CMS-1213-N-1
Submitter : Mr. Jill Benson Date & Time:
Organization :
Category :
04/04/2004 12:04:00
Spine Hospital of South Texas
Individual
Issue Areas/Comments
GENERAL
GENERAL
I am the CNO at a small speciality hospital. We perform spine surgery and pain management only. The new ruling for CMS on the 10 QualityInnitiatives does not address any scenario we might have at our facility,yet we will be faced with having our funding cut in 2005 if we do not submitdata in June, 2004. I have contacted our QIO and they had a project to submit the Surgical data on antibiotic usage, but are not taking new hospitalsinto the study. This does not seem fair that we should be penalized when we cannot comply.

CMS-1213-N-2
Submitter : Mr. lorin gardner Date & Time:
Organization :
Category :
02/21/2004 12:02:00
retired
Individual
Issue Areas/Comments
GENERAL
GENERAL
It no good.

CMS-1213-N-3

Submitter : Mr. Heather Olson
Date & Time: 02/23/2004 12:02:00
Organization : Iowa Hospital Association
Category : Association

Issue Areas/Comments
GENERAL

Please find the attached comments from the Iowa Hospital Association regarding CMS' Proposed Rule to implement the Inpatient Psychiatric
Facility Prospective Payment System, file code CMS-1213-P. February 23, 2004

May 25, 2004

Dennis G. Smith
Interim Director of the Centers for Medicare & Medicaid Services
P.O. Box 8012
Baltimore, MD 21244-8012

Ref: CMS—1213—P-Medicare Program; Prospective Payment System for Inpatient Psychiatric Facilities; Proposed Rule (68 Federal Register 66920), November 28, 2003.

Dear Mr. Smith,

On behalf of Iowa's 26 hospitals with Inpatient Psychiatric Facilities (IPFs), the Iowa Hospital Association (IHA) is pleased to take this opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule to implement a prospective payment system (PPS) for services delivered in Inpatient Psychiatric Facilities (IPF) as required by the Balanced Budget Refinement Act of 1999. While IHA acknowledges the statutory requirement of CMS to implement a PPS for IPFs, we would like to express concern regarding numerous provisions included in the Notice of Proposed Rule Making (NPRM) and the negative impact these provisions will have on Iowa hospitals with inpatient psychiatric units. Based on IHA's analysis of all the provisions included in the NPRM, Iowa hospitals providing inpatient psychiatric services will experience a 1.4 percent reduction in Medicare reimbursement upon full implementation of these changes. Iowa hospitals are already among the lowest paid in the country and with the state's aging population, fourth in percent of citizens over 65 and second in percent of citizens 85 and older. These facilities cannot continue to absorb reductions in Medicare payments at a time when costs are escalating due to nursing and other allied health professional shortages, rising prescription drug and technology costs, and skyrocketing professional and general insurance premiums.

Several payment adjustments in the proposed rule create concern for Iowa hospitals that already struggle for payment of inpatient psychiatric services from a variety of payers including the state's mental health delivery system and the Iowa Medicaid program, payers that are financially responsible for a large percentage of patients in these units. At a time when the mental health delivery system is very vulnerable in Iowa with closures of inpatient psychiatric facilities and the availability of beds steadily declining, hospitals are now faced with another decline in reimbursement from the Medicare program resulting from the implementation of the IPF PPS. If the proposed provisions in the rule are finalized as they currently stand, CMS will further exacerbate the financial woes these units face which will require hospitals to evaluate the ongoing delivery of these services, and has the potential to eliminate access to psychiatric care for Medicare beneficiaries.

National Per Diem Base Rate IHA opposes the proposal to incorporate a 15 percent Behavioral Offset to the base rate.

The proposal to decrease the base rate by 15 percent based upon an assumption that providers will keep patients longer under a per diem PPS undermines the integrity of healthcare providers and the oath they have taken to do no harm to any patient by keeping them unnecessarily admitted to an inpatient unit. The professionals working in such facilities have the specialized training to provide necessary care to psychiatric patients and the knowledge of when that care is most appropriately delivered in an inpatient psychiatric setting, or in a less intensive setting.

Secondly, CMS requires its contractors to conduct extensive medical review and auditing to determine whether or not the services provided were medically necessary. IHA contends that CMS has existing procedures in place to determine the appropriateness of care delivered and recommends this current approach be utilized. If CMS finds it necessary it pursue an offset, IHA recommends data collection and thorough analysis prior to implementing any negative adjustment.

Lastly, in addition to the 15 percent behavioral adjustment CMS has proposed another payment adjustment based upon the patient's length of stay. The greatest adjustment, 26 percent, would be on the first day, a 12 percent adjustment for days 2 though 4, a 5 percent adjustment for days 5 through 8, and thereafter the enhanced rates for length of stay cease. This approach in conjunction to current medical review and auditing provide adequate controls for determining inappropriate provider practices on an individual basis.

Wage Index IHA opposes the application of a 72.828 percent labor share adjustment to the base rate and urges CMS to use the methodology included in the Medicare Prescription Drug Improvement and Modernization Act of 2003.

IHA opposes applying 72.828 percent of the wage index to the base rate. In section 403 of the recently enacted Medicare Prescription Drug, Improvement and Modernization Act of 2003, the portion of the standardized amount adjusted by the labor share was reduced from 71 percent to 62 percent for inpatient acute care services for areas with wage indices less than 1.0. For acute care services delivered in the outpatient setting, only 60 percent of the standard rate is adjusted by the wage index. IHA encourages

CMS to review its recommendation to attribute 72.828 percent of the payment to labor, and to follow suit with the recent legislation.

Reclassified Wage Index IHA recommends CMS apply the reclassified wage indices to the IPF PPS.

CMS states in the NPRM it believes the actual location of the IPF as opposed to the location of the affiliated providers is the most appropriate method for determining wage adjustments for these facilities. However, hospitals in Iowa compete from the same labor pool for inpatient psychiatric employees as the acute care hospital. Psychiatric staffing is highly specialized making it even more difficult to find qualified employees which forces hospitals to draw from an even larger geographic pool for qualified employees. CMS concurs with this premise with the statement on page 66940 "We also believe the IPFs generally compete in the same labor market as inpatient acute care hospitals." Until CMS has actual data confirming otherwise, IHA strongly recommends the use of reclassified areas in the application of wage indices for the IPF PPS.

Wage Index Data Collection With the implementation of IPF PPS, nearly every service delivered within a hospital will be reimbursed under a PPS and payments accordingly will be adjusted by the area wage index. For each PPS, e.g.,
skilled nursing facility and inpatient rehabilitation, CMS notes that specific wage indices should be developed for each reimbursement system. To do this data must be captured for each unit. IHA urges CMS to reconsider continuing to exclude these units from the wage index calculation worksheets. If units are subject to a wage index adjustment, it is only logical that the wage data from these facilities be collected and used for the corresponding wage index.

Adjustment for Patients Admitted Through Hospital Emergency Departments IHA urges CMS to provide an adjustment for patients admitted to IPF from the hospital emergency department.

Throughout the NPRM, CMS notes the discrepancy in cost for services delivered in a hospital inpatient psychiatric unit as opposed to an inpatient psychiatric facility and has subsequently not proposed a site of service payment adjustment. CMS did state it believes payments should reflect the resource needs of patients and in that regard, IHA urges CMS to consider a payment adjustment for admissions to inpatient psychiatric units with the emergency departments (ED) as the source of admission as these costs are not covered under the proposed PPS. The ED functions as the main entry point for patients with psychiatric crises and in Iowa, 45 percent of all Medicare inpatient psychiatric unit admissions to Iowa hospitals come through the hospital emergency department. Patients who do not have a routine source of medical care are usually admitted through the ED and may have a host of other medical issues. Providing psychiatric services in a hospital ED presents a unique and extremely specialized type of service. Hospitals also incur extra overhead costs simply by maintaining staffed and ready emergency departments, and these costs must be recognized in this payment system. IHA urges CMS to recognize the specialized care of treating such patients in hospital emergency departments and provide a corresponding payment adjustment.

DSH Adjustment IHA urges CMS to conduct further analysis and provide a DSH adjustment.

Inconsistent with other PPS', the proposed rule rejected a disproportionate share hospital (DSH) adjustment based on an inverse of the expected result from the regression analysis. IHA urges CMS to conduct further analysis and provide a DSH adjustment as hospital psychiatric units encounter a large percentage psychiatric patients with low-income and Medicare beneficiaries that are also Medicaid eligible. The overhead cost of attempting to collect co-payments and deductibles for this patient group is higher than for the average Medicare patient. If CMS does not provide a DSH adjustment for IPF PPS, at the very minimum, Medicaid eligible patients in these units should be included in the overall hospital Medicaid eligible day count for disproportionate share percentage calculation purposes.

Teaching Hospital Adjustment IHA opposes the extension of the current acute care hospital intern and resident caps to IPFs.

CMS states in the NPRM it is considering extending to IPFs, the indirect teaching caps that are now used to limit the number of residents in acute care hospitals. There is an obvious problem with this proposal in that the data used to calculate the acute care teaching caps currently does not include interns and residents from inpatient psychiatric units. CMS has not provided information on how the caps would account for inclusion of residents and interns from IPFs, nor has CMS suggested how the caps would be applied to IPFs. Therefore, IHA opposes this recommendation. IHA urges CMS to apply a teaching adjustment to these units based on the ratio of the number of interns and residents assigned to the psychiatric unit to the average daily census for the unit.

Recertification Requirements IHA opposes changing the recertification period from the eighteenth day to the tenth day of hospitalization.

Current regulations require the first recertification to occur on the eighteenth day of admission to an inpatient psychiatric unit to verify the patient's stay is medically necessary. CMS is proposing to shorten this time period to the tenth day of hospitalization. Increasing the recertification frequency will duplicate processes currently in place as required by the Conditions of Participation for psychiatric hospitals in subpart E of part 482. CMS recognizes this duplication and yet continues to propose additional administrative burden on inpatient psychiatric units. The increased frequency of physician recertification in addition to already stringent medical records documentation requirements will not serve to ensure Medicare beneficiaries will receive better care. Rather, it will only serve to increase the cost of providers to pay for additional physician services as many more patients will need to be recertified at the tenth day as opposed to the eighteenth day. Increasing unnecessary administrative burdens only serve to increase the cost of delivering care at a time when health care costs continue to grow, without a corresponding improvement in the delivery of patient care.

Replacing the Current DSM Codes with ICD-9 Codes
CMS is proposing to replace the Diagnostic Statistical Manual of Mental Disorders (DSM) coding system the mental health community utilizes with the International Classification of Diseases-9th Revision (ICD-9) system. There are many inherent issues with this proposal. First, this will require

hospitals to make changes to their charge master system, and these changes will only be for Medicare billing as other payers use the DSM for mental health coding. While not required by the Administrative Simplification Act, the intent of the Act was to create standardization in the health care field. If other payers are not using ICD-9 for mental health coding, this proposal creates less standardization and places another burden on the hospital to bill uniquely for the Medicare program.

Second, the crosswalk from the DSM to the ICD-9 is not an exact correlation. The codes themselves may match; however, their specifications do not. IHA request CMS provide clarification so both the provider of psychiatric services as well as hospital coders understand how this is to be implemented.

Lastly, the implementation of the ICD-10 is fast approaching and these codes more closely match the DSM coding system. Waiting to replace DSM coding until the implementation of ICD-10 would be more appropriate and less burdensome for IPFs.

Co-morbid conditions CMS has proposed to incorporate adjustments to the fifteen diagnosis related groups (DRGs) if the patient presents with one or more of the seventeen identified co-morbid conditions. It is very important CMS recognize the increased cost of providing care to those with co-morbid conditions and IHA urges CMS reconsider its proposed list of co-morbid conditions and expand it to include a broader list of conditions. Further, the proposed rule did not address how CMS would pay for patients presenting with co-occurring diagnosis that fall into more than one DRG. IHA urges CMS to address how it intends to pay for co-occurring diagnosis. As people age they tend to have multiple health conditions that warrant attention, and these needs continue while the patients are hospitalized for psychiatric care.

Electroconvulsive Therapy Electroconvulsive Therapy (ECT) continues to be a valuable treatment option and has evolved substantially over the past few years. Today the standard of practice for ECT is under anesthesia in an operating room or special procedure room with appropriate support personnel. IHA recommends ECT be included in DRG 424 with other operating room procedures, or categorized into its own group and reimbursed appropriately.

Phase-In Period CMS has proposed a three-year phase in period for implementation of the IPF PPS. Given the complexity of this rule, the many troubling proposed provisions as outlined in this comment letter, and to allow sufficient time to refine this payment system as it matures, IHA strongly supports a longer transition period of five years.

Hold-Harmless Provision Given the fragile nature of the mental health system in Iowa and this vulnerable population, IHA urges CMS mitigate the negative financial losses this system will impose on Iowa IPFs to ensure Medicare beneficiaries continue to have access to inpatient psychiatric services until this payment system has time to mature. IHA supports a hold harmless provision or floor amount on the amount of losses due to the implementation of the IPF PPS.

Thank you for your review and consideration of these comments. If you have any questions please contact Heather Olson at the Iowa Hospital Association, 515/288-1955

Sincerely,

Heather Olson
Director, Finance Policy

CMS-1213-N-4

Submitter: Ms. Ann Langan
Date & Time: 02/24/2004 12:02:00
Organization : St. Cloud Hospital
Category : Individual
Issue Areas/Comments
GENERAL

see attached letter

Department of Health and Human Services
Centers for Medicare and Medicaid Services (CMS)
Offices of Strategic Operations and Regulatory Affairs

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CMS-1213-N-5

Submitter : Ms. Mary Sherwin

Date & Time: 02/24/2004 12:02:00

Organization : Cheshire Medical Center

Category : Individual

Issue Areas/Comments
GENERAL

CMS-1213-P Comment letter attached

Department of Health and Human Services
Centers for Medicare and Medicaid Services (CMS)
Offices of Strategic Operations and Regulatory Affairs

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