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August 28, 2008

Mr. Kerry N. Weems, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 445-G
Washington, DC 20201

RE: CMS-1404-P: Proposed Changes to the Hospital Outpatient PPS and CY 2009 Payment Rates

NOTE: "PARTIAL HOSPITALIZATION" COMMENTS

Dear Mr. Weems,

As an association representing behavioral healthcare provider organizations and professionals, the National Association of Psychiatric Health Systems (NAPHS) appreciates the opportunity to provide comments on "Medicare: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2009 Payment Rates" as published in the July 18, 2007, *Federal Register*.

We are specifically providing comments on the proposed partial hospitalization program and hospital outpatient mental health services.

ABOUT NAPHS

Founded in 1933, NAPHS advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Our members are behavioral healthcare provider organizations, including more than 600 psychiatric hospitals, general hospital psychiatric and addiction treatment units, residential treatment centers, youth services organizations, outpatient networks, and other providers of care. Our members deliver all levels of care, including partial hospitalization services, outpatient services, residential treatment, and inpatient care.

Partial hospitalization – specifically – has long been a level of care offered by NAPHS members. In our most recent *NAPHS Annual Survey*, nearly 40% (38.6%) all NAPHS members responding offered psychiatric partial hospitalization services for their

communities, and one-quarter (25.2%) offered partial hospital addiction services. Throughout the years, these NAPHS members have been a stable group of providers working hard to meet a community need. Patients may use partial hospitalization either as a transition from a hospital program or as an alternative to inpatient care.

NAPHS has been a major proponent and supporter of the Medicare partial hospitalization benefit since the inception of the benefit in the late 1980s. In fact, NAPHS worked with Congress in crafting the legislation, which became the basis for this benefit. 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. The benefit continues to have a very important place as psychiatric reimbursement has moved to prospective payment and the importance of placing patients at the appropriate level of care has been re-emphasized. Without partial hospitalization as an option, one could imagine even more patients in overcrowded emergency departments. There is much evidence that emergency department care is an inefficient and very expensive way to care for patients experiencing a mental health crisis.

“OPPS: PARTIAL HOSPITALIZATION” COMMENTS

Declining median costs for partial hospitalization services over the past several years have raised questions and concerns for the Centers for Medicare and Medicaid Services (CMS), providers, and their associations about the adequacy of payments to support this critical service. Although there remained questions about the data, CMS still implemented a 15% reduction in the per diem for 2006, another 5% decrease in 2007, and a 13% reduction in 2008, which resulted in a PHP per diem rate of \$203.

In the 2008 and 2009 proposed outpatient prospective payment system (OPPS) rules, CMS considered the number of services being provided in a day of care as a possible explanation for the continuing decline in the calculated per diem cost. Although CMS expectations are that a typical PHP program should provide five to six units of services per day, CMHCs in 2007 had the vast majority of days with three or fewer units of service, while hospital-based programs had the overwhelming majority of their days with four or more units of service. In the 2009 proposed rule, CMS proposes to create two separate APCs for PHP, one rate for three units of services and another rate for four or more units of service. NAPHS supports the creation of two new APCs for PHP.

Unfortunately, the proposed payment rates CMS calculates for combined CMHC and hospital-based median cost data—\$140 for three units of service per day and \$174 for four or more units of service per day—represents another significant reduction in payments for PHP services, even for the new high-intensity APC, which will be paid at 14% less than the PHP rate for 2008.

NAPHS and AHA Analysis of PHP Data

In response to the steep reduction in PHP rates over the past several years, the National Association of Psychiatric Health Systems (NAPHS) and the American Hospital Association (AHA) hired the Wellington Group to conduct analyses of three years of data (including data from 2003, 2004, and 2006) to better understand the reason for the continuing decline in PHP median costs and provide insights for policy decisions. Attached to this comment letter is a document that describes the results and analysis. Our comments below are based on this analysis by the Wellington Group.

Why Access To Care Is Threatened

The mix of providers – community mental health centers (CMHCs) and hospitals – is significantly shifting. On the surface, it seems that since 2003 the PHP provider base has remained relatively stable (based on the overall number of PHP providers—a decline of 2%). But this does not truly reflect the significant changes that have occurred in the mix of providers – both CMHCs and hospitals.

For example, hospital providers have declined by 16%, while CMHC providers have increased by 53%. However, Florida, Louisiana, and Texas account for almost all of the additional CMHCs. Although CMHCs now account for a disproportionate share of the days of care, close to 80% of the CMHCs are only in six southern states. On the other hand, hospitals are more dispersed. For example, 80% of the states have two or more hospital programs. In the case of CMHCs, more than half the states do not have any CMHC providers, and only 30% of the states have more than one CMHC.

What this means is that **in most areas of this country, Medicare beneficiaries are relying on hospital-based partial hospitalization programs as the sole type of provider for this level of care.** Therefore, the decline in hospital-based partial hospitalization programs (16% between 2003 and 2006) is directly affecting access to partial hospitalization in many areas of the country. In fact, the number of states that had only hospital-based PHPs – and now do not – is growing. In addition, rural areas are being hit the hardest with loss of PHP programs. For example, rural hospital-based PHPs have declined during the 2003-2006 period by 47%.

The Level of Intensity of PHP Programs Is Changing; Hospitals Remain Committed To Intent of PHP Statute

At the same time that rates were declining during the 2003-2006 period, the proportion of CMHC PHP days with three or fewer units of service doubled from one-third to two-thirds. Also, the proportion of CMHC PHP days with five or more services decreased from 30% to 11%.

During this same time frame, **hospital-based PHPs remained committed to the CMS vision of partial hospitalization as a high-intensity service.** For example, the proportion of hospital-based PHP days with four or more units of services remained stable at just over two-thirds of hospital days. According to the CMS CY2009 proposed rule, this trend

continues, with close to 75% of days being provided with four or more units of service. Also, the proportion of hospital-based PHP days with five or more units of service actually increased from 2003 to 2006 (from 13% to 18%).

NAPHS RECOMMENDATION

The National Association of Psychiatric Health Systems provides the following recommendation:

- To ensure access to clinically intensive partial hospitalization programs, NAPHS supports CMS' two-tier payment proposal, but would **recommend that only hospital data be used to set the two-tier rate structure.**

Why Hospital-Based PHP Data Needs To Be Used To Set PHP Rates

There are a number of reasons supporting our recommendation that only hospital data be used to set the two-tier rate structure.

1. **Hospital-based PHP data is more reliable because it is based on detailed and audited cost reports**, which are more sophisticated than CMHC financial reporting systems.
2. **Hospital-based PHP median costs** from the start of OPSS have been **consistent and stable** (ranging from \$200 to \$225).
3. **CMHC median costs have wildly fluctuated** (from highs of more than \$1,000 per day to lows of \$140). CMHC outlier payments have also greatly fluctuated.
4. **The PHP rate cap only affects hospital outpatient mental health services.** CMHCs are not eligible providers for hospital outpatient services, but CMHC data affects the rate cap for hospital outpatient services. A combined PHP rate potentially reduces access to hospital outpatient mental health services.
5. **Hospital-based PHP data is national in scope, while CMHC is regional.** Eighty percent (80%) of the states have two or more hospital-based PHPs, while 78% of CMHCs are only in six southern states.
6. **Hospital-based PHPs are meeting the intent of PHP statute and CMS rules.** More than 70% of hospital-based PHP days have four or more units of service. In fact, hospital-based PHPs have increased the proportion of days with four or more units of service over the past few years—continuing to meet the needs of patients, while rates have been declining. On the other hand, CMHCs have reduced units of service so that more than 73% of the days have three or fewer units of service.
7. **The current PHP rate of \$203 per day is about the same as the cost of hospital-based PHP days of four or more units of service (\$205).** Any further reduction in

rates, especially for the higher intensity programs, will impact access to this level of care.

8. **In many states beneficiaries' only access to PHP services is in hospital-based programs. If these programs close, it is likely more patients will be hospitalized—costing Medicare more money.**
9. **The PHP rates should be based on hospital data, which is reliable, predictable, and national in scope.**
10. **Although our recommendation will result in payment for PHP services in 2009 that are higher than what they would be if CMS finalized its proposed policy, we point out that the overall expenditures for PHP services should still decline from the previous year under our proposal.**

COMMENTS ON OTHER PHP PROPOSALS

Proposal To Deny Payment for Low Intensity Days

CMS proposes to deny payment for any PHP claim for days where fewer than three therapeutic services are provided. CMS states that three services should be the minimum number of services allowed in a PHP day and that days with one or two services do not meet the statutory intent of a PHP program. NAPHS supports CMS's proposal to deny payment for these "low unit" days. However, there are some rare instances when a patient becomes ill or has a family or personal emergency and needs to leave the program early on that day and would, therefore, receive less than three services. For these very limited cases, we believe CMS should implement a medical review process to ensure all appropriate claims are paid.

We recommend that CMS create a modifier to be used to trigger a "suspension of claim for medical review" and potential payment at a reduced rate (perhaps as discrete outpatient services).

Proposal To Add Patient Eligibility Criteria

CMS proposes to revise 42 CFR 410.43 to move certain patient eligibility criteria from policy to regulation. In general, we support the addition of the criteria to the regulations as a way of strengthening the benefit.

However, we ask that CMS clarify that these requirements will be used as general eligibility requirements and not patient-specific requirements with the potential to deny coverage of services or payments for individual patients. Our specific concern is with the requirement for 20 hours per week of therapeutic services. We support the requirement that a partial hospitalization program be designed for patients who require 20 hours per week of therapeutic services. We do, however, recognize that, for valid medical reasons, based on an individualized treatment plan, an individual patient may not participate in 20

hours of therapeutic services within a given week. Patients may be transitioning into or out of partial hospitalization. A patient may need an occasional day to accommodate to the rigorous demands of this very intensive level of service.

We ask that a range of hours be established (perhaps between 16 and 20) as a guideline that allows appropriate individualized clinical flexibility.

CONCLUSION

CMS in the CY 2006 final rule made the following observation:

“...we stated in the proposed rule that we would continue to analyze the CMHC data in developing payment rates, and cautioned that we may use only hospital data in the future if the data continues to be unstable.”

It is our view, based on the points discussed above, that the time is now to move to only hospital-based PHP data to set the rates, which will ensure that access to the highly intensive PHP programs remain available to Medicare beneficiaries.

Thank you for your consideration of our comments. We look forward to working with CMS and the Department of Health and Human Services to ensure that Medicare beneficiaries continue to have access hospital outpatient mental health and partial hospitalization services.

Sincerely,



Mark Covall
Executive Director

ATTACHMENT: Wellington Group study