American Hospital Association

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Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1306-P, Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2006 (RY 2007); Proposed Rule.

Dear Dr. McClellan:

On behalf of the American Hospital Association's (AHA) 4,800 member hospitals, health care systems and other health care organizations, and our 33,000 individual members, we appreciate this opportunity to submit comments on the rate year (RY) 2007 inpatient psychiatric facilities (IPF) prospective payment system (PPS) proposed rule. While the bulk of the rule proposes routine updates to the new payment system, we have concerns with some of the policies set forth in the rule. Our detailed comments follow.

Timing of the Rule
While the proposed rule was delivered to the Federal Register on Friday, January 13, the rule was not posted to the Centers for Medicare & Medicaid Services (CMS) Web site until Wednesday, January 18 and not published in the *Federal Register* until Thursday, January 23. As we stated previously, we believe that the 60-day comment period begins the day the rule is published in the *Federal Register*, as specified in §1871 of the Social Security Act which states: "The Secretary shall provide for notice of the proposed regulation **in the *Federal Register*** and a period of not less than 60 days for public comment thereon" [emphasis added]. If CMS chooses to start the comment period based on the date of display, it must ensure, at the very least, that the display copy is promptly posted to its Web site to provide interested parties sufficient time to review the rule and draft comments before the comment period ends.

BUDGET NEUTRAL BASE RATE

Behavioral Offset
In the proposed rule, CMS again includes an offset to account for changes in coding and length

of stay that may occur as a result of the transition to a per diem-based prospective payment system. However, CMS does not indicate whether an analysis was conducted to determine if continuing an adjustment of such magnitude is warranted. We believe the assumptions CMS made, for both this rate year and last, overestimate the likely impact of changes in hospitals' behavior for several reasons.

First, accurate coding is already a high priority in distinct-part units and some freestanding facilities. In distinct-part units, those assigning the appropriate codes to psychiatric patients' records already code for many other patients for whom payment is based on the diagnosis related group (DRG) to which they are assigned, and the co-morbidities recorded for them. Therefore, coding practices in general hospitals with distinct-part units, which care for 50 percent of psychiatric patients, should not undergo any major changes.

Second, the system includes a variable per diem adjustment that reduces payments based on length of stay, minimizing hospitals' incentive to keep patients for additional days of care. This decreased payment, coupled with strong utilization review by many payors, makes it less likely that stays will increase.

Third, because the PPS is being phased in, and only 50 percent of the payment made for a patient's stay in the second year will be based on the IPF PPS, the incentive for behavior change is diminished.

We urge CMS to analyze the preliminary 2005 claims data and adjust the calculations for the behavioral offset to maintain IPF spending at appropriate levels.

TEFRA Caps

As noted in prior comments to CMS, we believe an error was made in the calculation of the baseline against which budget neutrality is measured. Under the Balanced Budget Act of 1997 (BBA), the temporary caps on facility-specific (TEFRA) payments expired in 2002. Yet, CMS used those capped payments, inflated by the market basket rate for each year until the PPS actually began in 2005, to establish the baseline for budget neutrality purposes. We believe that CMS should have used what would have been spent, absent the expired temporary caps inflated forward using the market basket rate, to establish the baseline. Using the capped payments inappropriately reduced the allowed aggregate spending under the PPS each year.

UPDATE ON PER-DIEM BASE RATE

Market Basket

CMS proposes to implement a rehabilitation, psychiatric and long-term care hospital – or "RPL" – market basket index, a measure of inflation based on 2002 data for the RY 2007 PPS-based portion of payments. CMS historically has used the inpatient-excluded hospital market basket, which also includes cancer and children's hospitals.

The AHA generally supports the shift to an "RPL" market basket. We agree that the cost structures of children's and cancer hospitals likely are different than those of other inpatient PPS-

exempt hospital types now under prospective payment, and should be removed. However, we have some reservations about the methodology used in constructing the "RPL." For instance, CMS had to piece together data from each of the three provider types by using disparate length-of-stay trimming methodologies to create a sufficient data pool. CMS also has had to fill in perceived gaps or inadequacies in the data by substituting inpatient PPS data where necessary. Thus, we believe that CMS should work with providers to improve the areas of the cost report where CMS lacks confidence so that data from the inpatient PPS is not necessary. We further believe that CMS should regularly re-analyze the market basket in an effort to refine it, particularly since these providers only recently converted to prospective payment and their cost structures may be changing. This also will ensure that the labor-related share to which the wage index applies is as accurate as possible, which is of particular importance given that this portion of the payment can be adjusted either positively or negatively depending on the provider. In addition, a regular analysis will allow CMS to continue to consider the possibility of provider-specific market basket indices.

PATIENT-LEVEL ADJUSTMENTS

CMS is not proposing significant changes to the patient level payment adjustments in RY 2007, as it plans to wait until at least one year's worth of claims and cost-report data are available. However, we do have comments on the proposed changes to the comorbidities adjustments.

Comorbidities Adjustments

Tracheostomy Comorbidity Category

We recommend adding code V55.0 to the tracheostomy comorbidity category which includes code V44.0, tracheostomy status. If treatment were being provided to the tracheostomy such as toilet or cleansing, the correct code would be V55.0, rather than V44.0. Page 54 of the December 1, 2005 version of the *Official Guidelines for Coding and Reporting* specifically cited this as an example.

Chronic Renal Failure Comorbidity Category

We recommend that code 404.03 – hypertensive heart disease and renal disease, malignant, with heart failure and renal failure – should qualify for both the cardiac conditions and chronic renal failure comorbidity adjustments. This is similar to a diabetic patient that has both uncontrolled diabetes and chronic renal failure (codes 250.42 and 585.9) or uncontrolled diabetes and gangrene (codes 250.42 and 785.4). Coding rules allow for both these conditions to be coded separately, and each one qualifies for a different comorbidity.

If ICD-9-CM conventions and the *Official Guidelines for Coding and Reporting* (Section I, C, 7, a, 4) would not require a combination code (404.03) for hypertensive heart and kidney disease, these conditions would be reported using the following codes:

- Malignant hypertensive heart disease with heart failure (code 402.01), which currently is included in the cardiac conditions comorbidity category with an adjustment factor of 1.11; and

- Chronic renal failure (code 585.6-585.9 or, as of October 1, 2005, changed to chronic kidney disease), which currently is included in the chronic renal failure comorbidity with an adjustment factor of 1.11.

When the stage of chronic kidney disease (CKD) is unknown – or if the documentation only refers to chronic renal failure, or chronic kidney disease, or chronic renal insufficiency – only code 404.03 would be assigned and only the cardiac conditions adjustment applied. However, when CKD is documented as stage III to V, or as end-stage renal disease, they would correctly get an adjustment for the cardiac condition and the renal failure because two codes would be reported: 404.03, plus a code from 585.3 to 585.6.

We recommend that CMS be sensitive to ICD-9-CM combination codes in constructing variables for any future regression analyses to avoid any potential coding conflicts.

Digestive and Urinary Artificial Openings Comorbidity Category
We recommend adding codes V55.1 to V55.6 to the artificial openings, digestive and urinary comorbidity category. The rationale for adding these codes is similar to our comment under tracheostomy. Codes V44.1 to V44.6 listed in this comorbidity are status codes. The ICD-9-CM instructions have an exclusion note under V44 for artificial openings requiring attention or management to be coded using category V55.

Obstetrical Psychiatric Diagnoses
Claims that do not contain a principal diagnosis from Chapter 5 of the ICD-9-CM or DSM, or are listed in the code first table, do not receive the DRG adjustment.

We recommend that processing logic be developed to allow a DRG adjustment for mental health conditions in obstetrical (OB) patients. We recommend that the processing system look for cases with a principal diagnosis of 648.30 to 648.34 or 648.40 to 648.44, and then search the secondary diagnosis for Chapter 5 codes (290 to 319) to assign a DRG adjustment.

The *Official Guidelines for Coding and Reporting* require that the OB code be listed first, followed by the appropriate mental health disorder or drug dependence code – Chapter 11 (OB) codes have sequencing priority over codes from other chapters (Guideline I, C, 11, a, 1).

For example, if a pregnant patient is admitted for continuous cocaine dependence, the principal diagnosis would be reported 648.32 with a secondary diagnosis of 304.21. A patient admitted for a postpartum panic attack would be coded with a principal diagnosis of 648.44 and secondary diagnosis of 300.01.

FACILITY-LEVEL ADJUSTMENTS

CMS does not propose any significant changes to the facility-level payment adjustments until one year's worth of claims data are available. However, we have some concerns regarding the wage index adjustment.

Wage Index Adjustment
After a yearlong transition, the fiscal year (FY) 2006 inpatient general acute hospital wage index fully incorporates the Office of Management and Budget's revised standards defining Metropolitan Statistical Areas, based on the 2000 Census data, including its new definitions of Core-Based Statistical Areas (CBSA). For the IPF PPS, CMS proposes fully implementing the new labor market definitions for RY 2007.

While CMS discusses the effects on some hospitals previously classified as urban now re-designated as rural, it does not discuss the effects on some hospitals previously classified as rural being re-designated as urban. These facilities will lose the 17 percent rural adjustment, which in the vast majority of cases is not offset by the corresponding increase in their wage index. We believe that CMS should provide a transition for these hospitals to protect them against extreme losses due to this policy change. Specifically, we recommend that CMS add a hold-harmless provision that prevents the per-diem rate under the PPS portion of payments for these facilities from dropping below what they would have otherwise received had they remained designated as rural for RYs 2007, 2008 and 2009. CMS commonly provides a hold harmless provision for providers who are disproportionately harmed by policy changes related to labor market area changes. Under the inpatient PPS, for instance, hospitals that were urban and became rural based on CBSA changes were given a three-year hold harmless period due to the disproportionately negative affect. Almost 50 rural facilities will experience a decrease in their per diem rates after being redesignated as urban under the new CBSAs. These facilities provide crucial access to psychiatric services and cannot withstand up to a 16.3 percent decrease in their per diem rates.

OTHER ADJUSTMENTS AND POLICIES

Outlier Payments
CMS proposes raising the outlier fixed-loss threshold amount from $5,700 to $6,200. However, CMS neither presented its methodology for calculating the threshold, nor provided detailed evidence indicating the need to raise the threshold amount in the rule. We urge CMS to recompute the threshold calculations using the 2005 claims data in advance of the final rule to ensure that the two percent of aggregate spending set aside for outliers does not go unspent. We further recommend that CMS use the same methodology employed under the inpatient PPS to calculate the threshold. If CMS is unable to analyze the 2005 claims data, we believe that it should maintain the threshold at its current level. In addition, we urge CMS to provide a more thorough description of its methodology and calculations in the final rule.

Physician Recertification
During the first year of the PPS, CMS required physician recertification of medical necessity by day 18. However, there has been confusion surrounding the conditions of participation requirements for inpatient acute-care facilities versus inpatient psychiatric facilities. In the rule, CMS proposes making physician certification requirements consistent between the two; thus, physician certification would be required at admission (or shortly thereafter), and recertification would be required on day 12. Subsequent recertification would be required depending on the recommendation of the hospital utilization review committee, but occur no less frequently than every 30 days.

Our members tell us that day 18 recertification is preferable, as the recertification process is administratively burdensome, and while there may have been some confusion at first, this has dissipated. In addition, the variable per diem adjustment guards against an incentive to keep patients longer, thus an earlier recertification is unnecessary. Given no evidence to the contrary, CMS should maintain the current recertification policy. We suggest CMS clarify that facilities may choose to recertify earlier for consistency across their units or payor types, if they so choose.

Same Day Transfers

Our membership advises us that same day transfers result from difficulty in diagnosing mental health disorders and/or substance use in combination with a physical ailment. Frequently, a patient is admitted to the psychiatric unit for a full evaluation, after which it's determined that the patient's medical condition is too complex for treatment in that unit. Such situations are in no way reflective of units trying to skirt billing rules. In fact, facilities are only acting in accordance with physicians' orders to admit patients. The AHA supports CMS' current policy for 2005 claims that same day transfers be paid the PPS per diem. We believe that if CMS conducts a thorough examination of the 2005 claims, it will not find this to be a prevalent occurrence. If CMS then decides that it would like to investigate other options for payment, we urge the agency to convene the field through an open-door forum or other such venue to discuss the possibilities. This is a very complex issue, and we do not have enough time during the comment period, nor the appropriate claims data, to adequately assess the options presented by CMS in the rule. However, the AHA and state hospital associations would be happy to participate in future dialogues about this issue.

We do, however, support CMS' instructions to count a day for cost reporting purposes if the day of admission and the day of discharge are the same; thus, both the hospital transferring the patient and the hospital receiving that patient will count that day for cost reporting purposes. In addition, we agree that only one day should be applied toward a beneficiary's 190-day, lifetime limit. Beneficiaries should not have their covered days inappropriately reduced because of difficulty diagnosing them and placing them in the appropriate care setting.

Data

We urge CMS to release an impact file with the final rule in the form of a downloadable Excel file. While the AHA appreciates CMS' release of a limited data set, most providers are unable to purchase and analyze such an extensive file. A more limited file that will assist providers in determining the impact of the final rule on them, such as the files released as part of the inpatient PPS rulemaking cycle, is essential for providers and associations to analyze payment rules and provide informed comments. In addition, we urge CMS to construct this file using 2007 rates and policies, with 2005 claims instead of 2002 claims for volume of services, to arrive at a more accurate assessment of the impact.

The AHA appreciates the opportunity to submit these comments on the proposed rule regarding the IPF PPS payment update. If you have questions about our remarks, please feel free to

contact me or Danielle Lloyd, senior associate director for policy, at (202) 626-2340 or dlloyd@aha.org.

Sincerely,

Rick Pollack
Executive Vice President