THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES

September 14, 2007

Mr. Kerry N. Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 443-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

REF: CMS-1392-P

RE: 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; Medicare and Medicaid Programs: Proposed Changes to Hospital Conditions of Participation; Proposed Changes affecting Necessary Provider Designations of Critical Access Hospitals

Dear Mr. Weems:

The Catholic Health Association of the United States (CHA) is pleased to submit the following comments, on the above notice of proposed rulemaking (NPRM), which was published in the *Federal Register* (Vol. 72, No. 148) on August 2, 2007. Our comments will focus on the proposed changes to the hospital outpatient prospective payment system (OPPS).

WASHINGTON OFFICE
1875 Eye Street, NW
Suite 1000
Washington, DC 20006-5409
Phone 202-296-3993
Fax 202-296-3997
www.chausa.org

1. Volatility of APC Relative Weights

CHA continues to object to the year-to-year volatility of the ambulatory payment classification (APC) weights and urges the Centers for Medicare and Medicare Services (CMS) to take appropriate steps to ensure stability in APC weights.

As has been the case in other years, again for CY 2008 the proposed rule shows significant swings in the APC relative weights. For 29 APCs, the proposed CY 2008 weights would decrease by 10 percent or more; for 17 of these, the reduction is greater than 20 percent and for 8 it is greater than 35 percent. In total, weights would be lower for 94 APCs. On the other hand, weights increase for 295 APCs, going up at least 10 percent for 99 of them. In fact, 59 APCs rise by at least 20 percent and 32 APCs gain 35 percent or more. For 379 APCs, no comparison could be made. Note that these comparisons are confounded by the increased packaging of services, making interpretation difficult.

One approach is to adjust medians derived from claims data to limit the amount of change that occurs from year-to-year. From the perspective of both hospital operations and payment policy, a stable payment environment is desirable. A stability policy should adjust the medians from claims data to ensure that no APC's median falls more than 5 percent compared to the medians used for payment in 2006.

2. OPPS: Packaged Services

CHA is concerned that in the drive to significantly increase the number of services that are packaged or formed to create a composite APC intended to moderate the growth in volume and OPPS spending, CMS may be devaluing medical necessity. We appreciate that it can be a fine line between medically necessary services and those that are questionable but we urge CMS to err on the side of caution. In particular, CHA is concerned that the new packaging efforts as well as the development of composite APCs will create disincentives to provide certain services rather than balance the incentives.

A. Proposed Packaging Approach**.**

Conceptually, CHA supports increased packaging of appropriate services. For instance, increased packaging would appear appropriate for several of the proposed seven categories of supportive ancillary services, including guidance services, image processing services, diagnostic radiopharmaceuticals and contrast media. CHA is concerned, however, about the proposed packaging of all imaging supervision and interpretation and observational services.

Packaging of Imaging Supervision and Interpretation Services. The radiology supervision and interpretation (S&I) services would be appropriate to package as the support or dependent service if the surgical services were separately paid. However, most of the surgical codes are packages as well. In these cases, there would apparently be no recognition of or payment for the S&I services.

Packaging of All Observational Services. CHA does not support the packaging of observational services reported under HCPCS code G0378 (Hospital observation services, per hour). Currently separate payment for such observation service is made for only three conditions – chest pain, asthma, or congestive heart failure. The costs and resource utilization for such patients are obviously much higher than those for patients requiring a lower level of emergency department visit service. Patients with any of these conditions have a higher acuity and a longer length of stay involving observational services.

Hospitals that specialize in the care of patients with cardiac problems and/or asthma could find themselves severely disadvantaged under the proposed packaging because the costs they incur in providing observation services for patients with these conditions would not be adequately covered under the proposed packaging methodology. This is clearly apparent from the example cited on page 42676 of the Federal Register, (Volume 72, Number 148). Currently a hospital outpatient department providing a separately

payable observational service in conjunction with HCPCS code 99285 – Emergency Dept Visit (independent service) would be paid a total of $768.07. Under the proposed packaging policy for observational service the same services would be paid a total of $348.81 in CY 2008. This is a loss of about 55 percent.

We are also concerned about this proposal because it could hurt rural hospitals that frequently use observation care to determine whether patients need to be transferred to other facilities for inpatient admissions.

While we understand CMS' concern about inappropriate incentives of the current OPPS, the proposed packaging of all observational services would not create a neutral incentive as regards the provision of observation services, but rather a disincentive.

B. Proposed Composite APCs

Conceptually, CHA supports the development of composite APCs. Further, we encourage CMS to consider composite APCs for other service combinations. We commend your efforts to determine payments based on multiple procedure claims. We support the proposed composite APCs for Low Dose Rate Prostate Brachytherapy and Cardiac Electrophysiologic Evaluation and Ablation.

We are concerned, however, about the ability of composite APCs that stretch across more than one day to accurately reflect the true cost and resource utilization of the related multi-day services. We understand the movement towards payment per episode, but a single episode does not typically last more than one day. Thus, until further research and analysis has been completed, we are opposed to multi-day composite APCs.

3. OPPS: Wage Index

CHA supports the use of the hospital inpatient area wage index values as was finalized for FY 2008 in the inpatient hospital prospective payment system final rule published in the Federal Register on August 22, 2007 for use in the CY 2008 OPPS.

4. OPPS: Outlier Payments

CHA supports the proposal to increase fixed-dollar outlier threshold for CY 2008 in order to keep the outlier payment percentage to 1 percent of the estimated total payments.

For CY 2008, CMS proposes to continue the current policy of setting aside 1.0 percent of aggregate OPPS payments for outlier payments.

For CY 2007, the outlier threshold is met when the cost of furnishing a service or procedure exceeds 1.75 times the APC payment amount and also exceeds the APC payment rate plus a $1,825 fixed-dollar threshold. For CY 2008, CMS proposes that outlier payments would be

triggered when a hospital's cost of furnishing a service or procedure exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $2,000 fixed-dollar threshold.

5. Inpatient Only Procedures

CHA continues to urge the elimination of the inpatient list primarily because the list is not binding on physicians.

The list was created to identify procedures that are typically provided only in an inpatient setting, and therefore would not be paid by Medicare under the hospital outpatient prospective payment system (OPPS)**.** There are numerous problems created by the inpatient list as has been documented in past comments. The biggest continuing problem is that such a list is not binding on physicians. Consequently, since the physician receives payment when a procedure on the inpatient list is performed on an outpatient basis, there is no incentive for the physician to be concerned whether Medicare will pay the hospital for the procedure. This is a particularly troubling issue in teaching hospitals. This fact underscores the reality that it is the physician, not the hospital, who determines whether a procedure will be performed in the outpatient or inpatient setting.

In the past, CMS has responded to such comments by saying that "[it] believes that appropriate education of physicians and other hospital staff by CMS, hospitals and organizations representing hospitals is the best way to minimize any existing confusion." While such education is important, it alone will not solve the problem. When it comes to economic issues physicians, quite understandably, pay little attention to how hospitals are paid. The CMS provider education staff does not appear to have made any headway on this matter.

6. Critical Access Hospitals (CAHs)

CHA strongly objects to the proposal that all CAH provider-based locations created or acquired after January 1, 2008 must be more than 35 miles (or 15 miles in the case of mountainous terrain or secondary roads) from any other hospital or CAH. We further object to the loss of CAH status if any new CAH location that meets the provider-based requirements fails to meet this distance requirement.

Approximately 850 of the 1300 CAHs nationwide are necessary provider CAHs and are therefore within 35 miles of another hospital or CAH. If this proposal is finalized, these CAHs will be significantly limited, if not in many cases prohibited, from opening new off campus provider-based sites, or converting existing sites provider-based after January 1, 2008. This is because in many areas, the necessary provider CAHs are located within 35 miles of several other hospitals or CAHs.

The proposal, if adopted, will likely have a disproportionate impact on rural Medicare beneficiaries. Such beneficiaries generally depend on CAHs for their health care needs. CAHs are unlikely to develop new clinical care services sites in outlying rural communities if doing so would threaten their CAH status.

It is worthwhile to note that many state necessary provider plans, which were approved by CMS, used criteria such as population, income and age demographics for geographic 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 CAH status.

7. Implantation of Spinal Neurostimulators

CHA urges CMS to create one APC for rechargeable neurostimulators and another APC for non-rechargeable neurostimulators, instead of combining them into one APC.

We realize that our recommendation, if adopted, would require the creation of one or more Level II HCPCS codes for reporting under the OPPS. However, we believe the difference in the median cost of the respective neurostimulators makes this administrative step worthwhile.

We are concerned that the CMS proposal, if finalized, would create a financial burden on hospitals and a disincentive to utilize rechargeable neurostimulators.

8. Quality Data

We strongly support the move to outpatient measures, and are very pleased that CMS chose not to utilize the surrogate inpatient measures originally suggested. However, we urge CMS to delay the implementation of the new requirement at least six months to allow an orderly developmental process as well as provide addition time for hospitals, especially small and rural hospitals, to get ready for the changeover. Part of this orderly development process must include sufficient time for the National Quality Forum and the Hospital Quality Alliance to assess the appropriateness of, respectively, endorsing or accepting all of the measures.

We agree with many of the selected measures in concept, but note that such measures need refinement to bring them into the realm of the acute care outpatient setting. Without seeing the "to be developed" specifications, it is difficult to offer an informed comment.

Some of these measures are lifted directly from the Physician Quality Reporting Initiative (PQRI) measure sets, and really apply to a physician practice or clinic setting. We believe, however, that there may be some advantages to aligning the PQRI with outpatient quality measures thereby creating incentives for cooperation between physicians and hospitals. One important note, however, is that most community hospitals do not have hospital-based clinics, so how do they fit in to gathering data for the measures?

We strongly object to the last measure: HbA1c <9 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 a hospital's control is whether the hospital measures the HbA1c when a diabetic patient is seen, and there is no evidence that this should always occur. This measure absolutely does not measure the outcome of any care that is provided in a hospital outpatient setting (ED, same day surgery, etc.) As noted earlier, this measure is strictly for a physician practice setting, or hospital-based clinic.

Having stated this objection, however, we want to support the importance of refining appropriate outcome measures for persons with chronic diseases (such as diabetes) in conjunction with aligned payment systems that are designed to encourage coordinated care. We hope CMS will promote new forms of payment to support and encourage coordinated care by, for example, paying for case management services. This would encourage hospitals and physicians to work together toward better outcomes for diabetics and other chronically ill persons. It would be unfair, however, to expect this type of outcome from hospital outpatient settings operating under the current, fragmented payment system.

We understand the January 1, 2008 start timeframe 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 are concerned whether it is feasible to meet that deadline.

9. Device-dependent APC – Proposed Payment When Devices Are Replaced with Partial Credit to the Hospital

CHA is very concerned about the proposal to require that hospitals report occurrences of devices being replaced under warranty or otherwise with a partial credit granted to the hospital as well as the proposed payment reductions for such cases. We recommend that CMS delete this proposal.

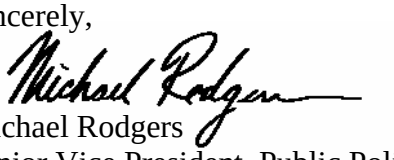
Operationally it will be difficult to identify these devices and procedures to reduce the charges and assign the modifier appropriately. It is unclear what "cost" should be considered when applying the 20 percent threshold and who will make this determination. For instance, how should hospitals handle volume discounts, manufacturer rebates, etc., when calculating the "cost" of the device? We are also concerned that losing 50 percent of the APC payment relative to the device is too high for a credit of only 20 percent to 40 percent of the device.

10. OPPS: Hospital Coding and Payments for Visits

CHA continues to support the need for national guidelines for hospital coding of emergency department and clinic visits. The development of such national guidelines must include the active involvement of hospitals and other stakeholders. Such national guidelines will better ensure consistency across the states as well as insurers.

In closing, thank you for the opportunity to review and comment on the proposed hospital outpatient PPS rule for CY 2008.

Sincerely,



Michael Rodgers
Senior Vice President, Public Policy & Advocacy