CMS-1392-P-734 **Medicare**

Submitter : Rose Marie Marsh **09/12/2007**

Organization : ST Dysonia
Individual

Category :

Issue Areas/Comments

OPPS: Packaged Services

OPPS: Packaged Services

Twice I've had botex shots without electronics and it doesn't work as well.

CMS-1392-P-735 **Medicare**

Submitter : Christine Hudson **09/12/2007**

Organization : None
Individual

Category :

Issue Areas/Comments

OPPS: Packaged Services

OPPS: Packaged Services

I support the efforts by CMS to improve patient access to care while keeping costs down. However, as a patient with cervical dystonia, (dystonia ia 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 botulinum toxin injections every four months to reduce the pain and severity of my neck spasms. Both the electrodiagnostic guidance service and the botulinum toxin injections I receive are crucial to help me function as normally as possible and to relieve the chronic pain of 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 the guidance equipment. This would result in injections being ineffective because the appropriate muscles were not injected with BOTOX. The guidance service is critically important for this treatment to be effective. I have personal experience with this situation because the first doctor that gave me BOTOX injections fifteen years ago did not use guidance equipment to identify the muscles that were in spasm and I experienced almost no relief from the pain and twisting motions of my cervical dystonia.

Thanks you for allowing me to provide these comments.

Sincerely,

Christine Hudson
Sammamish, Washington

CMS-1392-P-736 **Medicare**

Submitter : Mr. Jerry Di Paola **09/12/2007**

Organization : Bayshore Community Hospital
Health Care Professional or Association

Category :

Issue Areas/Comments

Implantation of Spinal Neurostimulators

Implantation of Spinal Neurostimulators

Please consider creating a separate APC for rechargeable neurostimulators. The rechargeable option translates into fewer stimulator replacements, an advantage to the patient and the healthcare system in the long run. Since the rechargeable stimulator has a higher price tag, creating a separate APC will help facilities continue to offer the advantage of clinical improvement without suffering a hardship by supplying the more expensive, but preferable neurostimulator. Using an individual HCPCS code for each type of stimulator is no different than choosing between hot biopsy forceps and snare technique for colonoscopy, and will have little to no adverse effect on hospital procedures, nor cause administrative burden.

CMS-1392-P-737 **Medicare**

Submitter : Dr. Christopher Elder **09/12/2007**

Organization : Asheville Orthopaedic Associates
Physician

Category :

Issue Areas/Comments

ASC Impact

ASC Impact

I am respectfully requesting that the proposed rate change be reconsidered. Due to a higher likelihood of complications, I feel the Ossatron is best administered in a hospital or ASC setting. Without the proper administration of anesthesia I don't feel like it can be used to its highest efficacy. I don't feel like this procedure can safely be used in an office setting without an increased risk. I am also concerned about fraudulent billing that may transpire if this procedure is limited to an office setting. We have all paid the high price caused by fraudulent billing and at least in a hospital or ASC setting, there is less likelihood of this happening. Once again I request that you reconsider this rate change.

Sincerely,
Christopher L. Elder

CMS-1392-P-738 **Medicare**

Submitter : Mr. Jason Bezozo **09/12/2007**

Organization : Banner Health Hospital

Category :

Issue Areas/Comments

Necessary Provider CAHs

Necessary Provider CAHs

On behalf of Banner Health, a non-profit healthcare system operating 20 hospitals in seven western states, I write to you today in response to the proposed rule referenced above, specifically in regards to proposals affecting the Critical Access Hospital (CAH) program.

Banner Health operates seven CAHs□Banner Lassen Medical Center in Susanville, California, Community Hospital in Torrington, Wyoming, East Morgan Community Hospital in Bruch, Colorado, Ogallala Community Hospital in Ogallala, Nebraska, Page Hospital in Page, Arizona, Platte County Memorial Hospital in Wheatland, Wyoming and Washakie Medical Center in Worland, Wyoming. These small, rural hospitals are the sole provider of emergency care and healthcare services in these communities.

This proposed rule would require provider-based facilities to comply with the 35-mile distance requirement (or 15 miles in the case of mountainous terrain) as of January 1, 2008. Several of our CAHs are strongly considering or planning for the addition of off-site clinics to enhance the access to clinical care in underserved communities near their facilities. This proposal effectively precludes our facilities from providing additional outpatient care□services that are greatly needed and would benefit patients in outlying areas.

Further, the goal of the CAH FLEX program was to develop patient care networks and protect access to healthcare services in medically underserved areas. This proposed regulation contradicts the intent of the program to ensure the availability of care at an efficient cost.

Due to these concerns, I respectfully ask you to 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 healthcare in the rural areas we serve. The CAH program was designed to provide financial stability for small, rural hospitals and this proposed rule would reverse this

standing policy and threaten the ability of CAHs to continue serving their communities. Such provisions would eliminate our flexibility to provide the care needed to all of our patients, not just those who are Medicare beneficiaries.

Thank you for your consideration. Please contact me if you have any questions.

Sincerely,

Jason Bezozo
System Director, Government Relations
Banner Health

CMS-1392-P-738-Attach-1.PDF

#738

Banner Health®

1441 North 12th Street, Phoenix, AZ 85006
602-495-4000
BannerHealth.com

September 12, 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:

On behalf of Banner Health, a non-profit healthcare system operating 20 hospitals in seven western states, I write to you today in response to the proposed rule referenced above, specifically in regards to proposals affecting the Critical Access Hospital (CAH) program.

Banner Health operates seven CAHs—**Banner Lassen Medical Center** in Susanville, California, **Community Hospital** in Torrington, Wyoming, **East Morgan Community Hospital** in Bruch, Colorado, **Ogallala Community Hospital** in Ogallala, Nebraska, **Page Hospital** in Page, Arizona, **Platte County Memorial Hospital** in Wheatland, Wyoming and **Washakie Medical Center** in Worland, Wyoming. These small, rural hospitals are the sole provider of emergency care and healthcare services in these communities.

This proposed rule would require provider-based facilities to comply with the 35-mile distance requirement (or 15 miles in the case of mountainous terrain) as of January 1, 2008. Several of our CAHs are strongly considering or planning for the addition of off-site clinics to enhance the access to clinical care in underserved communities near their facilities. This proposal effectively precludes our facilities from providing additional outpatient care—services that are greatly needed and would benefit patients in outlying areas.

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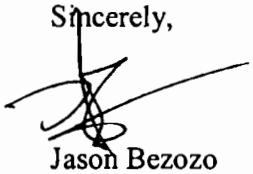
Thank you for your consideration. Please contact me if you have any questions.

Sincerely,



Jason Bezozo
System Director, Government Relations
Banner Health

CMS-1392-P-739 **Medicare**

Submitter : Christine Hudson **09/12/2007**

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 extend my support to your organization for working to improve patient access to services while controlling costs. 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 every four months to alleviate the pain and debilitating twisting motion of my neck. These injections are critically important in helping me live as normal a life as possible. I respectfully request that CMS not change the payment formula for physician- injectable drugs for 2008, and instead maintain the current formula. Any reduction in reimbursement will lead to fewer experienced physicians available to provide effective BOTOX injections. There are already very few physicians available with enough experience to identify and inject the appropriate muscles to relieve the spasms. I currently drive an hour each way to receive my BOTOX injections every four months from an experienced neurologist. In the fifteen years that I have been receiving BOTOX treatments, I have found only two doctors that have been able to successfully treat my dystonia symptoms. In addition, this proposed 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 taking the time to review my comments on this important matter.
Sincerely,
Christine Hudson

CMS-1392-P-740 **Medicare**

Submitter : James Purdy **09/12/2007**

Organization : Northeast Hospital Copr. Hospital

Category :

Issue Areas/Comments

Partial Hospitalization

Partial Hospitalization

see attached commets

CMS-1392-P-740-Attach-1.DOC

#140

September 12, 2007

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

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

Dear Mr. Kuhn:

The proposed 24% reduction in Medicare reimbursement for Partial Hospital Programs would have serious negative impact on the viability of our programs. We request CMS reconsider this proposed reduction and maintain, at least, our current level of funding.

Our PHP programs are part of our behavioral health system which is embedded in a community hospital system north of Boston, known as the Northeast Hospital Corp. Outpatient Partial Hospital programs are critical to our continuum of care which includes acute inpatient medical and behavioral health beds, outpatient psychiatry services, a range of outpatient medical services, as well as, extended care facilities and assisted living residences. Our PHP provides care to patients from all parts of our system and reduces or prevents more costly inpatient utilization and allows patients to maintain productive lives in their communities.

Thank you for your review and consideration of this issue.

Sincerely,

James Q. Purdy
Vice President, Inpatient Behavioral Health
Northeast Hospital Corp.

CMS-1392-P-741 **Medicare**

Submitter : Mrs. Dorothy Prosinski **09/12/2007**

Organization : Bayshore Community Hospital
Health Care Professional or Association

Category :

Issue Areas/Comments

Implantation of Spinal Neurostimulators

Implantation of Spinal Neurostimulators

Please consider creating a separate APC for rechargeable neurostimulators. The rechargeable option translates into fewer stimulator replacements, an advantage to the patient and the healthcare system in the long run. Since the rechargeable stimulator has a higher price tag, creating a separate APC will help facilities continue to offer the advantage of clinical improvement without suffering a hardship by supplying the more expensive, but preferable neurostimulator. Using an individual HCPCS code for each type of stimulator is no different than choosing between hot biopsy forceps and snare technique for colonoscopy, and will have little to no adverse effect on hospital procedures, nor cause administrative burden.

CMS-1392-P-742 **Medicare**

Submitter : Mr. David Gafford **09/12/2007**

Organization : DAPA Family Recovery Programs
Other Health Care Professional

Category :

Issue Areas/Comments

OPPS: Partial Hospitalization

OPPS: Partial Hospitalization

DAPA Family Recovery Programs
6260 Westpark, Suite 300
Houston, Texas 77057
713-783-8889 telephone facsimile 713-783-0499

September 11, 2007

Department of Health and Human Services
Attn: CMS-1488-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Sir/Madam;

I am writing to you regarding the proposed 24% reduction in reimbursement for Partial Hospitalization Program (PHP) services, (APC Code 0033), proposed for FY 2008. I appreciate the opportunity to offer comment during this period.

I work with DAPA Psychiatric and Substance Abuse Programs, which operates PHP programs for the general adult and the geriatric populations suffering from severe emotional and behavioral disturbances, primarily the severely and persistently mentally ill (SPMI). I am advocating on behalf of these populations because they are largely disabled, disadvantaged, disenfranchised and virtually without protection or support in our culture.

The proposed reduction in reimbursement severely threatens the existence of the programs offered to this population, not only here at DAPA, but elsewhere across the nation. With each successive cutback by CMS, these programs have suffered necessary cutbacks in programming: reductions in staff-to-patient ratios, reductions in program supports, and reductions in staff growth and development opportunities. These reductions manifest in the care available to this very needy population. The proposed cut for next year threatens the very continuance of the programs.

The elimination of this level of care will serve only to increase the utilization of institutional care: emergency room presentations, acute inpatient confinements, incarcerations for legal infractions due to uncontrolled symptomology, and an increase in elderly admissions to nursing homes because aging in place is no longer viable due to the loss of the role played by PHPs in bolstering the supports of the elderly and their untrained and non-professional families.

I understand that there are efforts being made to envision a reimbursement system that would bring PHP payment outside of the APC Codes of OPPS. I also understand that such a change may involve time and planning and legislative involvement, perhaps unachievable prior to year-end. Due to the potentially fatal result on the current program offerings across the nation, I urge you to employ your discretionary authority to freeze

the rate at the FY2007 level, continue to work with AABH and other involved organizations of advocacy and the concerned legislators to devise a long-term correction of the problem.

Thank you.

Respectfully yours,

David R. Gafford

CMS-1392-P-743 **Medicare**

Submitter : Jeff Hill **09/12/2007**

Organization : Galena Stauss Hospital
Critical Access Hospital

Category :

Issue Areas/Comments

Necessary Provider
CAHs

Necessary Provider CAHs

Mr. Kuhn,

Please see attached.

Thank you,

Jeff Hill

CMS-1392-P-743-Attach-1.WPD

#743

September 14, 2007

Mr. Herb Kuhn
Acting Deputy Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue
Washington, D.C. 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 Designation of Critical Access Hospitals

Dear Deputy Administrator Kuhn:

I am writing on behalf of the Galena Stauss Hospital & Healthcare Center, Galena, Illinois in reference to proposed changes that will impact the Critical Access Hospital (CAH) program. I respectfully urge you to withdraw the provisions in this rule relating to provider based off-site facilities owned by "necessary provider" Critical Access Hospitals (CAHs).

Of major concern is the provision that would restrict CAHs from operating any offsite facilities after January 1, 2008 unless they meet the 35 mile criteria. All of our Illinois CAHs are "necessary providers." For my hospital, it will be geographically impossible to find a new off-campus location that would meet the 35 mile requirement.

As you well know, physician shortages are one of the most difficult challenges facing our rural hospitals. This will have a serious negative impact on the provision of physician services, especially in our rural designated shortage areas in Illinois.

The CAH program was enacted to help struggling small rural hospitals maintain the financial strength to enable them to care for their communities. The proposed rule changes run counter to this goal and would jeopardize the ability of hospitals like mine to provide essential health care for our seniors.

With these issues in mind, I again, respectfully urge you to withdraw the provisions in this rule relating to off-site clinics owned by CAHs. .

Thank you for your consideration. Please contact me with any questions you may have.

Sincerely,

Jeff Hill, CEO
Galena Stauss Hospital & Healthcare Center
815-776-7266

CMS-1392-P-744 **Medicare**

Submitter : Mrs. Janet Lytton **09/12/2007**

Organization : Rural Health Development
Critical Access Hospital

Category :

Issue Areas/Comments

Necessary Provider
CAHs

Necessary Provider CAHs

Please reconsider the new proposed regulation for CAHs

CMS-1392-P-744-Attach-1.DOC

#744

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 a concerned beneficiary of a CAH in the State of Nebraska.

> I have worked CAHs across the State of Nebraska and receive care at a CAH and am concerned if their designation would be taken away. Many of our CAHs in Nebraska are considered "necessary providers" as they are providing healthcare to our rural beneficiaries and without these CAHs, these patients would have to travel many miles in order to receive care. Most of the CAHs also have PBRHCs as a part of their facility. Some are attached to the hospitals but many are in the outreaching small towns, some as far as 35 miles away. These PBRHC is the only healthcare available without traveling many miles. Since we are in the rural areas it is very hard to keep providers on staff and are continually recruiting for physicians, physician assistants or nurse practitioners. With many of the solo practitioners retiring, the communities will come to the CAH to ask if they can supply this service in their small town. If this regulation was put into place and would jeopardize our CAH, we would not be able to provide the necessary healthcare services needed in these communities.

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,
Janet Lytton, RHIT, Rural Health Development

CMS-1392-P-745 **Medicare**

Submitter : Dr. Patrick Wheat **09/12/2007**

Organization : Woodcrest Healthcare, Inc
Physician

Category :

Issue Areas/Comments

OPPS: Partial Hospitalization

OPPS: Partial Hospitalization

I am writing in response to the proposed rule referenced above, specifically in regards to proposals that would adversely affect CMHC□S Partial Hospitalization Programs.

I am a board certified psychiatrist for the Woodcrest Healthcare, Inc. Partial Program in Natchitoches, Louisiana. We are a small, family owned business, which has been serving the mental patients of our area for ten years. During those ten years, we have seen successive cuts in funding exceeding 50% from our original reimbursement rates.

In the aftermath of Hurricanes Rita and Katrina in 2005, the cost of doing business in Louisiana has risen substantially. Insurance rates across the State have risen from 50-200% (Insurance Journal 10/24/2006), Nursing Salaries have increased by 10-15% (Louisiana Nurses Association, 2005), use of high cost staffing agencies have increased by 25% and cost for labor has increased by 7.4% statewide and 28.7% in New Orleans (US Bureau of Labor and Statistics 4th Quarter 2005). The proposed wage index in Louisiana has been lowered post hurricane instead of adjusted upward. This results in a much lower payment rate for Louisiana. The time lag on the wage indexing is a huge factor for Hurricane Zone providers. The wage index decrease makes the assumption that the cost of labor has actually decreased since the

hurricanes. That would mean that despite the biggest shortage in staffing for hospitals in the past 20 years, as well as the loss of professional and paraprofessional staff, salaries have gone down. Any employer in the Gulf Coast states can verify that this is not correct. Wages have increased substantially.

CMS recognizes that this program represents □the most resource intensive of all outpatient mental health treatment□. This program is just one step down from an inpatient psychiatric stay and has actually higher requirements than an inpatient stay. The current Standard of Practice for Partial

Hospitalization Programs is an average of 4 professional services per day. Services provided in a partial hospitalization program are provided both on a group and individual basis. Partial Hospitalization Programs require extensive amounts of professional services, inclusive of nursing, social work, therapy, ancillary services and psychiatry.

The proposed rule referenced above continues to place extreme hardship on providers of Partial Hospitalization Programs. The rate proposed for 2008 once again falls below the actual cost of providing such services. Cost analysis demonstrates that the proposed APC rate is insufficient to provide the cost of care to the mentally ill in these programs.

We simply cannot provide these valuable services at the rates proposed. The proposed cut of 23.7% will cripple our business and we will be forced to close. This program is too important to our patients to close, and for our services to no longer be available. Our closing would leave them with no support system and many will end up being hospitalized for extended periods of time, some for the duration of their life, which will significantly burden the healthcare system as a whole.

Due to these concerns, I respectively ask that you withdraw the provisions in this rule pertaining to reduction in rates for Partial Hospitalization Programs. As stated above, such provisions would have a devastating impact on the access to quality health care in my community and across the state of Louisiana.

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

Sincerely,
Dr. Patrick Wheat, Psychiatrist

CMS-1392-P-746 **Medicare**

Submitter : Ms. Erin Keyser **09/12/2007**

Organization : Woodcrest Healthcare
Individual

Category :

Issue Areas/Comments

OPPS: Partial Hospitalization

OPPS: Partial Hospitalization

Psychiatric patients have very special needs that must be met to help them live independently and productively. They need to have regular therapy, appointments with a psychiatrist, and supervision and planning of their medication. They also need a place that teaches skills and strategies to help them get through issues and difficulties in their life that will keep them out of a psychiatric hospital. Community Mental Health Centers meet these needs and have changed many psychiatric patients quality of life, enabling them to do things they never thought possible and reach goals unattainable without the help of therapy and medication.

This year, Medicare wants to change the amount of money it will allow for these important services. Some CMHCs, especially in rural communities, will have to close because they cannot afford to pay their expenses. These programs are too important to their patients for them to close and for these services to no longer be available. The closings leave them with no support system and many will end up being hospitalized for extended periods of time, some for the duration of their life.

Please reconsider the changes in funding for these programs, especially the programs located in rural areas.

Thank you,
Erin Keyser - Billing Coordinator

CMS-1392-P-747 **Medicare**

Submitter : Ms. Colleen Scanlon **09/12/2007**

Organization : Catholic Health Initiatives
Hospital

Category :

Issue Areas/Comments

GENERAL

GENERAL

Please see attached comments from Catholic Health Initiatives.

CMS-1392-P-747-Attach-1.PDF

#747

CATHOLIC HEALTH INITIATIVES

A spirit of innovation, a legacy of care

1999 Broadway
Suite 2600
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Denver, CO
80202

P 303.298.9100
F 303-298-9690

September 12, 2007

Kerry Weems
Acting 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, Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates (Vol. 72, No. 148), August 2, 2007.

Dear Mr. Weems:

Catholic Health Initiatives appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for the calendar (CY) 2008 outpatient prospective payment system (PPS). Catholic Health Initiatives is a non-profit, faith-based, mission-driven health system that includes 73 hospitals, 42 long-term care, assisted-living and residential units, and two community health service organizations in 19 states.

We support the comments submitted to CMS by the Catholic Health Association and the American Hospital Association. We particularly urge caution in proceeding with various packaging proposals, including packaging of drugs with procedures. We are concerned that packaging could be used as a "back-door" means of inappropriately cutting Medicare payments.

Our detailed comments will focus on the following two provisions of the proposed rule that are of particular importance to Catholic Health Initiatives:

Necessary Provider Critical Access Hospitals (CAH)
CMS proposes to clarify that if a CAH operates a provider-based facility or a psychiatric or rehabilitation distinct part unit that was created after January 1, 2008, it must comply with the CAH distance requirement of a 35-mile drive to the nearest hospital (or 15 miles in the case of mountainous terrain or secondary roads).

CMS believes that the necessary provider CAH designation cannot be considered to extend to any facilities not in existence when the CAH originally received its necessary provider designation from the state. In the case of a necessary provider CAH that violates the proposed requirement, CMS would terminate its provider agreement. This could be avoided if the CAH corrected the violation or converted to a hospital paid under the PPS.

Approximately 850 of the 1300 CAHs nationally are necessary provider CAHs and are therefore within 35 miles of another hospital or CAH. Catholic Health Initiatives operates 21 CAHs and several of them are necessary providers. These hospitals operate numerous rural health clinics and other provider-based facilities. In some cases, additional sites or relocation of existing off-campus sites will be needed to better serve the needs of patients in these rural communities.

If this proposal is adopted, our CAHs will be significantly limited in or prohibited from opening new off campus provider-based sites, or converting existing sites to provider-based status. CMS states in the proposed regulation that these new restrictions are "consistent with our belief that the intent of the CAH program is to maintain hospital-level services in rural communities while ensuring access to care." **These arbitrary limitations on provider-based service locations will have the exact opposite effect – access to services will be reduced.**

CAH provider-based entities are located in different places for various reasons. Hospitals consider available land, natural boundaries, increased need, preference of physicians and other practitioners, etc. While community members may be willing to travel a distance to a hospital for urgent care or services not available elsewhere, beneficiaries may need something closer to home for more routine visits, therapy, lab work, etc. By forcing CAHs to have services on-campus, CMS will be leaving some community members without access to services.

We are particularly concerned that CMS does not appear to exclude rural health clinics from the proposed rule. Clinics are often a way that CAHs recruit physicians to practice in the area. By hiring a physician at one of the CAHs' provider-based clinics, the CAH guarantees that there is a physician in the area to serve on the medical staff of the hospital. There are small communities nationwide that would not have a physician without a rural health clinic.

The proposed rule will also prevent necessary providers from replacing outdated facilities with new, more modern provider-based facilities in locations that best suit the needs of their population. For example, one of our CAHs operates six rural health clinics in a high poverty area. The hospital plans to build a medical office building in a new area of town to improve services and enhance physician recruitment and retention. The hospital had planned to locate one of the rural health clinics in the new building. As we understand this proposal, that move could not happen without loss of CAH status. This hospital could not survive without CAH status.

It should be noted that many state necessary provider plans, which were approved by CMS, used criteria such as population, income and age demographics for areas to determine if a hospital could qualify as a necessary provider. It would seem reasonable that new off-campus sites within geographic areas used to establish necessary provider status should not affect continuing necessary provider status.

We urge CMS to rescind this proposal to avoid limiting access to health care services in rural areas.

Quality Data

Catholic Health Initiatives supports the move to outpatient quality measure and is pleased that CMS chose not to use the surrogate impatient measure originally suggested.

We agree with many of the selected measures in concept, but these measures need refinement to bring them into the realm of the acute care outpatient setting. Without seeing the specifications -- which are yet to be developed -- we do not understand exactly which patient population we are addressing, with the exception of the emergency department acute myocardial infarction measures. The surgery related measures might come from several areas in the hospital outpatient setting.

Some of these measures are taken directly from the PQRI measure sets and apply to a physician practice or clinic setting. Most community hospitals do not have hospital-based clinics, so we are unclear how these hospitals fit into gathering data for these measures. We do not object to including them if the final specifications make it clear exactly which patients we are addressing.

We strongly object to the last measure: Hemoglobin A1c >9.0 percent for diabetics. This is an outcome measure that is totally dependent on physician office practice and patient compliance. For the hospital outpatient setting, the only possible thing that is under the hospital's control is whether we measure the HbA1c when a diabetic patient is seen. And there is no evidence that this measurement should always occur. The measure absolutely does not grade the outcome of any care that is provided in a hospital outpatient setting (ED, same day surgery, etc.). This measure is strictly for a physician practice setting, or hospital-based clinic.

We urge CMS to remove PQRI #1: Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus from the outpatient quality data that must be reported by hospitals.

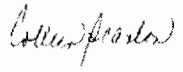
We understand the 2008 start of the outpatient measures in the context of the law. However, with the need for CMS to hire a database contractor, develop the database, finalize the specifications and get them out to vendors, allow time for the vendors to create software, give hospitals time to develop and test the data extracts of their outpatient files, send the data, and do the additional abstraction, we doubt that it is feasible to start on January 1, 2008. We do not believe that the statute requires data

collection to begin on January 1. It could start later in the year when hospitals and vendors are fully prepared to begin the program.

We urge CMS to delay data collection on the outpatient measures until the measures have been fully field-tested, the data specifications have been finalized, and the data collection software is fully operational.

Thank you for providing us with an opportunity to comment. Please contact me at 303-383-2693 or colleenscanlon@catholichealth.net for additional information on any of the issues we have raised.

Sincerely



Colleen Scanlon, RN, JD
Senior Vice President, Advocacy

CMS-1392-P-748 **Medicare**

Submitter : Ms. Jeanette Brown **09/12/2007**

Organization : bayshore community hospital
Other Health Care Professional

Category :

Issue Areas/Comments

Implantation of Spinal Neurostimulators

Implantation of Spinal Neurostimulators

Please consider creating a separate APC for rechargeable neurostimulators. The rechargeable option translates into fewer stimulator replacements, will be better for the patient and the healthcare system overall. Separate APC's will allow facilities to offer better services to its patients without supplying the more expensive neurostimulator.

CMS-1392-P-749 **Medicare**

Submitter : Mr. Joe Keyser II **09/12/2007**

Organization : Woodcrest Healthcare
Individual

Category :

Issue Areas/Comments

OPPS: Partial Hospitalization

OPPS: Partial Hospitalization

I am writing in response to the proposed rule referenced above, specifically in regards to proposals that would adversely affect CMHC□S Partial Hospitalization Programs.

The proposed rule referenced above continues to place extreme hardship on providers of Partial Hospitalization Programs. The rate proposed for 2008 once again falls below the actual cost of providing such services. Cost analysis demonstrates that the proposed APC rate is insufficient to provide the cost of care to the mentally ill in these programs.
Due to these concerns, I respectively ask that you withdraw the provisions in this rule pertaining to reduction in rates for Partial Hospitalization Programs. As stated above, such provisions would have a devastating impact on the access to quality health care in my community and across the state of Louisiana.

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

Sincerely,
Joe Keyser II

CMS-1392-P-750 **Medicare**

Submitter : Mrs. Dixie Snadoz **09/12/2007**

Organization : Woodcrest Healthcare, Inc
Nurse

Category :

Issue Areas/Comments

OPPS: Partial Hospitalization

OPPS: Partial Hospitalization

SUBJECT: CMS-1392-P-MEDICARE PROGRAM; PROPOSED CHANGES TO THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM AND CY 2008 PAYMENT RATES

I am writing in response to the proposed rule referenced above, specifically in regards to proposals that would adversely affect CMHC□S Partial Hospitalization Programs.

I am a nurse for the Woodcrest Healthcare, Inc. Partial Program in Natchitoches, Louisiana. We are a small, family owned business, which has been serving the mental patients of our area for ten years. During those ten years, we have seen successive cuts in funding exceeding 50% from our original reimbursement rates.

In the aftermath of Hurricanes Rita and Katrina in 2005, the cost of doing business in Louisiana has risen substantially. Insurance rates across the State have risen from 50-200% (Insurance Journal 10/24/2006), Nursing Salaries have increased by 10-15% (Louisiana

Nurses Association, 2005), use of high cost staffing agencies have increased by 25% and cost for labor has increased by 7.4% statewide and 28.7% in New Orleans (US Bureau of Labor and Statistics 4th Quarter 2005). The proposed wage index in Louisiana has been lowered post hurricane instead of adjusted upward. This results in a much lower payment rate for Louisiana. The time lag on the wage indexing is a huge factor for Hurricane Zone providers. The wage index decrease makes the assumption that the cost of labor has actually decreased since the hurricanes. That would mean that despite the biggest shortage in staffing for hospitals in the past 20 years, as well as the loss of professional and paraprofessional staff, salaries have gone down. Any employer

in the Gulf Coast states can verify that this is not correct. Wages have increased substantially.

CMS recognizes that this program represents □the most resource intensive of all outpatient mental health treatment□. This program is just one step down from an inpatient psychiatric stay and has actually higher requirements than an inpatient stay. The current Standard of Practice for Partial Hospitalization Programs is an average of 4 professional services per day. Services provided in a partial hospitalization program are provided both on a group and individual basis. Partial Hospitalization Programs require extensive amounts of professional services, inclusive of nursing, social work, therapy, ancillary services and psychiatry.

The proposed rule referenced above continues to place extreme hardship on providers of Partial Hospitalization Programs. The rate proposed for 2008 once again falls below the actual cost of providing such services. Cost analysis demonstrates that the proposed APC rate is insufficient to provide the cost of care to the mentally ill in these programs.

We simply cannot provide these valuable services at the rates proposed. The proposed cut of 23.7% will cripple our business and we will be forced to close. This program is too important to our patients to close, and for our services to no longer be available. Our closing would leave them with no support system and many will end up being hospitalized for extended periods of time, some for the duration of their life, which will significantly burden the healthcare system as a whole.

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

provisions would have a devastating impact on the access to quality health care in my community and across the state of Louisiana.

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

Sincerely,
Dixie Sandoz

CMS-1392-P-751 **Medicare**

Submitter : Ms. Wendy Ussery **09/12/2007**

Organization : Bamberg County Hospital
End-Stage Renal Disease Facility

Category :

Issue Areas/Comments

Packaged Services

Packaged Services

If you cut the reimbursement for our hospital, if would affect the amount of services we would be able to offer our community.

CMS-1392-P-752 **Medicare**

Submitter : Mr. Russell Keene **09/12/2007**

Organization : Androscoggin Valley Hospital
Hospital

Category :

Issue Areas/Comments

OPPS: Partial Hospitalization

OPPS: Partial Hospitalization

See Attachment

CMS-1392-P-752-Attach-1.DOC

#752

September 11, 2007

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 a the Chief Executive Officer at Androscoggin Valley Hospital in Berlin, New Hampshire.

We received our CAH designation in 2005 and are characterized as a necessary provider. Our ability to provide provider-based clinics has certainly provided greater access to numerous patients in an area that is geographically challenged because of the vast variances between institutions and the travel difficulties based on road conditions, especially so during the winter season, which is generally five to six months duration. As we continue to develop long-term strategic initiatives, it is clear to us that in order to accentuate greater care to our constituency, additional off-site clinics will be necessary and are currently in the planning stage.

We currently provide numerous provider based locations which has served to benefit various institutions and communities. Based on significant recruiting difficulties, we are currently discussing additional provider based locations that would provide much needed specialty care such as orthopaedics,, ENT, and general surgery. Limitations, such as there being contemplated, would impact rural areas by precluding appropriate and necessary creativity which is especially important considering the physician shortages that we are seeing in so many specialties. We, in fact, continue to struggle to recruit primary care as an example. During the last 24 months, we have lost 8 providers and struggle to even attract candidates. This is but one

minor example where provider based clinicians could be of paramount importance in providing access to Medicare beneficiaries.

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

< How you received your CAH designation
< The types of provider based clinics that your hospital already opens
< The types of such off-site clinics that you are considering in the future
< Any evidence you can provide about how the limiting of off-site clinics would impede care in your community
< Any evidence you can provide about how few providers are operating in your community for Medicare beneficiaries

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,

Russell G. Keene
Chief Executive Officer

RGK:nd

CMS-1392-P-753 **Medicare**

Submitter : Dr. Bruce Moor **09/12/2007**

Organization : River Radiology
Physician

Category :

Issue Areas/Comments

Payment for Diagnostic Radiopharmaceuticals

Payment for Diagnostic Radiopharmaceuticals

Our center works closely with cancer practices and cancer centers in the local hospitals. As PET-CT scanning becomes more and more important in the diagnosis and management of cancer patients, we are burdened by shrinking reimbursement. Please reinstitute fair payment for expensive radiopharmaceuticals, such as F18 FDG.

CMS-1392-P-754 **Medicare**

Submitter : Mrs. Haley Lacaze **09/12/2007**

Organization : Woodcrest Healthcare, Inc.
Other Health Care Professional

Category :

Issue Areas/Comments

OPPS: Partial Hospitalization

OPPS: Partial Hospitalization

I am writing in response to the proposed rule referenced above, specifically in regards to proposals that would adversely affect CMHC□S Partial Hospitalization Programs.

I am a therapist for the Woodcrest Healthcare, Inc. Partial Program in Natchitoches, Louisiana. We are a small, family owned business, which has been serving the mental patients of our area for ten years. During those ten years, we have seen successive cuts in funding exceeding 50% from our original reimbursement rates.

In the aftermath of Hurricanes Rita and Katrina in 2005, the cost of doing business in Louisiana has risen substantially. Insurance rates across the State have risen from 50-200% (Insurance Journal 10/24/2006), Nursing Salaries have increased by 10-15% (Louisiana Nurses Association, 2005), use of high cost staffing agencies have increased by 25% and cost for labor has increased by 7.4% statewide and 28.7% in New Orleans (US Bureau of Labor and Statistics 4th Quarter 2005). The proposed wage index in Louisiana has been lowered post hurricane instead of adjusted upward. This results in a much lower payment rate for Louisiana. The time lag on the wage indexing is a huge factor for Hurricane Zone providers. The wage

index decrease makes the assumption that the cost of labor has actually decreased since the hurricanes. That would mean that despite the biggest shortage in staffing for hospitals in the past 20 years, as well as the loss of professional and paraprofessional staff, salaries have gone down. Any employer in the Gulf Coast states can verify that this is not correct. Wages have increased substantially.

CMS recognizes that this program represents □the most resource intensive of all outpatient mental health treatment□. This program is just one step down from an inpatient psychiatric stay and has

actually higher requirements than an inpatient stay. The current Standard of Practice for Partial Hospitalization Programs is an average of 4 professional services per day. Services provided in a partial hospitalization program are provided both on a group and individual basis. Partial Hospitalization Programs require extensive amounts of professional services, inclusive of nursing, social work, therapy, ancillary services and psychiatry.

The proposed rule referenced above continues to place extreme hardship on providers of Partial Hospitalization Programs. The rate proposed for 2008 once again falls below the actual cost of providing such services. Cost analysis demonstrates that the proposed APC rate is insufficient to provide the cost of care to the mentally ill in these programs.

We simply cannot provide these valuable services at the rates proposed. The proposed cut of 23.7% will cripple our business and we will be forced to close. This program is too important to our patients to close, and for our services to no longer be available. Our closing would leave them with no support system and many will end up being hospitalized for extended periods of time, some for the duration of their life, which will significantly burden the healthcare system as a whole.

Due to these concerns, I respectively ask that you withdraw the provisions in this rule pertaining to reduction in rates for Partial Hospitalization Programs. As stated above, such provisions would have a devastating impact on the access to quality health care in my community and across the state of Louisiana.

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

Sincerely,
Haley Lacaze

CMS-1392-P-755 **Medicare**

Submitter : Mrs. Heather Riehn **09/12/2007**

Organization : Mrs. Heather Riehn
Individual

Category :

Issue Areas/Comments

OPPS: Partial Hospitalization

OPPS: Partial Hospitalization

Psychiatric patients have very special needs that must be met to help them live independently and productively. They need to have regular therapy, appointments with a psychiatrist, and supervision and planning of their medication. They also need a place that teaches skills and strategies to help them get through issues and difficulties in their life that will keep them out of a psychiatric hospital. Community Mental Health Centers meet these needs and have changed many psychiatric patients quality of life, enabling them to do things they never thought possible and reach goals unattainable without the help of therapy and medication.

This year, Medicare has changed the amount of money it will allow for these important services. Some CMHCs, especially in rural communities, have closed because they cannot afford to pay their expenses. These programs are too important to their patients for them to close and for these services to no longer be available. The closings leave them with no support system and many will end up being hospitalized for extended periods of time, some for the duration of their life.

Please reconsider the changes in funding for these programs, especially the programs located in rural areas. An increase in funding will allow patients to keep these valuable services that help them to lead productive lives.

Thank you,
Heather Reihn

CMS-1392-P-756 **Medicare**

Submitter : Dr. Carol Jannik **09/12/2007**

Organization : Woodcrest Healthcare, Inc
Other Health Care Professional

Category :

Issue Areas/Comments

OPPS: Partial Hospitalization

OPPS: Partial Hospitalization

I am writing in response to the proposed rule referenced above, specifically in regards to proposals that would adversely affect CMHC□S Partial Hospitalization Programs.

I am a psychologist for the Woodcrest Healthcare, Inc. Partial Program in Natchitoches, Louisiana. We are a small, family owned business, which has been serving the mental patients of our area for ten years. During those ten years, we have seen successive cuts in funding exceeding 50% from our original reimbursement rates.

CMS recognizes that this program represents □the most resource intensive of all outpatient mental health treatment□. This program is just one step down from an inpatient psychiatric stay and has actually higher requirements than an inpatient stay. The current Standard of Practice for Partial Hospitalization Programs is an average of 4 professional services per day. Services provided in a partial hospitalization program are provided both on a group and individual basis. Partial Hospitalization Programs require extensive amounts of professional services,

inclusive of nursing, social work, therapy, ancillary services and psychiatry.

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

Sincerely,
Dr. Carol Jannik