



September 14, 2007

Kerry N. Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Attention CMS-1392-P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: CMS-1392-P, 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 (Vol. 72, No. 148), August 2, 2007.

Dear Mr. Weems:

The Connecticut Hospital Association (CHA), on behalf of its twenty-nine not-for-profit acute care hospital members, appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule for the calendar year (CY) 2008 outpatient prospective payment system (OPPS).

CHA has serious concerns regarding several OPPS proposals, specifically: separate billing for pharmacy overhead costs, implementation requirements for outpatient quality measure reporting, and the payment structure for type A and B emergency department (ED) visits. CHA makes the following recommendations:

- CMS should withdraw its proposal instructing hospitals to bill separately the pharmacy overhead charge. The proposal creates a huge, extremely complex administrative burden on hospitals. CMS should re-evaluate the recommendations of the Advisory Panel on Ambulatory Patient Classification and consider more streamlined approaches that limit new requirements to specific drugs with significant pharmacy overhead and administration costs.
- CMS needs to modify several parts of its proposed OPPS quality reporting program. First, the agency proposes to use the 10 outpatient measures that have received preliminary approval from the Hospital Quality Alliance (HQA) as the initial measures, but several of these measures have not yet been endorsed by the National Quality Forum (NQF), and all of them need work to further refine the specifications for data collection. We strongly urge CMS to delay data collection until the measures have been thoroughly field-tested and received NQF endorsement, the data specifications have been finalized, and the data collection software is fully operational. There is no requirement in the statute that data collection begin on January 1, 2008. For CY 2009 payment purposes, data collection could begin later in 2008 when the hospitals and vendors are fully prepared to commence the program.

- We have a particular concern with the Hemoglobin A1c measure (A1c>9.0) for outpatient reporting, which is an intermediate outcome measure that has not been risk-adjusted. Using this intermediate outcome indicator makes organizations accountable for something that may be out of their control. We suggest that this should be changed to a process indicator measuring appropriate assessment of Hgb A1c levels.
- We also urge CMS to modify its validation approach for the outpatient reporting program. We believe that, for 2009, data validation may be conducted as a learning tool for hospitals, but there should be no minimum reliability threshold required for the annual payment update.
- Finally, CHA recommends that CMS's payment structure for Type A and Type B emergency department (ED) visits be changed. We recommend that the following criteria be applied. If a hospital with a Type A 24/7 emergency department has a "fast track" area to which some patients are sent for expedited or specialized care, the fast track area is part of the Type A ED and can bill using the Type A ED CPT codes, regardless of the fast track's hours of operation, as long as: the fast track is a hospital-based facility which provides unscheduled episodic services to patients who present for immediate medical attention; the fast track area is physically located within the same building as the 24/7 ED; and the 24/7 ED and the fast track share a common patient registration system.

Our detailed comments follow.

Pharmacy Overhead Costs

CMS proposes that hospitals remove the pharmacy overhead charge from the charge for the drug or biological and instead report the pharmacy overhead charge on an uncoded revenue code line on the claim. This policy would be applied to the reporting of charges for all drugs and biologicals, including contrast agents, regardless of the item's packaged or separately payable status.

CMS believes that this change would allow the agency to identify pharmacy overhead costs for drugs and biologicals and, in future years when the 2008 claims data become available, to package these overhead costs into payment for the associated procedure, likely a drug administration procedure. CMS also believes that this policy would not violate the "uniform charge" regulation that prohibits hospitals from charging Medicare differently from all other payers because under this proposed policy the same total charges would be provided to all payers.

However, the proposal creates a huge, unnecessary, and extremely complex administrative burden on hospitals. Hospitals would be required to evaluate and re-price thousands of drugs in hospital chargemasters by January 1 so that a drug charge and pharmacy overhead charge can be developed for every drug administered during an outpatient encounter. This is an overwhelming task that the nation's hospitals will be unable to accomplish.

Thousands of drugs and dosages would need to be evaluated and examined for the resources they consume in the operations of the pharmacy – from October through December. Hospitals would find this task and the related time frames unworkable. CMS has vastly underestimated the difficulty in their proposal. Because of the enormity of this task, hospitals would be forced to apply simple across-the-board overhead percentages, which would undermine the validity and usefulness of the data.

CMS should withdraw its proposal and re-evaluate the recommendations of the Advisory Panel on Ambulatory Payment Classification (APC) Groups and consider more streamlined approaches that limit new requirements to specific drugs with significant pharmacy overhead and administration costs. Moving forward with the proposal will create significant complexity and burden in an area that is already one of the most difficult areas for hospital coders. In the end, it is unlikely that the CMS proposal will generate new data and understanding for setting future rates.

Quality Measures

Connecticut hospitals are committed to public accountability and to providing the highest quality healthcare to every patient, providing consumers with reliable information about hospital performance, and contributing to improving the quality of patient care in Connecticut. This is evidenced by Connecticut being the first state to achieve 100% hospital participation in the voluntary HCA initiative, participating in a demonstration project with CMS and our state Department of Public Health to align state and federal reporting, and Connecticut hospitals have had their performance information displayed on the CMS website since the first CMS release of data in October 2003. However, the Connecticut hospitals have several concerns related to the quality reporting section of the OPSS final rule.

CMS proposes to use the 10 outpatient measures that have received preliminary approval from the Hospital Quality Alliance (HQA) as the starting measures. The National Quality Forum (NQF) has not yet endorsed several of these measures. **We urge CMS to not include any measures that have not received final approval through NQF and we strongly urge CMS to commit to field test all measure specifications before beginning implementation, as has been done in the past. It is essential that all new measures should undergo a rigorous field test to identify for any operational issues and assess the degree to which they can be implemented successfully by hospitals and data vendors.**

CHA has a particular concern regarding the Hemoglobin A1c measure (A1c>9.0), which is an intermediate outcome measure that has not been risk-adjusted. CMS believes that an A1c>9.0 represents a level of control that is poor enough that risk-adjustment is not warranted. Using this intermediate outcome indicator makes organizations accountable for something that may be out of their control as it is in large part a measure of patient compliance. **We suggest that this should be changed to a process indicator measuring appropriate assessment of Hgb A1c levels.**

Regarding the other 30 measures that CMS identifies for possible inclusion for CY 2010 or later, we again urge CMS adopt measures that have been NQF-endorsed and appropriately field-tested.

Timing of Implementation of Quality Reporting

To be eligible for a full OPSS payment update in 2009, CMS proposes that hospitals submit quality data on these 10 measures effective with hospital outpatient services furnished on or after January 1, 2008. Before data collection can begin, hospitals will have to review the data specifications, become familiar with a new data collection tool, implement their reporting systems, develop any sampling methodologies, and educate and train staff. Likewise, data vendors will have to develop

the data abstraction and submission tools, test the software programs, create hospital educational materials and programs, and work with hospitals to implement the software programs.

This timeline for implementation of outpatient reporting will be extremely difficult for hospitals to meet. The information systems involved, data collection as well as clinicians involved will be different than those for the inpatient indicators.

Additionally, smaller hospitals may see their reporting burden increase dramatically with the implementation of the emergency department transfer measures. These hospitals have fewer trained staff available to abstract data. They will need longer lead time to identify and train appropriate clinicians in the data collection process.

CMS is well aware that there have been issues with submission of inpatient data for each of the past three quarters, even requiring extension of the submission deadline for third quarter 2004 data and quarterly reporting of multiple issues since then. The OPSS data will be a much larger volume of data and is expected to be transmitted two weeks immediately prior to the IPPS data deadline. The proximity of the two large data submissions raise concerns on our part that the warehouse will be unable to handle all submissions in a timely manner.

We urge CMS to delay data collection on the outpatient measures until the measures have been fully field-tested and are NQF-endorsed, the data specifications have been finalized, and the data collection software is fully operational.

Data Validation

CMS is proposing that data submitted under the outpatient quality reporting program meet validation requirements. For validation for the 2009 payment update, CMS proposes randomly selecting for reabstraction five patient charts from each hospital from among those patients receiving services in January 2008. To pass validation, hospitals must meet a minimum of 80 percent reliability from the chart reabstraction.

As discussed above, collecting data for the outpatient measures will involve the use of a new data collection tool with documentation criteria and forms that are different than the inpatient reporting program and likely collected by different clinicians.

We urge CMS to adopt an approach similar to the process used for the inpatient indicators and use 2009 data validation as a learning tool for hospitals, requiring no minimum reliability threshold to receive the annual payment update.

Emergency Department Visits

CHA is concerned about the payment structure for type A and B emergency department (ED) visits. Specifically, the new policy implemented by CMS' 2007 Final outpatient PPS rule led to significant confusion and concern about how hospital "fast tracks" are treated. Fast tracks generally function as a part of the ED that handle less emergent cases so that patient flow can be improved through a hospital ED. They can be physically adjacent or even located within the 24/7 ED, but hospitals often discontinue triaging patients to fast tracks during certain hours, such as the midnight shift.

We believe that paying ED fast tracks that do not operate on a 24/7 basis at the clinic rate is inconsistent with sound policy and effective hospital operations. ED overcrowding and ambulance diversion are significant issues that hospitals and emergency room personnel face everyday. Fast tracks have been developed to improve patient care, patient flow, and patient satisfaction. However, the CMS policy has led many hospitals to consider closing these special units, and therefore, exacerbate the ED diversion and overcrowding problems.

CHA believes CMS' policy can be improved to be more reasonable regarding the appropriate coding for fast track ED services. We recommend the following criteria be applied.

If a hospital with a Type A 24/7 emergency department has a "fast track" area to which some patients are sent for expedited or specialized care, the fast track area is part of the Type A ED and can bill using the Type A ED CPT codes, regardless of the fast track's hours of operation, as long as:

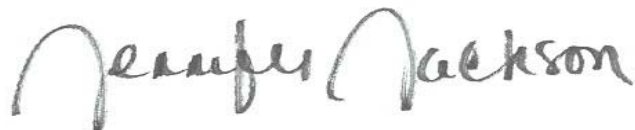
- 1. the fast track is a hospital-based facility which provides unscheduled episodic services to patients who present for immediate medical attention;**
- 2. the fast track area is physically located within the same building as the 24/7 ED; and**
- 3. the 24/7 ED and the fast track share a common patient registration system.**

Partial Hospitalization

We are also concerned about CMS' proposed changes to partial hospitalization payments. The original intent of the benefit was to provide Medicare beneficiaries with an alternative to inpatient psychiatric care that would allow patients to move more quickly out of the hospital to a less intensive, "step-down" program or that would prevent the need for hospitalization. Before the advent of this benefit, Medicare's mental health benefit structure was limited to inpatient psychiatric hospital care or outpatient, office-based visits. The partial hospitalization benefit created an important intermediary service between outpatient, office-based visits and inpatient psychiatric care. **We recommend CMS examine the cost-to-charge ratio for community partial hospitalization services, maintain payment rates, and further study differentiation of payment based on the intensity of service.**

We appreciate the opportunity to comment and would welcome the opportunity to answer questions or discuss these comments.

Sincerely,



Jennifer Jackson
President and CEO

JDJ:ljs
By E-mail