1392-P-625 **Medicare**

Submitter : Helen Tvelia **09/11/2007**

Organization : Western Medical Center Anaheim
Health Care Professional or Association

Category :

Issue Areas/Comments

Partial Hospitalization

Partial Hospitalization

Western Medical Center Anaheim is deeply concerned about the direct impact a fourth consecutive reduction will have on Partial Hospitalization and Outpatient services. I believe this rate cut will jeopardize the very existence of the partial hospitalization benefit itself which would adversely affect the population served as well as the overall community.
I recommend that CMS take the following course of action as recommended by AABH:
1. Allow the PHP per diem rate to remain the same as CY 2007 $234.73
2. Support a legislative amendment to:
- remove PHP from the APC codes and have independent status
- establish the current rate of $234.73 as the base per diem rate for services
- annually adjust the base rate by a conservative inflation factor such as the CPI
- establish quality criteria to judge performance that influences future rate increases
Respectfully submitted,
Helen D. Tvelia RN

CMS-1392-P-626 **Medicare**

Submitter : Ms. Carol Butler **09/11/2007**

Organization : Condell Medical Center
Other Health Care Professional

Category :

Issue Areas/Comments

Packaging Drugs and Biologicals

Packaging Drugs and Biologicals

Re: CMS proposal to eliminate separate payment for contrast agents used in echo procedures performed in hospital outpatient settings beginning in 2008.Contrast agents should continue to be eligible for separate payment.

I feel we open the door to push more patients to Invasive procedures to provide diagnostic answers that contrast currently provides.

CMS-1392-P-627 **Medicare**

Submitter : Debbie Martin **09/11/2007**

Organization : Stanislaus Surgical Hospital Hospital

Category :

Issue Areas/Comments

Implantation of Spinal Neurostimulators

Implantation of Spinal Neurostimulators

We request that Medicare reversethe proposed rul that assigns RC and non-rechargable (NRC) stimulators to the same APC reimbursement, and that Medicare create a new APC for RC neurostimulators, separate from NRC neurostimulators. Also the hospitals use of a G-Code for RC neruostimulators for the purpose of AOC assignment and appropriate payment will not be an administrative burden, but rather is an accepted mechanism for hospitals to receive the appropriate reimbursement under OPPS.