CMS-1392-P-721 Medicare

Submitter : Dr. Ryan Potter **09/12/2007**

Organization : SPINECARE Outpatient Surgery Center
Physician

Category :

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1392-P-721-Attach-1.DOC

#721

September 10, 2007

Mr. Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1392–P, Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: CMS-1392-P

Dear Mr. Kuhn:

Thank you for the opportunity to comment on the Proposed Rule CMS-1392-P, "Proposed Changes to the Hospital Outpatient Prospective Payment System (HOPPS) and CY 2008 Payment Rates" (the Proposed Rule) published in the *Federal Register* on August 2, 2007. My comments cover two main issues related to the HOPPS and ambulatory surgery center (ASC) payment methodologies.

I. ASC Procedures

There are several specific procedure issues we ask CMS to review and address. I believe that two procedures that have not been included on the ASC payment list, but that are paid under the HOPPS and should also be included on the ASC list. These procedures are described by CPT codes 22526 (percutaneous intradiscal electrothermal annuloplasty, single level) and 22527 (percutaneous intradiscal electrothermal annuloplasty, one or more additional levels). There is no reason why ASCs should not be entitled to payment for these two procedures. The procedures are safely done in ASCs, and they are not procedures routinely performed in a physician's office. I ask CMS to include both procedures on the ASC list in the final rule.

ASIPP also is concerned that procedures 72285 (discography - cervical or thoracic - radiological supervision and interpretation) and 72295 (discography – lumbar - radiological supervision and interpretation) have been packaged in all circumstances under the ASC proposed rule. These services are payable separately in the HOPD in certain circumstances and I believe the same should be true for ASCs.

Lastly, I ask CMS recalculate the payment rate of CPT code 64517. The proposed payment rate for this procedure is $178 for CY 2008. While I do recognize that the payment for the procedure following the transition period will be $295, a payment of $178 seems too low.

II. IMPLANTATION OF SPINAL NEUROSTIMULATORS

I ask that CMS create a new APC for implanting rechargeable neurostimulators upon expiration of the new technology transitional pass-through payment at the end of 2007.

I am concerned that the CMS proposal to pay rechargeable and non-rechargeable neurostimulator procedures under the same APC (0222) ($12,314 in hospital outpatient departments and $10,925 in ASCs) will impair Medicare Beneficiaries access to neurostimulation therapy utilizing rechargeable devices. The proposed payment structure could lead to such financial pressures on

the facilities purchasing these devices and ultimately cause the restrictive use of this technology despite the fact that rechargeable devices represent a major improvement in neurostimulation therapy for patients with chronic pain. If access to the rechargeable technology is inhibited than Medicare beneficiaries in need of this type of treatment for chronic pain will be relegated to non-rechargeable technology and subject to the risks and co-insurance costs associated with repeat surgical procedures for battery replacement. This outcome seems inconsistent with CMS's own determination that this technology offers beneficiaries substantial clinical improvement over non-rechargeable implantable which was evidenced by the decision to grant rechargeable implantable neurostimulators new technology pass-through payments for 2006 and 2007.

Implantable neurostimulators ensure that chronic pain patients have consistent pain control without interruption. The clinical benefit of the first generation non-rechargeable neurostimulator technologies is limited by the need for repeat surgical procedures for battery replacement any where from every two to four years depending on the usage of the device. Unfortunately, what we know from experience is that many physicians using non-rechargeable battery devices will utilize program settings that require less power in order to conserve the life of their non-rechargeable battery. This practice compromises the patient's opportunity to obtain optimal pain relief on a day-to-day basis; but patients choose this option as opposed to undergoing another surgical procedure. Rechargeable neurostimulators are capable of delivering continuous stimulation, even at high levels, to optimize patient relief without concern of rapid battery depletion.

Approximately 25 to 30 percent of all the neurostimulator implant procedures performed each year are required to replace a depleted, non-rechargeable battery. Thus, in the long term, the use of rechargeable devices likely would result in cost savings to the Medicare program and beneficiaries due to the decreased need for battery replacement procedures. The need for fewer surgeries also would reduce the chances that patients will experience operative complications such post-operative infection or other possible co-morbidities.

I ask CMS to create an APC for procedures using rechargeable implantable neurostimulators that is separate and distinct from the proposed APC grouping (0222) to create greater resource consistency. While we appreciate that CMS wants to bundle similar procedures that may utilize a variety of devices with different costs, it is inappropriate to bundle procedures when the absolute difference in cost is so significant. CMS's own analysis of the claims data associated with APC 0222 (shown in Table 35 of the preamble) reveals significantly higher costs for procedures associated with rechargeable neurostimulators ($18,089 median cost) than non-rechargeable neurostimulators ($11,608 median cost).

While I recognize the difference in median costs does not create a two times rule violation, the difference in median cost is not insignificant. CMS has assigned pass-through devices to a new APC or to a different, existing APC in absence of a "two-times" rule violation and for median costs differences significantly less than $1,000. I urge CMS to take a similar approach here. The creation of two separate APCs would result in more appropriate payment for both types of procedures—rechargeable and non-rechargeable neurostimulator procedures—based on their relative costs. To implement our recommendation, we further recommend that CMS create a G-Code to distinguish between implanting a rechargeable and a non-rechargeable neurostimulator.

Moreover, ensuring the payment rate is appropriate under the HOPPS system will result more appropriate payment in the ASC setting. Today, ASCs receive reimbursement for rechargeable generators through the DMEPOS fee schedule (L8689- rechargeable generator). With the current proposal ASC reimbursement will be based on 100% of the device component and approximately 65% of the service component of the APC payment. If the device component, as determined from the OPPS claims data, is based on a mix of rechargeable and non-rechargeable device costs, payments to ASCs will vastly underpay for the actual equipment, which costs the same in all

settings. Now that the two payments systems are inextricably linked it is even more incumbent upon CMS to ensure that payments are adequate under the HOPPS or Medicare beneficiaries may be left without an option to have this procedure performed at a HOPD or an ASC.

In summary my recommendations to CMS are:

- Create a new APC for procedures using rechargeable neurostimulators to recognize the full device and facility costs associated with these procedures.
- Establish new HCPCS II "G-codes" to differentiate between rechargeable and non-rechargeable neurostimulators.
- Alternatively, CMS could continue using the device C-code, C-1820, to assign rechargeable neurostimlutor procedures to a new APC.
- Maintain non-rechargeable neurostimulator procedures in APC 0222.

***

Thank you for your consideration of my comments.

Sincerely,

Ryan N. Potter, M.D.
5734 Spohn Drive
Corpus Christi, TX 78414
(361) 882-4452

CMS-1392-P-722 Medicare

Submitter : Shannon Ragusa **09/12/2007**

Organization : Medical Management Options
Health Care Provider/Association

Category :

Issue Areas/Comments

OPPS: Partial Hospitalization

OPPS: Partial Hospitalization

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

Dear Deputy Administrator Kuhn:

I am writing in response to the proposed rule referenced above, specifically in regards to proposals made affecting Partial Hospitalization Programs. I am a Licensed Professional Counselor and Marriage and Family Therapist working as the Director of Community Relations at Medical Management Options in Baton Rouge, Louisiana.

Just yesterday, I had two mentally ill homeless individuals enter my office and ask for help. Unfortunately, both had significantly decompensated and were at risk of hospitalization.

Fortunately, our organization is able to offer them a program that will help keep them out of the hospital and off the streets. I was able to assist them in locating housing and last night they slept in their own bed rather than a bench outside the local hospital. With these proposed cuts, I am concerned that the limited resources that are available for these mentally ill adults will diminish even further. I worry that without community resources many of these individuals will end up in the hospital or jail. I have worked for over ten years in our organization and I have seen the need grow not decrease, especially since Hurricanes Katrina and Rita. This rule would have an impact on these individuals, but on every taxpayer as well. Hospitalization and incarceration are both much more costly than providing community resources with supports in a supportive environment.

Lack of facilities, trained professionals and inadequate reimbursement will make mental healthcare in Louisiana worse off than prior to the Hurricanes Katrina and Rita.

The proposed rate reduction in reimbursement for Mental Health services will severely limit agencies□ ability to provide even the most limited services. This includes psychiatry and outpatient therapy, which is reimbursed at a rate that makes breaking even under the current reimbursement levels a challenge.

If the proposed rate cuts are implemented, there will be no way for residents to receive appropriate care. Many providers will go out of business; many residents will go without care.

Due to these concerns, I respectively ask that you withdraw the provisions in this rule pertaining to Partial Hospitalization Programs. As stated above, such provisions would be

devastating!

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

Sincerely,

Shannon Ragusa, LPC, LMFT
Medical Management Options

CMS-1392-P-723 Medicare

Submitter : Susan Butler **09/12/2007**

Organization : Medical Management Options
Health Care Provider/Association

Category :

Issue Areas/Comments

OPPS: Partial Hospitalization

OPPS: Partial Hospitalization

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

Dear Deputy Administrator Kuhn:

I am writing in response to the proposed rule referenced above, specifically in regards to proposals made affecting Partial Hospitalization Programs. I am a Licensed Clinical Social Worker and Hospital Administrator at Medical Management Options in Baton Rouge, Louisiana.

I work with a number of partial hospitalization programs in Baton Rouge, La. Since the hurricane, partial programs have had great difficulty recruiting nurses and licensed clinical social workers. Salary ranges of these professions have increased considerably because of demand and have

severely limited operations of some partial programs. In addition, in 2007, partial programs already received a rate cut. To receive another rate cut of 23% in addition to the increased hardship incurred by staffing shortages would put most partial programs in Louisiana out of business. This is one of the only existing intensive treatment programs left in Louisiana.

Lack of facilities, trained professionals and inadequate reimbursement will make mental healthcare in Louisiana worse off than prior to the Hurricanes Katrina and Rita.

The proposed rate reduction in reimbursement for Mental Health services will severely limit agencies□ ability to provide even the most limited services. This includes psychiatry and outpatient therapy, which is reimbursed at a rate that makes breaking even under the current reimbursement levels a challenge.

If the proposed rate cuts are implemented, there will be no way for residents to receive appropriate care. Many providers will go out of business; many residents will go without care.

Due to these concerns, I respectively ask that you withdraw the provisions in this rule pertaining to Partial Hospitalization Programs. As stated above, such provisions would be devastating!

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

Sincerely,

Susan Butler, LCSW
Medical Management Options

CMS-1392-P-724 Medicare

Submitter : Dr. David Charles **09/12/2007**

Organization : Alliance for Patient Access
Physician

Category :

Issue Areas/Comments

Packaged Services

Packaged Services

See attachment.

CMS-1392-P-724-Attach-1.RTF

#724

THE ALLIANCE FOR PATIENT ACCESS

September 12, 2007

Via Electronic Submission to: http://www.cms.hhs.gov/eRulemaking

Kerry Weems
Administrator, Centers for Medicare and Medicaid Services-Designate
U.S. Department of Health and Human Services
Attn: CMS-1392-P
7500 Security Boulevard
Baltimore, MD 21244

Re: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates; CMS-1392-P.

Dear Mr. Weems:

As chairman of the Alliance for Patient Access (AfPA), a national network of physicians whose mission is to ensure and protect patient access to approved medical treatments in the U.S., and as a neurologist who has been practicing in an academic setting for 13 years, I am pleased to submit comments on the proposed Hospital Outpatient Prospective Payment System update for 2008, particularly on the agency's proposals concerning **Packaged Services**, **Specified Covered Outpatient Drugs**, and **Implantation of Spinal Neurostimulators**.

OPPS: Packaged Services

Generally, AfPA concurs that increased packaging of services encourages hospitals to use items and services more judiciously, and that CMS should seek to package payment wherever appropriate. However, sweeping attempts to package payment for broad categories of services, as CMS is now proposing to do, is likely to create more problems than would be solved. CMS should continue to evaluate packaging determinations on a procedure-specific, case-by-case basis to ensure that packaging is medically and economically justified and does not create inappropriate and problematic financial incentives.

We are especially concerned about CMS's proposal to package payment for electrodiagnostic guidance (codes 95873 and 95874) for chemodenervation procedures (codes 64612-64614). Our physician members frequently use real-time electrodiagnostic procedures—electromyography or electrical stimulation to guide needle placement when performing chemodenervation procedures. In these procedures, the location of the injection is critical to success of the procedure, and the physician must ensure that the chemodenervation agent is delivered to the precise location in need of treatment. Chemodenervation involves injection of chemodenervation agents, such as

botulinum toxin type A, to control the symptoms associated with dystonia. Dystonia is a movement disorder that causes muscles to contract and spasm involuntarily. By injecting chemodenervation agents directly into the muscle tissue, the physician can block the nerve impulses that trigger muscle hyperactivity. However, for the treatment to be effective, the chemodenervation agent must be delivered to a precise location. As such, physicians often use electromyography or electrical stimulation guidance to guide the needle and ensure that the chemodenervation agent is injected in the most appropriate location to achieve the desired outcome. However, electrodiagnostic guidance procedures are not always required. Whether these procedures are medically necessary depends upon a number of factors, including the indication for chemodenervation, the specific muscles to be injected, and the cognitive ability of the patient.

We are concerned that CMS's proposal to package payment for the electromyography or electrical stimulation guidance may lead hospitals to discourage utilization of guidance equipment, even where medically indicated. Hospitals that do not use guidance services or that severely limit the utilization of these guidance services will reap a financial windfall for their decision.

We are also concerned that patient-centered hospitals that do not allow financial considerations to cloud medical decisionmaking would be penalized for their policy. Under CMS's proposal, the combined payment amount for the injection and guidance would be less than the total amount presently available when these services are paid separately. In fact, the combined payment amount for the injection and guidance would be approximately 15 percent less than the total amount presently available when these services are paid separately. As such, the hospital that incurs the cost of the guidance procedure will not be adequately reimbursed for the service furnished.

For the foregoing reasons, AfPA encourages CMS to reconsider its proposal to package electromyography and electrical stimulation guidance procedures (codes 95873 and 95874) because these guidance procedures do not accompany the base injection procedure in every instance and are furnished only when medically necessary.

OPPS: Specified Covered Outpatient Drugs

AfPA is also troubled by CMS's proposal to reduce payment for injectable drugs furnished in the hospital setting to 105 percent of average sales price. We are primarily concerned that reducing payment in this manner could under-reimburse many hospitals for their drug-related costs. While ASP may theoretically reflect the average price hospitals pay for drugs, and adequately compensate many hospitals for their purchasing-related costs, not all hospitals can acquire drugs and biologicals at the average sales price. In addition, a hospital's acquisition costs go beyond the simple purchase price for the drug or biological. Hospitals also incur overhead costs associated with storing and furnishing drugs and biologicals. These costs may be substantial for complex biologicals that require special handling. By reducing the supplemental payment above ASP from 6 percent to 5 percent, CMS is potentially under-reimbursing hospitals for these overhead and handling costs related to acquisition of drugs and biologicals. To the extent hospitals are unable to recoup the cost of purchasing, storing and furnishing pharmaceuticals,

they may be forced to make hard decisions about which drugs they are capable of storing. We oppose any proposal that could limit a vital access point for patients who depend on these therapies.

Perhaps most troubling is that CMS is proposing to make this change without clearly setting out any underlying data to support it. CMS does not provide adequate justification for this reduction other than to state that this payment amount is consistent with CMS's estimate of hospital acquisition costs. If CMS believes that hospital costs (total costs including overhead and handling) are lower in the hospital setting than in the physician's office, CMS should collect this data, present it to the public for comment and also consider the potential impact of different payment formulae on patient access before adopting any change in the payment formula.

Moreover, we are concerned about the payment disparity between hospital and physician office settings that would result from this change. In recent years, payments for physician-injected drugs have been the same across the two settings, *i.e.,* 106 percent of ASP. This has avoided the experiences of a few years back where some patients were being shifted between hospital outpatient and physician office settings depending upon which setting provided payment that more adequately covered provider acquisition costs. Payment parity should be maintained to ensure adequate access to therapies in both settings.

We request that CMS not change the payment formula for physician-injectable drugs for 2008, and instead maintain payment at 106 percent of ASP.

OPPS: Implantation of Spinal Neurostimulators

In the 2008 CMS Proposed Hospital Outpatient Payment System rule, CMS proposes to pay hospitals the same rate for rechargeable and non-rechargeable neurostimulators when implanted in hospital outpatient departments. The cost differential (according to CMS's claims data) between the two technologies is approximately $6,500. This is a meaningful difference that warrants separate reimbursement. We are concerned that this proposal, if implemented, will cause hospitals to make treatment decisions based on economics rather than the best course of care for patients who suffer from chronic, intractable pain.

Rechargeable neurostimulators offer a breakthrough in treatment for patients with complex pain over multiple areas. The enhanced capabilities of rechargeable technology allow physicians to manage patients' pain patterns instead of worrying about depleting the battery of conventional, non-rechargeable devices. Rechargeable devices eliminate the need for battery replacement surgeries associated with non-rechargeable devices, sparing patients the risk and inconvenience associated with multiple surgical procedures and increasing long-term efficiency for the Medicare program.

The importance of rechargeable neurostimulation technology was previously acknowledged by CMS when it granted the device new-tech add-on payment status in the hospital inpatient setting and pass-through status in the hospital outpatient setting. These additional payments to hospitals made it possible for patients with chronic pain to benefit from rechargeable pain-relief technology. With the conclusion of outpatient pass-through status, however, CMS is now

proposing to pay the same amount for rechargeable neurostimulators as it does for all other non-rechargeable devices. We are concerned that the proposed payment policy is insufficient and may jeopardize patient access to this important therapy.

We urge CMS to create a new APC to provide adequate payment for rechargeable technologies to ensure appropriate access to rechargeable neurostimulators.

* * * * *

In summary, AfPA encourages CMS to

- Maintain separate payment for electromyography and electrical stimulation guidance procedures (codes 95873 and 95874);
- Maintain the current payment formula for physician-injectable drugs for 2008 at 106 percent of ASP.
- Create a new APC to provide adequate payment for rechargeable technologies

Thank you for your consideration of our comments.

Sincerely yours,

David Charles, MD
Chairman

CMS-1392-P-725 Medicare

Submitter : Vickey Moore-Charles **09/12/2007**

Organization : Options Foundation
Health Care Provider/Association

Category :

Issue Areas/Comments

OPPS: Partial Hospitalization

OPPS: Partial Hospitalization

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

Dear Deputy Administrator Kuhn:

I am writing in response to the proposed rule referenced above, specifically in regards to proposals made affecting Partial Hospitalization Programs. I am an Executive Director at Options Foundation in Baton Rouge, Louisiana.

Options has over 100 residents living in our housing facilities. Many of our residents came to us during a time of crisis. The majority of them were homeless, not taking their medication properly, not seeing their psychiatrist on a regular basis not having the benefit of working closely with a

social worker and not attending group sessions. Without having the regular psychiatrist visits, the social worker, the group sessions and medication education and monitoring, which were the keys to keeping them healthy and safe, they were constantly going to the emergency room and finally admitted into the hospital. They were not able to live productive lives.

But when they started attending the partial hospitalization programs, I've seen tremendous change in each resident. They are more stable, their quality of life has changed and they have fewer, if any hospitalizations. Without this program, they will decompensate and the emergency room and hospital will become a revolving door again.

Lack of facilities, trained professionals and inadequate reimbursement will make mental healthcare in Louisiana worse off than prior to the Hurricanes Katrina and Rita.

The proposed rate reduction in reimbursement for Mental Health services will severely limit agencies□ ability to provide even the most limited services. This includes psychiatry and outpatient therapy, which is reimbursed at a rate that makes breaking even under the current reimbursement levels a challenge.

If the proposed rate cuts are implemented, there will be no way for residents to receive appropriate care. Many providers will go out of business; many residents will go without care.

Due to these concerns, I respectively ask that you withdraw the provisions in this rule pertaining to Partial Hospitalization Programs. As stated above, such provisions would be devastating!

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

Sincerely,

Vickey Moore-Charles, Executive Director
Options Foundation

CMS-1392-P-726 Medicare

Submitter : Dr. David Charles **09/12/2007**

Organization : Alliance for Patient Access
Physician

Category :

Issue Areas/Comments

Specified Covered Outpatient Drugs

Specified Covered Outpatient Drugs

See attachment.

CMS-1392-P-726-Attach-1.RTF

#726

THE ALLIANCE FOR PATIENT ACCESS

September 12, 2007

Via Electronic Submission to: http://www.cms.hhs.gov/eRulemaking

Kerry Weems
Administrator, Centers for Medicare and Medicaid Services-Designate
U.S. Department of Health and Human Services
Attn: CMS-1392-P
7500 Security Boulevard
Baltimore, MD 21244

Re: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates; CMS-1392-P.

Dear Mr. Weems:

As chairman of the Alliance for Patient Access (AfPA), a national network of physicians whose mission is to ensure and protect patient access to approved medical treatments in the U.S., and as a neurologist who has been practicing in an academic setting for 13 years, I am pleased to submit comments on the proposed Hospital Outpatient Prospective Payment System update for 2008, particularly on the agency's proposals concerning **Packaged Services**, **Specified Covered Outpatient Drugs**, and **Implantation of Spinal Neurostimulators**.

OPPS: Packaged Services

Generally, AfPA concurs that increased packaging of services encourages hospitals to use items and services more judiciously, and that CMS should seek to package payment wherever appropriate. However, sweeping attempts to package payment for broad categories of services, as CMS is now proposing to do, is likely to create more problems than would be solved. CMS should continue to evaluate packaging determinations on a procedure-specific, case-by-case basis to ensure that packaging is medically and economically justified and does not create inappropriate and problematic financial incentives.

We are especially concerned about CMS's proposal to package payment for electrodiagnostic guidance (codes 95873 and 95874) for chemodenervation procedures (codes 64612-64614). Our physician members frequently use real-time electrodiagnostic procedures—electromyography or electrical stimulation to guide needle placement when performing chemodenervation procedures. In these procedures, the location of the injection is critical to success of the procedure, and the physician must ensure that the chemodenervation agent is delivered to the precise location in need of treatment. Chemodenervation involves injection of chemodenervation agents, such as

botulinum toxin type A, to control the symptoms associated with dystonia. Dystonia is a movement disorder that causes muscles to contract and spasm involuntarily. By injecting chemodenervation agents directly into the muscle tissue, the physician can block the nerve impulses that trigger muscle hyperactivity. However, for the treatment to be effective, the chemodenervation agent must be delivered to a precise location. As such, physicians often use electromyography or electrical stimulation guidance to guide the needle and ensure that the chemodenervation agent is injected in the most appropriate location to achieve the desired outcome. However, electrodiagnostic guidance procedures are not always required. Whether these procedures are medically necessary depends upon a number of factors, including the indication for chemodenervation, the specific muscles to be injected, and the cognitive ability of the patient.

We are concerned that CMS's proposal to package payment for the electromyography or electrical stimulation guidance may lead hospitals to discourage utilization of guidance equipment, even where medically indicated. Hospitals that do not use guidance services or that severely limit the utilization of these guidance services will reap a financial windfall for their decision.

We are also concerned that patient-centered hospitals that do not allow financial considerations to cloud medical decisionmaking would be penalized for their policy. Under CMS's proposal, the combined payment amount for the injection and guidance would be less than the total amount presently available when these services are paid separately. In fact, the combined payment amount for the injection and guidance would be approximately 15 percent less than the total amount presently available when these services are paid separately. As such, the hospital that incurs the cost of the guidance procedure will not be adequately reimbursed for the service furnished.

For the foregoing reasons, AfPA encourages CMS to reconsider its proposal to package electromyography and electrical stimulation guidance procedures (codes 95873 and 95874) because these guidance procedures do not accompany the base injection procedure in every instance and are furnished only when medically necessary.

OPPS: Specified Covered Outpatient Drugs

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they may be forced to make hard decisions about which drugs they are capable of storing. We oppose any proposal that could limit a vital access point for patients who depend on these therapies.

Perhaps most troubling is that CMS is proposing to make this change without clearly setting out any underlying data to support it. CMS does not provide adequate justification for this reduction other than to state that this payment amount is consistent with CMS's estimate of hospital acquisition costs. If CMS believes that hospital costs (total costs including overhead and handling) are lower in the hospital setting than in the physician's office, CMS should collect this data, present it to the public for comment and also consider the potential impact of different payment formulae on patient access before adopting any change in the payment formula.

Moreover, we are concerned about the payment disparity between hospital and physician office settings that would result from this change. In recent years, payments for physician-injected drugs have been the same across the two settings, *i.e.,* 106 percent of ASP. This has avoided the experiences of a few years back where some patients were being shifted between hospital outpatient and physician office settings depending upon which setting provided payment that more adequately covered provider acquisition costs. Payment parity should be maintained to ensure adequate access to therapies in both settings.

We request that CMS not change the payment formula for physician-injectable drugs for 2008, and instead maintain payment at 106 percent of ASP.

OPPS: Implantation of Spinal Neurostimulators

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Rechargeable neurostimulators offer a breakthrough in treatment for patients with complex pain over multiple areas. The enhanced capabilities of rechargeable technology allow physicians to manage patients' pain patterns instead of worrying about depleting the battery of conventional, non-rechargeable devices. Rechargeable devices eliminate the need for battery replacement surgeries associated with non-rechargeable devices, sparing patients the risk and inconvenience associated with multiple surgical procedures and increasing long-term efficiency for the Medicare program.

The importance of rechargeable neurostimulation technology was previously acknowledged by CMS when it granted the device new-tech add-on payment status in the hospital inpatient setting and pass-through status in the hospital outpatient setting. These additional payments to hospitals made it possible for patients with chronic pain to benefit from rechargeable pain-relief technology. With the conclusion of outpatient pass-through status, however, CMS is now

proposing to pay the same amount for rechargeable neurostimulators as it does for all other non-rechargeable devices. We are concerned that the proposed payment policy is insufficient and may jeopardize patient access to this important therapy.

We urge CMS to create a new APC to provide adequate payment for rechargeable technologies to ensure appropriate access to rechargeable neurostimulators.

* * * * *

In summary, AfPA encourages CMS to

- Maintain separate payment for electromyography and electrical stimulation guidance procedures (codes 95873 and 95874);
- Maintain the current payment formula for physician-injectable drugs for 2008 at 106 percent of ASP.
- Create a new APC to provide adequate payment for rechargeable technologies

Thank you for your consideration of our comments.

Sincerely yours,

David Charles, MD
Chairman

CMS-1392-P-727 Medicare

Submitter : Ms. Michele Weiss **09/12/2007**

Organization : Cooper University Hospital
Other Technician

Category :

Issue Areas/Comments

OPPS Impact

OPPS Impact

If seperate payment for echo contrast agents is eliminated , patients would not receive the diagnostic testing that is required for Cardiac patients. Non diagnostic iamging could result in more expensive Invasive testing. We currently have policies requlating the use of contrast per protocols that were esablished by the American Society of Echocardiography, and only use contrast when it is absolutely necessary. I do not want to go back in time when contrast was not avaiable nor should our patients expect anything less then we are currently offer. Thank you
Michele Weiss, RDCS

CMS-1392-P-728 Medicare

Submitter : Dr. David Charles **09/12/2007**

Organization : Alliance for Patient Access
Physician

Category :

Issue Areas/Comments

Implantation of Spinal Neurostimulators

Implantation of Spinal Neurostimulators

See attachment.

CMS-1392-P-728-Attach-1.RTF

#728

THE ALLIANCE FOR PATIENT ACCESS

September 12, 2007

Via Electronic Submission to: http://www.cms.hhs.gov/eRulemaking

Kerry Weems
Administrator, Centers for Medicare and Medicaid Services-Designate
U.S. Department of Health and Human Services
Attn: CMS-1392-P
7500 Security Boulevard
Baltimore, MD 21244

Re: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates; CMS-1392-P.

Dear Mr. Weems:

As chairman of the Alliance for Patient Access (AfPA), a national network of physicians whose mission is to ensure and protect patient access to approved medical treatments in the U.S., and as a neurologist who has been practicing in an academic setting for 13 years, I am pleased to submit comments on the proposed Hospital Outpatient Prospective Payment System update for 2008, particularly on the agency's proposals concerning **Packaged Services**, **Specified Covered Outpatient Drugs**, and **Implantation of Spinal Neurostimulators**.

OPPS: Packaged Services

Generally, AfPA concurs that increased packaging of services encourages hospitals to use items and services more judiciously, and that CMS should seek to package payment wherever appropriate. However, sweeping attempts to package payment for broad categories of services, as CMS is now proposing to do, is likely to create more problems than would be solved. CMS should continue to evaluate packaging determinations on a procedure-specific, case-by-case basis to ensure that packaging is medically and economically justified and does not create inappropriate and problematic financial incentives.

We are especially concerned about CMS's proposal to package payment for electrodiagnostic guidance (codes 95873 and 95874) for chemodenervation procedures (codes 64612-64614). Our physician members frequently use real-time electrodiagnostic procedures—electromyography or electrical stimulation to guide needle placement when performing chemodenervation procedures. In these procedures, the location of the injection is critical to success of the procedure, and the physician must ensure that the chemodenervation agent is delivered to the precise location in need of treatment. Chemodenervation involves injection of chemodenervation agents, such as

botulinum toxin type A, to control the symptoms associated with dystonia. Dystonia is a movement disorder that causes muscles to contract and spasm involuntarily. By injecting chemodenervation agents directly into the muscle tissue, the physician can block the nerve impulses that trigger muscle hyperactivity. However, for the treatment to be effective, the chemodenervation agent must be delivered to a precise location. As such, physicians often use electromyography or electrical stimulation guidance to guide the needle and ensure that the chemodenervation agent is injected in the most appropriate location to achieve the desired outcome. However, electrodiagnostic guidance procedures are not always required. Whether these procedures are medically necessary depends upon a number of factors, including the indication for chemodenervation, the specific muscles to be injected, and the cognitive ability of the patient.

We are concerned that CMS's proposal to package payment for the electromyography or electrical stimulation guidance may lead hospitals to discourage utilization of guidance equipment, even where medically indicated. Hospitals that do not use guidance services or that severely limit the utilization of these guidance services will reap a financial windfall for their decision.

We are also concerned that patient-centered hospitals that do not allow financial considerations to cloud medical decisionmaking would be penalized for their policy. Under CMS's proposal, the combined payment amount for the injection and guidance would be less than the total amount presently available when these services are paid separately. In fact, the combined payment amount for the injection and guidance would be approximately 15 percent less than the total amount presently available when these services are paid separately. As such, the hospital that incurs the cost of the guidance procedure will not be adequately reimbursed for the service furnished.

For the foregoing reasons, AfPA encourages CMS to reconsider its proposal to package electromyography and electrical stimulation guidance procedures (codes 95873 and 95874) because these guidance procedures do not accompany the base injection procedure in every instance and are furnished only when medically necessary.

OPPS: Specified Covered Outpatient Drugs

AfPA is also troubled by CMS's proposal to reduce payment for injectable drugs furnished in the hospital setting to 105 percent of average sales price. We are primarily concerned that reducing payment in this manner could under-reimburse many hospitals for their drug-related costs. While ASP may theoretically reflect the average price hospitals pay for drugs, and adequately compensate many hospitals for their purchasing-related costs, not all hospitals can acquire drugs and biologicals at the average sales price. In addition, a hospital's acquisition costs go beyond the simple purchase price for the drug or biological. Hospitals also incur overhead costs associated with storing and furnishing drugs and biologicals. These costs may be substantial for complex biologicals that require special handling. By reducing the supplemental payment above ASP from 6 percent to 5 percent, CMS is potentially under-reimbursing hospitals for these overhead and handling costs related to acquisition of drugs and biologicals. To the extent hospitals are unable to recoup the cost of purchasing, storing and furnishing pharmaceuticals,

they may be forced to make hard decisions about which drugs they are capable of storing. We oppose any proposal that could limit a vital access point for patients who depend on these therapies.

Perhaps most troubling is that CMS is proposing to make this change without clearly setting out any underlying data to support it. CMS does not provide adequate justification for this reduction other than to state that this payment amount is consistent with CMS's estimate of hospital acquisition costs. If CMS believes that hospital costs (total costs including overhead and handling) are lower in the hospital setting than in the physician's office, CMS should collect this data, present it to the public for comment and also consider the potential impact of different payment formulae on patient access before adopting any change in the payment formula.

Moreover, we are concerned about the payment disparity between hospital and physician office settings that would result from this change. In recent years, payments for physician-injected drugs have been the same across the two settings, *i.e.,* 106 percent of ASP. This has avoided the experiences of a few years back where some patients were being shifted between hospital outpatient and physician office settings depending upon which setting provided payment that more adequately covered provider acquisition costs. Payment parity should be maintained to ensure adequate access to therapies in both settings.

We request that CMS not change the payment formula for physician-injectable drugs for 2008, and instead maintain payment at 106 percent of ASP.

OPPS: Implantation of Spinal Neurostimulators

In the 2008 CMS Proposed Hospital Outpatient Payment System rule, CMS proposes to pay hospitals the same rate for rechargeable and non-rechargeable neurostimulators when implanted in hospital outpatient departments. The cost differential (according to CMS's claims data) between the two technologies is approximately $6,500. This is a meaningful difference that warrants separate reimbursement. We are concerned that this proposal, if implemented, will cause hospitals to make treatment decisions based on economics rather than the best course of care for patients who suffer from chronic, intractable pain.

Rechargeable neurostimulators offer a breakthrough in treatment for patients with complex pain over multiple areas. The enhanced capabilities of rechargeable technology allow physicians to manage patients' pain patterns instead of worrying about depleting the battery of conventional, non-rechargeable devices. Rechargeable devices eliminate the need for battery replacement surgeries associated with non-rechargeable devices, sparing patients the risk and inconvenience associated with multiple surgical procedures and increasing long-term efficiency for the Medicare program.

The importance of rechargeable neurostimulation technology was previously acknowledged by CMS when it granted the device new-tech add-on payment status in the hospital inpatient setting and pass-through status in the hospital outpatient setting. These additional payments to hospitals made it possible for patients with chronic pain to benefit from rechargeable pain-relief technology. With the conclusion of outpatient pass-through status, however, CMS is now

proposing to pay the same amount for rechargeable neurostimulators as it does for all other non-rechargeable devices. We are concerned that the proposed payment policy is insufficient and may jeopardize patient access to this important therapy.

We urge CMS to create a new APC to provide adequate payment for rechargeable technologies to ensure appropriate access to rechargeable neurostimulators.

* * * * *

In summary, AfPA encourages CMS to

- Maintain separate payment for electromyography and electrical stimulation guidance procedures (codes 95873 and 95874);
- Maintain the current payment formula for physician-injectable drugs for 2008 at 106 percent of ASP.
- Create a new APC to provide adequate payment for rechargeable technologies

Thank you for your consideration of our comments.

Sincerely yours,

David Charles, MD
Chairman

CMS-1392-P-729 Medicare

Submitter : William Butterworth **09/12/2007**

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,
William S. Butterworth

CMS-1392-P-730 Medicare

Submitter : Mr. Wendell Alford **09/12/2007**

Organization : Madison Parish Hospital
Critical Access Hospital

Category :

Issue Areas/Comments

OPPS Impact

OPPS Impact

Mr. 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 administrator at Madison Parish Hospital in Tallulah, Louisiana. Madison Parish Hospital is a publicly owned and operated hospital.

Madison Parish Hospital serves a rural population in the Mississippi River Delta with a poverty rate of approximately 40% and an unemployment rate of 17%. This hospital was granted CAH status on January 1, 2005 and is stipulated a Necessary Provider by the State of Louisiana. The proposed change as listed above will negatively affect the improvement in access to care for years to come in Madison Parish. We serve a population that has an extremely high percentage of people with diseases such as hypertension, diabetes, asthma, chronic obstructive pulmonary disease and cancer.

Madison Parish Hospital has in its plans the opening of at least one rural health clinic more closely located to the population base that we serve, primarily the poor and elderly. Many of the patients we serve have no form of transportation and access to health is very difficult for them. The hospital planned to open the clinic in a closer proximity to the patient base thereby improving access to primary care and reducing cost to the patient and the taxpayer. It would be impossible to have the clinic built and certified by January 1, 2008.

Page 2

I respectively ask that you withdraw the provisions of this rule pertaining to off-site primary care delivery systems owned by CAHs. These provisions would have a devastating impact on the access to health care in my rural community. This is contrary to the intention of the CAH program. Provisions of this nature would eliminate our ability to provide the care needed in

rural communities for today and for the future.

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

Sincerely,

C. Wendell Alford, R.Ph.
Administrator
Madison Parish Hospital

CMS-1392-P-731 **Medicare**

Submitter : **Dr. John Carey** **09/12/2007**

Organization : **Jacksonville Spine Center**
Physician

Category :

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1392-P-731-Attach-1.DOC

#731

September 12, 2007

Mr. Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1392–P, Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: CMS-1392-P

Dear Mr. Kuhn:

Thank you for the opportunity to comment on the Proposed Rule CMS-1392-P, "Proposed Changes to the Hospital Outpatient Prospective Payment System (HOPPS) and CY 2008 Payment Rates" (the Proposed Rule) published in the *Federal Register* on August 2, 2007. My comments cover two main issues related to the HOPPS and ambulatory surgery center (ASC) payment methodologies.

I. ASC Procedures

There are several specific procedure issues we ask CMS to review and address. I believe that two procedures that have not been included on the ASC payment list, but that are paid under the HOPPS and should also be included on the ASC list. These procedures are described by CPT codes 22526 (percutaneous intradiscal electrothermal annuloplasty, single level) and 22527 (percutaneous intradiscal electrothermal annuloplasty, one or more additional levels). There is no reason why ASCs should not be entitled to payment for these two procedures. The procedures are safely done in ASCs, and they are not procedures routinely performed in a physician's office. I ask CMS to include both procedures on the ASC list in the final rule.

ASIPP also is concerned that procedures 72285 (discography - cervical or thoracic - radiological supervision and interpretation) and 72295 (discography – lumbar - radiological supervision and interpretation) have been packaged in all circumstances under the ASC proposed rule. These services are payable separately in the HOPD in certain circumstances and I believe the same should be true for ASCs.

Lastly, I ask CMS recalculate the payment rate of CPT code 64517. The proposed payment rate for this procedure is $178 for CY 2008. While I do recognize that the payment for the procedure following the transition period will be $295, a payment of $178 seems too low.

II. IMPLANTATION OF SPINAL NEUROSTIMULATORS

I ask that CMS create a new APC for implanting rechargeable neurostimulators upon expiration of the new technology transitional pass-through payment at the end of 2007.

I am concerned that the CMS proposal to pay rechargeable and non-rechargeable neurostimulator procedures under the same APC (0222) ($12,314 in hospital outpatient departments and $10,925 in ASCs) will impair Medicare Beneficiaries access to neurostimulation therapy utilizing rechargeable devices. The proposed payment structure could lead to such financial pressures on

the facilities purchasing these devices and ultimately cause the restrictive use of this technology despite the fact that rechargeable devices represent a major improvement in neurostimulation therapy for patients with chronic pain. If access to the rechargeable technology is inhibited than Medicare beneficiaries in need of this type of treatment for chronic pain will be relegated to non-rechargeable technology and subject to the risks and co-insurance costs associated with repeat surgical procedures for battery replacement. This outcome seems inconsistent with CMS's own determination that this technology offers beneficiaries substantial clinical improvement over non-rechargeable implantable which was evidenced by the decision to grant rechargeable implantable neurostimulators new technology pass-through payments for 2006 and 2007.

Implantable neurostimulators ensure that chronic pain patients have consistent pain control without interruption. The clinical benefit of the first generation non-rechargeable neurostimulator technologies is limited by the need for repeat surgical procedures for battery replacement any where from every two to four years depending on the usage of the device. Unfortunately, what we know from experience is that many physicians using non-rechargeable battery devices will utilize program settings that require less power in order to conserve the life of their non-rechargeable battery. This practice compromises the patient's opportunity to obtain optimal pain relief on a day-to-day basis; but patients choose this option as opposed to undergoing another surgical procedure. Rechargeable neurostimulators are capable of delivering continuous stimulation, even at high levels, to optimize patient relief without concern of rapid battery depletion. They can usually last nine years (2-3 times longer than the non-rechargeable batteries), even at the highest power settings.

Approximately 25 to 30 percent of all the neurostimulator implant procedures performed each year are required to replace a depleted, non-rechargeable battery. Thus, in the long term, the use of rechargeable devices likely would result in cost savings to the Medicare program and beneficiaries due to the decreased need for battery replacement procedures. The need for fewer surgeries also would reduce the chances that patients will experience operative complications such post-operative infection or other possible co-morbidities.

I ask CMS to create an APC for procedures using rechargeable implantable neurostimulators that is separate and distinct from the proposed APC grouping (0222) to create greater resource consistency. While we appreciate that CMS wants to bundle similar procedures that may utilize a variety of devices with different costs, it is inappropriate to bundle procedures when the absolute difference in cost is so significant. CMS's own analysis of the claims data associated with APC 0222 (shown in Table 35 of the preamble) reveals significantly higher costs for procedures associated with rechargeable neurostimulators ($18,089 median cost) than non-rechargeable neurostimulators ($11,608 median cost).

While I recognize the difference in median costs does not create a two times rule violation, the difference in median cost is not insignificant. CMS has assigned pass-through devices to a new APC or to a different, existing APC in absence of a "two-times" rule violation and for median costs differences significantly less than $1,000. I urge CMS to take a similar approach here. The creation of two separate APCs would result in more appropriate payment for both types of procedures—rechargeable and non-rechargeable neurostimulator procedures—based on their relative costs. To implement our recommendation, we further recommend that CMS create a G-Code to distinguish between implanting a rechargeable and a non-rechargeable neurostimulator.

Moreover, ensuring the payment rate is appropriate under the HOPPS system will result more appropriate payment in the ASC setting. Today, ASCs receive reimbursement for rechargeable generators through the DMEPOS fee schedule (L8689- rechargeable generator). With the current proposal ASC reimbursement will be based on 100% of the device component and approximately 65% of the service component of the APC payment. If the device component, as determined from

the OPPS claims data, is based on a mix of rechargeable and non-rechargeable device costs, payments to ASCs will vastly underpay for the actual equipment, which costs the same in all settings. Now that the two payments systems are inextricably linked it is even more incumbent upon CMS to ensure that payments are adequate under the HOPPS or Medicare beneficiaries may be left without an option to have this procedure performed at a HOPD or an ASC.

In summary my recommendations to CMS are:

- Create a new APC for procedures using rechargeable neurostimulators to recognize the full device and facility costs associated with these procedures.
- Establish new HCPCS II "G-codes" to differentiate between rechargeable and non-rechargeable neurostimulators.
- Alternatively, CMS could continue using the device C-code, C-1820, to assign rechargeable neurostimlutor procedures to a new APC.
- Maintain non-rechargeable neurostimulator procedures in APC 0222.

***

Thank you for your consideration of my comments.

Sincerely,

John E. Carey, MD, MS
Jacksonville Spine Center
10475 Centurion Parkway North, Suite 201
Jacksonville, FL 32256
904-223-3321
904-223-2169 fax
www.jaxspine.com

CMS-1392-P-732 Medicare

Submitter : Dr. Michael Menefee 09/12/2007

Organization : Mills-Peninsula Health Services Hospital

Category :

Issue Areas/Comments

Partial Hospitalization

Partial Hospitalization

Re: Reduction in Reimbursement Rate for Mental Health Partial Hospitalization

Hello! I am the Director of Behavioral Health Outpatient Services for Mills-Peninsula Hospital□s, one of Sutter Health□s affiliates. We are located on the San Francisco Peninsula and service San Mateo County. We provide a full range of outpatient levels of care, including Partial Hospitalization for adult psychiatric patients.

The reductions we have experienced over the past two years have been difficult to absorb, but we have been able to do so without reductions in programming or staffing. Further reduction in reimbursement will require us to both curtail programming and reduce staffing, all to the detriment of patient care and all likely to extend patient care at the PHP level rather than enhance step down to the Intensive Outpatient Level.

I ask that you reconsider the impact of this reduction. In my assessment, it will extend treatment time and ultimately generate no savings for CMS. I understand the need to control expenditures; living without annual increases is one thing, absorbing cut after cut is another.

CMS-1392-P-733 Medicare

Submitter : Mr. Matthew Haas **09/12/2007**

Organization : Holyoke Medical Center, Inc.
Hospital

Category :

Issue Areas/Comments

OPPS: Partial Hospitalization

OPPS: Partial Hospitalization

THE CENTER FOR BEHAVIORAL HEALTH
HOLYOKE MEDICAL CENTER, INC.
575 BEECH STREET
HOLYOKE, MA 01040
(413) 534-2628

September 10, 2007

Mr. Herb Kuhn, Acting Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

RE: CMS-1392-P: Proposed Changes to Partial Hospitalization OPPS

Dear Mr. Kuhn,

I□m writing in response to CMS□s invitation for comments regarding the proposed Partial Hospitalization rate cuts. As Director of Behavioral Health at Holyoke Medical Center, I oversee a continuum of Behavioral Health care that includes Psychiatric Inpatient, PHP, Intensive Outpatient and Outpatient services. The PHP has been an essential component of Holyoke□s system of care, providing a rigorous, but less intensive, treatment option for patients who would otherwise require psychiatric inpatient admission, or in "step-down" cases, would otherwise require longer inpatient psychiatric stays.

The intensive group format of PHP, combined with close psychiatric oversight and active psychiatric treatment, provides a strongly stabilizing treatment setting. Our patients get better, and they□re grateful for it. Some excerpts from recent patient satisfaction surveys speak for themselves:
---□The program is excellent and effective. The staff are highly skilled and educated in their jobs to treat clients with courtesy, dignity and respect. I wouldn□t change a thing.□
---□The service is perfect. I can□t say or suggest anything other than to keep up the good work so that people like me benefit from this program. Thanks."
---□Staff does a WONDERFUL job of helping to orient people to the program. Staff is by far the strongest point of this program□knowlegable and respectful.□
---□I consider this experience to be one of the best of my life.□

In short, PHP works.

As committed as I am to the PHP as part of our continuum of care, I am also concerned that the program actually runs at financial loss, despite our aggressive efforts to maintain the highest possible contracted rates from managed care companies.

The proposed 24% rate cut will put Medicare in the bottom tier of payors, with payment that is significantly below actual costs for providing the services. At a time when costs continue to rise, and in the wake of Medicare rate cuts in the previous two years, this reduction in payment may make it difficult to maintain the financial sustainability of our Partial Hospitalization Program.

I strongly urge CMS to reconsider the proposed rate cut and keep the PHP rates at their current level at a minimum. CMS runs the risk of decimating a level of care that is an essential component in the continuum of treatment, a level of care that helps people change their lives for the better.

I appreciate having the opportunity to offer these comments. Please do not hesitate to contact me if you have any questions.

Sincerely,

Matthew Haas, LICSW, LADC-I
Director of Behavioral Health Services
Holyoke Medical Center, Inc.
haas_matt@holyokehealth.com

CMS-1392-P-733-Attach-1.DOC

#733

THE CENTER FOR BEHAVIORAL HEALTH
HOLYOKE MEDICAL CENTER, INC.
575 BEECH STREET
HOLYOKE, MA 01040
(413) 534-2628

September 10, 2007

Mr. Herb Kuhn, Acting Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

RE: CMS-1392-P: Proposed Changes to Hospital Outpatient PPS

Dear Mr. Kuhn,

I'm writing in response to CMS's invitation for comments regarding the proposed Partial Hospitalization rate cuts. As Director of Behavioral Health at Holyoke Medical Center, I oversee a continuum of Behavioral Health care that includes psychiatric inpatient, PHP, Intensive Outpatient and Outpatient services. The PHP has been an essential component of Holyoke's system of care, providing a rigorous, but less intensive, treatment option for patients who would otherwise require psychiatric inpatient admission, or in "step-down" cases, would otherwise require longer inpatient psychiatric stays. The intensive group format of PHP, combined with close psychiatric oversight and active psychiatric treatment, provides a strongly stabilizing treatment setting. Our patients get better, and they're grateful for it. Some excerpts from recent patient satisfaction surveys speak for themselves:

- "The program is excellent and effective. The staff are highly skilled and educated in their jobs to treat clients with courtesy, dignity and respect. I wouldn't change a thing."
- "The service is perfect. I can't say or suggest anything other than to keep up the good work so that people like me benefit from this program. Thanks."
- "Staff does a WONDERFUL job of helping to orient people to the program. Staff is by far the strongest point of this program--knowledgeable and respectful."
- "I consider this experience to be one of the best of my life."

In short, PHP works.

As committed as I am to the PHP as part of our continuum of care, I am also concerned that the program actually runs at loss, despite our aggressive efforts to maintain the highest possible contracted rates from managed care companies.

The proposed 24% rate cut will put Medicare in the bottom tier of payors, with payment that is significantly below actual costs for providing the services. At a time when costs continue to rise,

and in the wake of Medicare rate cuts in the previous two years, this reduction in payment may make it difficult to maintain the financial sustainability of our Partial Hospitalization Program.

I strongly urge CMS to reconsider the proposed rate cut and keep the PHP rates at their current level, at the very least. CMS runs the risk of decimating a level of care that is an essential component in the continuum of treatment, a level of care that helps people change their lives for the better.

I appreciate having the opportunity to offer these comments. Please do not hesitate to contact me if you have any questions.

Sincerely,

Matthew Haas, LICSW, LADC-I
Director of Behavioral Health Services
Holyoke Medical Center, Inc.
haas_matt@holyokehealth.com