

Submitter :

Date: 08/22/2007

Organization :

Category : Nurse Practitioner

Issue Areas/Comments

Capital IPPS Payment Adjustments

Capital IPPS Payment Adjustments

test

Submitter : Ms. Jason Spring
Organization : HealthPark Hospital
Category : Hospital

Date: 08/23/2007

Issue Areas/Comments

GENERAL

GENERAL

We understand from our Anesthesiologist, Dr. Farrell Hass and our other Anesthesiologists that the RUC submitted to CMS a recommendation to boost the anesthesia conversion factor to account for a calculated 32 percent work underevaluation, which would result in an increase of nearly \$4.00 per anesthesia unit excluding any other Medicare payment adjustments. HealthPark Hospital is committed to support this positive payment change since it would help not only our Anesthesia Department but also our Hospital.

Submitter : Mark Young
Organization : AutoGenimics.com
Category : Laboratory Industry

Date: 08/23/2007

Issue Areas/Comments

GENERAL

GENERAL

Will this also apply to mismgt of Warfarin dosing that requires additional hospital stay or treatment?

Submitter : Ms.
Organization : Ms.
Category : Nurse

Date: 08/24/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment

#4

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

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

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

Submitter : Ms. Mike Messina
Organization : Ms. Mike Messina
Category : Health Care Provider/Association

Date: 08/27/2007

Issue Areas/Comments

Capital IPPS Payment Adjustments

Capital IPPS Payment Adjustments

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

Dear Ms. Norwalk:

I am writing to express my strongest support for the proposal to increase anesthesia payments under the 2008 Physician Fee Schedule. I am grateful that CMS has recognized the gross undervaluation of anesthesia services, and that the Agency is taking steps to address this complicated issue.

When the RBRVS was instituted, it created a huge payment disparity for anesthesia care, mostly due to significant undervaluation of anesthesia work compared to other physician services. Today, more than a decade since the RBRVS took effect, Medicare payment for anesthesia services stands at just \$16.19 per unit. This amount does not cover the cost of caring for our nation's seniors, and is creating an unsustainable system in which anesthesiologists are being forced away from areas with disproportionately high Medicare populations.

In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly \$4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC's recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

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To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : Heidi Lehlbach

Date: 08/28/2007

Organization : Akron General Medical Center

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

Please reconsider this ammendment. As an ATC, PT I can honestly say that the athletic training profcssion is an asset in the outpatient setting. The athletic trainers have extensive knowlege of rehabilitation and exercise progression and are capable of treating all patients. Please do not restrict or prevent them from sharing their knowlege and skills.

Submitter : Mr. Sean Schneider
Organization : Sportscare at Shawnee Mission Medical Center
Category : Other Health Care Professional

Date: 08/28/2007

Issue Areas/Comments

Capital IPPS Payment Adjustments

Capital IPPS Payment Adjustments

Dear Sir or Madam:

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As an athletic trainer, I am qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam ensure that my patients receive quality health care. State law and hospital medical professionals have deemed me qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,
Sean Schneider A.T.C., CSCS

Submitter : Miss. Veronica Koehne

Date: 08/28/2007

Organization : Cincinnati Children's Hospital Medical Center

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I think your attitude towards non-Medicare patients is out of line. As a Health Information professional working at a well-known pediatric facility, I think it is misguided of CMS to not realize that almost all private insurance carriers usually follow what CMS does in regards to IPPS and to not give those of us who do not deal with a large Medicare population any kind of guidance is pathetic. Your attitude towards those of us who deal with the pediatric population is a slap in the face and it comes off as though the children of this country are not as important as our elderly population. So much for our government at work for us. Thanks for all you so called help.

Submitter : Miss. Chelsey Thompson
Organization : National Athletic Trainers Association Member
Category : Individual

Date: 08/28/2007

Issue Areas/Comments

GENERAL

GENERAL

see attachment

#9

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

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

Submitter : Miss. Chelsey Thompson

Date: 08/28/2007

Organization : National Athletic Trainers Association Member

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam:

My name is Chelsey Thompson. I am a first year graduate assistant athletic trainer at Clemson University, working with our Women s Tennis team. Two weeks ago, I took the national certification exam in hopes of obtaining my credentials.

I am writing today to voice my opposition to the therapy standards and requirements in regards to the staffing provisions for rehabilitation in hospitals and facilities proposed in 1385-P.

While I am concerned that these proposed changes to the hospital Conditions of Participation have not received the proper and usual vetting, I am more concerned that these proposed rules will create additional lack of access to quality health care for my patients.

As a soon to be athletic trainer, I will be qualified to perform physical medicine and rehabilitation services, which you know is not the same as physical therapy. My education, clinical experience, and national certification exam will ensure that my patients receive quality health care. State law and hospital medical professionals have deemed athletic trainers qualified to perform these services and these proposed regulations attempt to circumvent those standards.

The lack of access and workforce shortage to fill therapy positions is widely known throughout the industry. It is irresponsible for CMS, which is supposed to be concerned with the health of Americans, especially those in rural areas, to further restrict their ability to receive those services. The flexible current standards of staffing in hospitals and other rehabilitation facilities are pertinent in ensuring patients receive the best, most cost-effective treatment available.

Since CMS seems to have come to these proposed changes without clinical or financial justification, I would strongly encourage the CMS to consider the recommendations of those professionals that are tasked with overseeing the day-to-day health care needs of their patients. I respectfully request that you withdraw the proposed changes related to hospitals, rural clinics, and any Medicare Part A or B hospital or rehabilitation facility.

Sincerely,

Chelscy Thompson

Submitter :

Date: 08/31/2007

Organization :

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1385-P
P.O. Box 8018
Baltimore, MD 21244-8018

Re: CMS-1385-P
Anesthesia Coding (Part of 5-Year Review)

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In an effort to rectify this untenable situation, the RUC recommended that CMS increase the anesthesia conversion factor to offset a calculated 32 percent work undervaluation a move that would result in an increase of nearly \$4.00 per anesthesia unit and serve as a major step forward in correcting the long-standing undervaluation of anesthesia services. I am pleased that the Agency accepted this recommendation in its proposed rule, and I support full implementation of the RUC's recommendation.

To ensure that our patients have access to expert anesthesiology medical care, it is imperative that CMS follow through with the proposal in the Federal Register by fully and immediately implementing the anesthesia conversion factor increase as recommended by the RUC.

Thank you for your consideration of this serious matter.

Submitter : jane doe
Organization : jane doe
Category : Individual

Date: 08/31/2007

Issue Areas/Comments

GENERAL

GENERAL

see attached

1533-FC-12-Attach-1.PDF

#12.

test

Submitter : Mr. Michael Glindmeyer
Organization : ECU ATEP
Category : Other Health Care Provider

Date: 08/31/2007

Issue Areas/Comments

GENERAL

GENERAL

My name is Michael Glindmeyer and I am a senior athletic training student at Eastern Kentucky University.

I am voicing my concern with new hospital regulations for rehabilitation. I am going to be entering the profession very soon as I will be taking my board exam in April of 2008. I know that in my past few years of education in the athletic training program that athletic trainers are in deed capable of rehabilitation in hospitals and other facilities. Our scope of practice is different from physical therapist and due to their shortage, athletic trainers may be great substitutes for practices in hospitals.

Athletic trainers go through a highly educated program and rigorous board exam that ensures their capabilities as a healthcare profession as recognized by the American Medical Association. I would hope that the particular individuals who taking action against the athletic training profession digress and reconsider our importance in healthcare.

Sincerely,

Michael Glindmeyer
Senior athletic training student at Eastern Kentucky
University

Submitter : Mrs. Margaret A. Scott
Organization : Central NJ Brain Tumor Support Group
Category : Individual

Date: 09/04/2007

Issue Areas/Comments

Capital IPPS Payment Adjustments

Capital IPPS Payment Adjustments

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

I am a brain tumor patient and I would like to request a change to the structure of proposed MS-DRGs 23 and 24 so that all craniotomy cases involving the implantation of a chemotherapeutic agent (ICD-9-CM procedure code 00.10) would be assigned to MS-DRG 23.

You propose the following titles for these MS-DRGs:

MS-DRG 23: Craniotomy with major device implant or acute complex CNS PDX with MCC

MS-DRG 24: Craniotomy with major device implant or acute complex CNS PDX without MCC

I would like to suggest that the DRGs be restructured so that their titles are the following:

MS-DRG 23: Craniotomy with acute complex CNS PDX with MCC or major device implant

MS-DRG 24: Craniotomy with acute complex CNS PDX without MCC

Rationale: The proposed titles do not take into account the costs involved in implanting a device such as the Gliadel Wafer (and other new treatments in the pipeline). Gliadel is a device implanted into the brain which slowly releases chemotherapy. It is now considered the standard of care for malignant brain tumors.

When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

Margaret A. Scott
Manchester NJ
Bearer of an Astrocytoma in the right parietal lobe

GENERAL

GENERAL

Re: CMS-1533-P. Request for modification to MS-DRG 23 and MS-DRG 24

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When Gliadel was first approved by the FDA, the payment for a brain tumor surgery with Gliadel was so low that many community hospitals could not afford to

1533-FC-14

use the treatment and many patients lost access to it. CMS corrected the problem a few years later, by creating a new DRG for such cases (DRG 543). This removed the major barrier to access for Gliadel and put the decision on its use back into the hands of the doctors. (Thank you for that DRG!)

The current proposed rule removes the DRG that you created to solve this problem, and without modifications to the new replacement MS-DRGs, we may go back to loss of access to this standard of care. This can be corrected by changing the structure of the new MS-DRGs to allow all cases involving the implantation of devices to be assigned to MS-DRG 23, even without a MCC.

Thank you for your consideration of this important matter!

Margaret A. Scott
Manchester NJ
Bearer of an Astrocytoma in the right parietal lobe

Submitter : Mr. Joseph Garland
Organization : St Francis Hospital & health Center
Category : Other Technician

Date: 09/07/2007

Issue Areas/Comments

Capital IPPS Payment Adjustments

Capital IPPS Payment Adjustments

I am a practicing sonographer, with experience greater than sixteen years. My concern is for continued quality improvement of non-invasive diagnostic.

Contrast agents already may be underutilized, and the proposal will increase the financial disincentive to use contrast, even when its use is medically appropriate. .

Underutilization of contrast agents is not in the best interest of Medicare patients or Medicare itself, as inconclusive diagnosis may result in the performance of more invasive and costly diagnostic tests.

Contrast agents are relatively costly in comparison with the echo procedures with which they are to be packaged, which increases the financial disincentive created by packaging these agents with the underlying echo procedures.

IF CMS nonetheless decides to package echo contrast, it is required by statute to create separate payment groups for contrast-enhanced and un-enhanced procedures, which would require the creation of new HCPCS codes to identify contrast-enhanced procedures.

Submitter : Ms. Peggy Minnick
Organization : BHC Alhambra Hospital
Category : Hospital

Date: 09/07/2007

Issue Areas/Comments

Capital IPPS Payment Adjustments

Capital IPPS Payment Adjustments

This refers to Outpatient proposed prospective payment system rule (OPPS). I concur with comments submitted by California Health Care Association.

Submitter : Mrs. Lorri Pasqua

Date: 09/08/2007

Organization : Mrs. Lorri Pasqua

Category : Individual

Issue Areas/Comments

Capital IPPS Payment Adjustments

Capital IPPS Payment Adjustments

This change what make it impossible for people with dystonia to function, to have some kind of normally life. It will hurt so many people with dystonia to make this kind of chance.

Submitter : Ms. Christine Buliano
Organization : Ms. Christine Buliano
Category : Individual

Date: 09/11/2007

Issue Areas/Comments

Capital IPPS Payment Adjustments

Capital IPPS Payment Adjustments

Glial wafers must be able to be used by hospitals during surgery. Please assure all of us that you will set us specific coding by hospitals to allow continued use of this very effective treatment.

Thank you

Submitter : Dr. Wendy Hunter
Organization : Scripps Mercy Hospital
Category : Other Health Care Professional

Date: 09/12/2007

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

1533-FC-19-Attach-1.DOC

1533-FC-19-Attach-2.DOC



Scripps Mercy Hospital
4077 Fifth Avenue, MER 12
San Diego, CA 92103

September 12, 2007

To Whom It May Concern:

I am writing to express my concern about the CY 2008 proposed rate cut for partial hospitalization. As a psychologist and manager for an outpatient program that serves the persistently severely mentally ill population, there is already a dearth of treatment options for these people. Many programs have closed over the last several years because of rate cuts and the inability to provide necessary services at the reduced rates.

Without treatment our patients are more likely to need more frequent hospitalization and/or to become a greater burden to society via homelessness, substance abuse, and other non-socially acceptable behaviors. This is a waste of their humanity, and reflects poorly on us as a nation. How we treat the poorest and most unfortunate among us is a reflection of our own mental health, or lack of it. Those of us who have chosen to work with this group of people need the economic support of those who prefer to avoid these people but who also want us to keep their illness from affecting their lives. And, like any other professional, we deserve fair pay for the services we provide.

Please reconsider this proposal and do not reduce the rate of reimbursement. Our patients depend on our treatment services, and my employees deserve a reasonable wage for the important and necessary work they have chosen to do.

Thank you for your time and attention.

Sincerely,

Wendy J Hunter, Ph.D.
Clinical Psychologist
Program Manager
Scripps Mercy Hospital Behavioral Health Outpatient Program
San Diego, California

Submitter : Ms. Patricia Speelman
Organization : Pacific Hospital of Long Beach
Category : Hospital

Date: 09/13/2007

Issue Areas/Comments

GENERAL

GENERAL

see attachment

Submitter : Kathryn Bennett
Organization : Bloomington Hospital
Category : Hospital

Date: 09/14/2007

Issue Areas/Comments

Capital IPPS Payment Adjustments

Capital IPPS Payment Adjustments

Observation

GENERAL

GENERAL

Regarding the changes to observation, it is a hardship and expense for hospitals to report the observation hours accurately with the many rules in place, such as stopping observation hours during surgery, etc. These "rules" prevent the hospitals from being able to accurately report observation hours using an automated system. Thus, it requires man hours to collect and report these hours accurately, and all without any reimbursement. If payment is being cut, can we not cut some of the reporting requirements to make up for the loss in reimbursement?

1533-FC-22

Submitter : Ms. Anna Weinstein

Date: 09/14/2007

Organization : American College of Radiation Oncology

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

1533-FC-22-Attach-1.PDF



American College of Radiation Oncology

5272 River Road • Suite 630 • Bethesda, MD 20816
(301) 718-6515 • FAX (301) 656-0989 • EMAIL acro@paiimgmt.com

September 14, 2007

Mr. Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Room 455-G Hubert H. Humphrey Buildings
200 Independence Avenue, S.W.
Washington D.C. 20201

Re: Proposed Rule: 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 (CMS-1392-P)

Dear Mr. Weems:

The American College of Radiation Oncology (“ACRO”) appreciates the interest of the Centers for Medicare and Medicaid Services (CMS) in receiving comments on the Proposed Rule that addresses the 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 (CMS-1392-P). With a current membership of approximately 1000, ACRO is a dedicated organization that represents radiation oncologists in the socioeconomic and political arenas. Over 20% of the radiation oncologists in the United States are members of ACRO. ACRO’s mission is to promote the education and science of radiation oncology, to improve oncologic service to patients, to study the socioeconomic aspects of the practice of radiation oncology, and to encourage education in radiation oncology. Our members practice in both freestanding centers and hospital outpatient departments.

ACRO would like to extend its appreciation for the opportunity to comment on the proposed regulations.¹ This letter will comment on the following sections:

- Packaging of Guidance Services and Image Processing Services;
- High Dose Electronic Brachytherapy; and
- Stereotactic Radiosurgery Services.

¹ “Proposed Rule: 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 (CMS-1392-P)” *Federal Register*, Volume 72, No. 148, August 2, 2007, p. 42627.

A. OPPTS PACKAGED SERVICES: Guidance Services and Image Processing Services

ACRO would like the opportunity to review the packaging information in order to understand how the costs of the dependent CPT are assigned to independent procedures. Specifically, ACRO requests that CMS detail: (a) which dependent procedures are associated with which independent procedures; (b) the percentage of independent procedures that were associated with each assigned dependent procedure; (c) the costing of each procedure with and without the packaging methodology. CMS should make this information publically available through its web site. Only through such transparency, can specialty societies comment on how these codes are packaged and the potential impact. **We encourage CMS to delay the proposed packaging until complete information is made available and various constituencies have the opportunity to fully comment. We understand that the APC Panel has recommended a delay in packaging the image guidance procedures associated with radiation oncology. ACRO supports this APC Panel recommendation.**

ACRO would also like to make CMS aware that packaging dependent procedures is only appropriate for technologies that are established with stable use rates. ACRO is concerned that some dependent procedures are currently beginning to evolve into the standard of care as they are more readily available. Packaging technologies as they are being disseminated appears to “lock in” a given penetration rate at today’s rate and may significantly underfund the technology as it spreads. This may weaken support for radiation oncology in general and/or slow the spread of new, important technologies. ACRO believes that a stable use rate would require at approximately five years to achieve. ACRO supports delaying the packaging of technologies that have not reached a stable use rate in the community.

B. OPPTS NEW HCPCS AND CPT Codes: High Dose Electronic Brachytherapy

ACRO would like CMS to be aware of the need to regulate this new technology. While ACRO is in agreement with the current CMS definition of a radioactive source, there is a need to recognize that electronic brachytherapy artificially creates radioactivity. This newly created radioactive material must be closely monitored by individuals trained in handling radioactive materials and knowledgeable in public and patient safety issues. ACRO remains concerned that patient safety and good clinical outcomes require careful consideration of total dose, time dose relationships, volume of tissue treated, organs at risk and other radiobiological considerations. Electronic brachytherapy carries the same risks for patient and public safety as does traditional radionuclide brachytherapy; in addition, there are the compounding risks of heat and electrical injury to the patient. Therefore, ACRO feels strongly that the use of electronic brachytherapy, as with all radiation treatment, should be supervised, delivered and managed by physicians trained and experienced in the use of radiation therapy. **ACRO will be working closely with state regulatory agencies to educate the regulatory officials on the issues involved in electronic brachytherapy, the appropriate safeguards and training required for safe handling.**

C. SRS TREATMENT DELIVERY SERVICES

ACRO is one of the specialty societies that urge CMS to recognize CPT codes 77372 and 77373 under OPPTS rather than continuing the use of Level II HCPCS codes. We believe that, while there may be differential facility resources, one technology should not be favored over another. Such a stance is in line with CMS's own belief that hospitals should be motivated to be efficient providers choosing the cost effective technology most appropriate to the treatment of the clinical condition.² Specifically, ACRO can find no clinical justification for the dramatic decline in reimbursement for G0251 – LINAC based stereotactic radiosurgery, over G0339 or G0340. ACRO urges the reimbursement for G0251 to be set at APC 0067.

Conclusion

ACRO's comments on the OPPTS regulations seek to ensure ongoing access to radiation oncology services. In many communities, hospital outpatient units are the key providers of radiation services. Maintaining patient access is crucial since our patients often require services 5 days a week for many weeks of life saving therapy. Patient accessibility and continuity are key components of service quality.

ACRO appreciates the opportunity to comment on the regulations. We hope that our comments highlight our sincere interest in making radiation oncology services cost effective, properly reimbursed and readily accessible to cancer patients.

Sincerely,



Louis Munoz, M.D., FACRO
President
American College of Radiation Oncology
5272 River Road
Suite 630
Bethesda, Maryland 20816

Sincerely,



Paul Wallner, D.O., FAOCR
Chair, Socioeconomics Committee
American College of Radiation Oncology
5272 River Road
Suite 630
Bethesda, Maryland 20816

CC: Herb Kuhn, Centers for Medicare and Medicaid Services
Rick Ensor, Centers for Medicare and Medicaid Services
Edith Hambrick, M.D., Centers for Medicare and Medicaid Services
Ken Marsalek, Centers for Medicare and Medicaid Services
Pam Ohrin, Centers for Medicare and Medicaid Services
Liz Richter, Centers for Medicare and Medicaid Services
Ken Simon, M.D., Centers for Medicare and Medicaid Services
Pam West, Centers for Medicare and Medicaid Services

² *Federal Register*, Volume 72, No. 148, August 2, 2007, pages 42648-9 and 42651.

Submitter : Ms. Mahvash Azadegan
Organization : Ms. Mahvash Azadegan
Category : Other Health Care Professional

Date: 09/14/2007

Issue Areas/Comments

GENERAL

GENERAL

(see attachment)

1533-FC-23-Attach-1.DOC

1533-FC-23-Attach-2.DOC



September 10, 2007

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

Dear Sirs:

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

I appreciate the opportunity to submit comments regarding CMS's proposed OPPS rates concerning APC Code 0033 - Partial Hospitalization Programs and 0322, 0323, 0324, 0325 – Outpatient Psychiatric Services

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

I am aware of The Association of Ambulatory Behavioral Healthcare (AABH) and I support their response to this situation which is as follows:

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

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

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

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

Respectfully,

Mahvash Azadegan, M.A., L.M.F.T
Psychotherapist

Submitter : Mrs. Tiffani Barnhart
Organization : Mrs. Tiffani Barnhart
Category : Other Health Care Professional

Date: 09/14/2007

Issue Areas/Comments

GENERAL

GENERAL

see attachment

1533-FC-24-Attach-1.DOC



September 10, 2007

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

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Respectfully,

Tiffani Barnhart, M.A., M.F.T.I., N.C.C.
Psychotherapist Intern, Nationally Certified Counselor

Submitter : Ms. Sally Aintablian
Organization : Ms. Sally Aintablian
Category : Other Health Care Professional

Date: 09/14/2007

Issue Areas/Comments

GENERAL

GENERAL

See attachment

1533-FC-25-Attach-1.DOC



September 10, 2007

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

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Sally Aintablian, M.A., M.F.T.I.
Psychotherapist Intern

Submitter : Mr. Tim Keeley

Date: 09/14/2007

Organization : Mr. Tim Keeley

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

See attachment

1533-FC-26-Attach-1.DOC



September 10, 2007

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Department of Health and Human Services
Attention: CMS-1392-P
Mail Stop: C4-26-05
7500 Security Blvd.
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Psychotherapist Intern

Submitter : Mrs. Kimeng Long

Date: 09/14/2007

Organization : Mrs. Kimeng Long

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

see attachment

1533-FC-27-Attach-1.DOC



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 Attention: CMS-1392-P
 Mail Stop: C4-26-05
 7500 Security Blvd.
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CMS has identified the true Median Cost of APC 325 for group therapy at \$66.17. With a minimum of 4 services per day (many programs offer more), CMS would recognize the minimum cost at \$264.68 per day. These data are inconsistent with a rate of \$179.88 and indicate that a higher payment rate is necessary to prevent providers from running substantial deficits that will risk financial viability.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Allow the PHP per diem to remain the same as the CY2007 per diem rate of \$234.73.
2. YOUR NAME OR ORGANIZATION encourages CMS to go with AABH to the legislature and support a legislative amendment to:
 - Remove PHP from the APC codes and have independent status using Home Health as an example
 - Establish the current rate of \$234.73 as the base per diem rate for services
 - Annually adjust the base rate by a conservative inflation factor such as the CPI
 - Establish quality criteria to judge performance and that influences future rate reimbursement

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

Respectfully,

Kimeng Long, R.N.
Registered Nurse