THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES

October 6, 2006

Honorable Mark B. McClellan, MD, PhD
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, DC 20201

REF: CMS-1506-P

RE: Medicare Program; Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates; CY 2007 Update to the Ambulatory Surgical Center Covered Procedures List; Ambulatory Surgical Center Payment System and CY 2008 Payment Rates; Medicare Administrative Contractors; and Reporting Hospital Quality Data for FY 2008 Inpatient Prospective Payment System Annual payment Update Program - HCAHPS® Survey, SCIP, and Mortality; Proposed Rule

Dear Dr. McClellan:

The Catholic Health Association of the United States (CHA) is pleased to submit the following comments, with two exceptions, on the above notice of proposed rulemaking (NPRM), which was published in the Federal Register (Vol. 71, No. 163, pages 49506-49977) on August 23, 2006. Today, through separate correspondence, we are also submitting our comments on the NPRM for the Reporting Hospital Quality Data for FY 2008 Inpatient Prospective Payment System Annual Payment Update (Section XXIII - File code CMS-4125-P). In addition, we will submit our comments on the NPRM for the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates in subsequent correspondence.

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.

Comparing CY 2006 (final rule) to the proposed CY 2007 rule (see below table) reveals that in most instances the APC weight volatility will likely significantly increase. This signal of increasing instability among APC weights creates unnecessary challenges to a hospital's ability to adequately plan and budget, even for the short term, let alone for the long term.

APC Weight Volatility	CY 2006 Final Rule	CY 2007 Proposed Rule	Percent Change
DECREASE:			
Total	219	277	+26.5%
10% or more	59	59	0.0%
20% or more	12	27	+125%
INCREASE:			
Total	148	360	+143.2%
10% or more	41	109	+165.6%
30% or more	17	26	+52.9%

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

CHA understands that changes in weights are inevitable. However, it believes that the magnitude of the changes (both positive and negative) should be moderated. One approach is to adjust medians derived from claims data to limit the amount of change that occurs from year-to-year. 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. Device-Dependent APCs.

CHA strongly recommends that CMS continue the CY 2006 policy of adjusting the median costs of device-dependent APCs' medians for which comparisons with prior years are valid to the higher of the CY 2007 unadjusted APC median or 90 percent of the adjusted median on which the payment was based for the CY 2006 OPPS.

CMS proposes to base the payment rates for device dependent APCs in CY 2007 on median costs calculated using claims with appropriate device codes and which have no token charges for devices reported on the claim. The agency does not propose any adjustment of these median costs as in years past to moderate the decreases in medians from CY 2006 to CY 2007; thus, there will be no payment floors or use of external data in CY 2007.

A comparison of the final CY 2006 payment rate to the proposed CY 2007 payment for device-dependent APCs revealed that payment would:

- decrease for 11 APCs, including 6 which decreased by more than 10%; without any hold harmless floor, their reduction would range from 22 to 12.8 percent, and

- Increase for 30.

In CY 2005 CMS adopted a hold harmless policy to begin the transition to the use of pure claims data for all APC services in order to ensure the appropriate relativity of the median costs for all payable OPPS services. CHA understands and appreciates this goal, but believes such a transition must be gradual. The policy must do a better job of balancing the desirability of the goal and the continued availability of critical and essential outpatient services for Medicare beneficiaries. Complete termination of the hold harmless policy could well tip the scale against the continuation of certain services.

3. Visits - Emergency Department Visit Guidelines

As CMS reported, the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA) convened an independent expert panel for the purpose of developing hospital visit guidelines. The panel submitted its recommendations in June 2003 for reporting three levels of hospital clinic and emergency visits and a single level of critical care services to CMS. I response, CMS noted several areas of concern regarding the proposed guidelines. The following comments, based on evaluations by several of our member facilities, are offered in regard to the AHA/AHIMA Emergency Department Visit Guidelines.

A. Three versus five levels of codes: We agree with CMS that there should be five levels of codes for both clinic and ED visits for the purposes of consistency in coding/billing to all payers.

B. Lack of clarity for some interventions: We agree with CMS that there is a lack of clarity in specific intervention descriptions. Several member facilities piloted the AHA/AHIMA guidelines using both nursing and coding staff to interpret the guidance. There observations are as follows:

- There is a lack of specificity in certain definitions. Additional descriptions and definitions would be beneficial in reducing incorrect interpretations by coders.

- It would be helpful to provide examples of patient acuity or symptoms as additional explanation for visit levels. For instance, an example might be a description of the typical patient for the respective visit levels.

- Based on existing guidelines, several ED encounters did not meet any criteria to be assigned a Level I ED visit. For example, patient presenting with chest pain, received an initial nursing assessment, vitals, and low pain scale assessment. Patient received blood chemistry (with separately billed venipuncture), EKG, x-ray, no oral or sublingual medications. Patient was discharged home with a diagnosis of costochondritis and instructions to take Ibuprofen. It would be inappropriate to disallow payment for a patient who presents to the ED with chest pain and requires clinical evaluation to rule out cardiac risk.

- Current guidelines do not take trauma level care into consideration for ED level.

- More clearly define ED visit level criteria. For example:

    - Are triage assessments for the Emergency Medical Treatment and Active Labor Act (EMTALA) requirements considered to be a Level I ED visit?

    - Does a primary assessment qualify for Level I ED Intervention "assisting physician with examination?"

    - Are scheduled follow-up visits appropriate to be assigned to an ED visit level when there are no other health provider options?

    - Need to clarify if the application of an off-the-shelf splint (not separately billable) is considered first aid?

    - Can interaction with home health, community services, housing authorities, or some other type of assistance be considered contributory factors or do they need to be specific to law enforcement or protective services personnel?

C. Treatment of separately payable services: We agree with CMS that this needs to be re-addressed. Current interventions include items that currently are separately billable (i.e. cardiac monitoring, fecal disimpaction) and are therefore inconsistent. In general we feel that there needs to be more descriptions on interventions for all levels. Status N procedures should be included as contributory factors for ED visit level assignment. They are separately identifiable procedures but are bundled for payment.

D. Some interventions appear overvalued: We agree with CMS for continuous irrigation of eye (Morgan lens) as being overvalued as a level five intervention. We also feel there are inconsistencies in the interventions reflecting the same degree of complexity within each level.

E. Other observations: Based on our members' evaluations, there is an overall concern that existing level assignment does not accurately capture resource consumption in the ED. The facility level should be representative of all resources that are not

otherwise captured in payments for other separately payable services. This should include staff involvement with indirect patient care such as counseling and coordination of care in the ED. For example, there is no accommodation for nursing time involved with tasks to support patient care but is not direct hands-on patient care. Examples are as follows: coordinating consultations, dealing with a belligerent or unruly patient, extra time spent with family, and time providing complex discharge instructions.

More specifically, the following interventions have not been identified as contributory factors to ED visit level determinations: ace/sling application, pre-fabricated splint application, different levels of dispositioning, seizure precautions, language barrier, drug and/or alcohol influence, triage/primary care assessment, assisting with activities of daily livings (ADLs), obtaining consents, prepping for surgery, preparing an ED patient for Observation/Inpatient status, oral suction, remaining with the patient during testing procedures, arranging transportation for a departing patient, discharge instructions, burn/abrasion care/wound care (more than simple first aid), working with a patient in restraints, behavioral health assessments, post mortem care, pediatric 1:1 (no adult), telephone calls to follow-up on potential drug seeker (numerous telephone calls are placed to local clinics and pharmacies to obtain information about the patients' prescription drug use).

4. 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 have 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 perform the procedure on an inpatient basis. 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." From our perspective, it does no good for hospitals or their representative organizations to try to educate physicians as to this situation. Physicians, quite understandably, pay little attention to how hospitals are paid. Their behavior is affected only by how they personally are paid. And the CMS provider education staff does not appear to have made any headway on this matter as well.

5. Medicare Contracting Reform Mandate

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) PL 108-173 included certain "Medicare contracting reform" for Medicare fee-for service provisions. These reform provisions were intended to improve Medicare's administrative services to beneficiaries and health care providers and to bring standard contracting principles to Medicare, such as competition and performance incentives. The MMA provisions replaced the prior Medicare intermediary and carrier contracting authorities. The MMA requires that the CMS complete the transition to the new contracting program by October 1, 2011.

One provision of the change repealed the ability of providers to nominate their servicing intermediary. In the NPRM, CMS proposes that providers would be assigned to the Medicare

administrative contractor (MAC) that is contracted to administer the types of services billed by the provider within the geographic locale in which the provider is physically located or provides health care services. CMS proposes to allow large chain providers that were formerly permitted by CMS to "nominate" an intermediary to request an opportunity for similar consideration under the new contractor program. And, qualified chain providers that were formerly granted single intermediary status would not need to re-request such privileges at this time.

A. **CHA strongly supports the right of a large health system comprised of individual providers to request the consolidation of its Medicare billing activities to the MAC with jurisdiction over the geographic locale in which the system's home office *or* billing office (if located in a different locale) is located.**

B. **Large multi-hospital systems that have previously elected to use a single fiscal intermediary (FI) should be allowed to remain with the same FI (if it is designated as a MAC), until a MAC is designated for the health system's home/billing office in order to avoid unnecessary multiple transitions.**

C. **This recognition should also be extended to a health care system which timely requested and was acknowledged as meeting the requirements for designation to one intermediary/MAC; but for which a final transition (to the one intermediary/MAC) had not taken place due to issues solely on the part of Medicare.**

In closing, thank you for the opportunity to review and comment on the proposed hospital outpatient PPS rule for CY 2007.

Sincerely,

Michael Rodgers
Senior Vice President, Public Policy and Advocacy