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August 26, 2009

Ms. Charlene Frizzera, 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-1414-P: Medicare Program: Proposed Changes to the Hospital Outpatient PPS and CY 2010 Payment Rates

NOTE: "PARTIAL HOSPITALIZATION" and "PHYSICIAN SUPERVISION" COMMENTS

Dear Ms. Frizzera,

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 the proposed rule titled "Medicare: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates" as published in the July 20, 2009, *Federal Register*.

We are specifically providing comments on the proposed partial hospitalization payment rates and physician supervision.

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*, more than half (56%) all NAPHS members responding offered psychiatric partial hospitalization services for their communities, and more than a third (35.8%) 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

NAPHS strongly supports 1) the proposed PHP rates for CY2010 and 2) the two-tiered payment structure for PHP payments outlined in the proposed rule.

Last year, in response to the steep reductions in PHP rates over several years, the National Association of Psychiatric Health Systems and the American Hospital Association 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.

The study found that 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 in only 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 the loss of PHP programs. For example, rural hospital-based PHPs have declined during the 2003-2006 period by 47%.

The study also found that **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 service remained stable at just over two-thirds of hospital days. According to the CMS CY2010 proposed rule, this trend continues, with 70% of days being provided with four or more units of service. Also, the study found that the proportion of hospital-based PHP days with five or more units of service actually increased from 2003 to 2006 (from 13% to 18%).

CMS noted in the proposed rule that there is a two-year delay between data collection and rulemaking, so the changes made by CMS in CY2009 will not be reflected in the claims data until next year when CMS will be developing the update for CY2011. **Therefore, the findings of the Wellington study are still the best available data on the trends in PHP care nationwide. That is another key reason why the current payment structure should remain in place for CY2010.**

Recommendation and Rationale: Why CMS Needs to Continue Using Only Hospital Data to Develop Rates

Based on the above points, we strongly urge CMS to continue the two payment structure for partial hospitalization (with high- and low-intensity rates) and to use only hospital data for determining 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 data is regional.** Eighty percent (80%) of the states have two or more hospital-based PHPs, while 78% of CMHCs are in only 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 77% of the days have three or fewer units of service.
7. **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.**
8. **The PHP rates should be based on hospital data, which is reliable, predictable, and national in scope.**

“PHYSICIAN SUPERVISION” COMMENTS

We appreciate the opportunity to discuss physician supervision issues in the 2010 proposed rule.

The Current Role of Physician Supervision in Outpatient and Partial Hospitalization Programs

Patients in a psychiatric partial hospitalization program or a hospital-based outpatient program are under the care of an attending physician who supervises the treatment plan.

In a PHP, this involves the following:

- Certification that the patient needs partial hospitalization and recertification of the need at regular intervals
- Completion of a comprehensive psychiatric evaluation within 24 hours of admission
- Establishment and regular review and revision of an individualized, multidisciplinary plan of care for each patient
- Provision of psychiatric treatment on an intensive basis as evidenced through regular face-to-face meetings documented in progress notes

Physicians carry out the same functions in a hospital-based outpatient treatment program with an intensity commensurate with the acuity of the patient.

The availability of partial hospitalization services decreases the use of inpatient hospitalization by providing services for patients who, in the absence of partial services, would be hospitalized. A day of partial hospitalization consists of, at an absolute minimum, three (and most typically four to five) highly structured, multidisciplinary group sessions. One of the units of service must be a psychotherapy group. Treatment is provided by a highly skilled interdisciplinary team comprised of psychiatrists, psychologists, nurses (including advanced practice nurses), masters prepared social workers, occupational therapists, and activity therapists. Many treatment team members meet Medicare criteria as independent practitioners. They practice within the scope of their license and make the interdisciplinary contribution to the care of the patient that is both clinically indicated and required by the definition of the benefit.

Physicians are an integral and regular physical presence in partial hospitalization programs. They are readily available for consultation, face-to-face evaluations, and program oversight. Programs have well-defined procedures for handling medical and psychiatric emergencies.

Support for Proposed Policies for Direct Supervision of Hospital Outpatient Therapeutic Services

We strongly support the proposal made in the 2010 outpatient prospective payment system proposed rule that would allow non-physician practitioners (specifically physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives) **to directly supervise all hospital outpatient therapeutic services that they may perform themselves in accordance with the provisions outlined in the proposed rule.** We think it is appropriate that professionals be permitted to provide incident to supervision for the services they can perform independently.

We recommend that licensed clinical social workers be added to the group of non-physician practitioners who may supervise the outpatient therapeutic services that they may perform themselves in accordance with the provisions outlined in the proposed rule. Under current regulations, clinical social worker services are covered by Part B as services that would be covered if furnished by a physician. The regulations at 42 CFR §410.73 (Clinical social worker services), state:

(b) Covered clinical social worker services. Medicare Part B covers clinical social worker services. (1) *Definition* "Clinical social worker services" means, except as specified in paragraph (b)(2) of this section, the services of a clinical social worker furnished for the diagnosis and treatment of mental illness that the clinical social worker is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which the services are performed. The services must be of a type that would be covered if they were furnished by a physician or as incident to a physician's professional service and must meet the requirements of this section. CSWs are highly trained and qualified professionals who are equipped to perform comprehensive psychosocial assessment and are therefore familiar with all domains; the patient's clinical, familial, social, and support circumstances. They participate actively in the

development and delivery of an individualized plan of active treatment services, and provide psychotherapy services.

Our Concerns and Recommendations on Physician Supervision

While we welcome the addition of non-physician providers as professionals who may directly supervise services they may perform themselves, we also want to explore clinically appropriate ways physicians and NPPs can be available to provide supervision of outpatient services based on the nature of the therapeutic service being provided.

We believe the intent of direct physician supervision (the requirement that the physician be *immediately available*) can be met by a physician or NPP being immediately available by phone (or other appropriate forms of communication) at all times the therapeutic service is being provided and physically available within a defined timeframe, based on the care being delivered. Hospitals would be responsible for using their internal policy and procedure development and approval process to define the specific requirements of this availability as Medicare requires in other areas.

We recommend that CMS undertake a thorough evaluation of the supervision requirements for incident to services. The current definitional confusion (as well as the significant concern from the field that the proposed rule does not adequately resolve the confusion) cannot be ignored. Our constituents are telling us that direct physician supervision is not the clinically appropriate standard for the therapeutic services they provide. Further, conforming with the proposed levels of supervision would make it impossible to continue to provide the beneficiary access that currently exists because supervising professionals are not available in adequate numbers to provide direct supervision of services that do not require that level of involvement. CMS has significant regulatory flexibility available to design a supervision model that would provide both safe and accessible services without compromising either value. We suggest that CMS develop a process (clinically informed and submitted for public comment) that would lead to the identification of the appropriate level of supervision necessary for specific clinical services.

We are concerned about the unintended consequences of the requirement that a supervising professional must be physically present in the hospital campus areas that are under the hospital's control. We think the timely availability of the supervising professional is the important requirement—not the physical place where the professional is located.

If partial hospitalization services and hospital-based outpatient psychiatric services were required to meet the requirement that “a physician must be present on the premises of the entity accorded status as a department of the hospital and immediately available to furnish assistance and direction for as long as patients are being treated at the site,” there would be a very significant impact on beneficiary access. Programs have been designed based on the current understanding of the level of physician supervision required of hospital outpatient incident to services. Most communities do not have enough physicians (or as expanded in the 2010 proposed rule to include NPPs) to assure that one could be physically present in the outpatient department at all times that partial hospitalization services and hospital-based outpatient services are furnished. Requiring hospitals to hire and pay physicians or NPPs to be available only for supervision of incident to services has significant cost and patient access implications (services would be forced to closed if they cannot meet the supervision requirements). The professional

time of these individuals is too much in demand to be squandered; their time can be much more productively spent in other clinical activities – still without jeopardizing their ability to be available to intervene in support of incident to services should that be necessary.

There is also no demonstrated evidence that such a level of presence at all times would enhance a program of services designed (and required by regulation) to be carried out by an interdisciplinary team of highly qualified professionals. The cost structure has been very thoroughly studied and set based on the general physician supervision standard.

RECOMMENDATIONS:

To summarize, **NAPHS recommends** that CMS:

- **continue the two payment structure** for partial hospitalization (with high- and low-intensity rates)
- continue to **use only hospital data** for determining rates
- implement the proposal to **allow non-physician practitioners (specifically physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives) to directly supervise all hospital outpatient therapeutic services that they may perform themselves** in accordance with the provisions outlined in the proposed rule
- **add licensed clinical social workers to the group of non-physician practitioners who may supervise** the outpatient therapeutic services that they may perform themselves in accordance with the provisions outlined in the proposed rule
- undertake a **thorough evaluation of the supervision requirements for incident to services**
- **rethink the unintended consequences of the requirement that a supervising professional must be physically present in the hospital campus areas that are under the hospital's control.** The timely availability of the supervising professional is the important requirement—not the physical place where the professional is located.
- meet the intent of direct physician supervision (the requirement that the physician be *immediately available*) by **allowing a physician or NPP to be immediately available by phone (or other appropriate forms of communication) at all times the therapeutic service is being provided** and physically available within a defined timeframe, based on the care being delivered

CONCLUSION

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,

A handwritten signature in black ink that reads "Mark Covall". The signature is written in a cursive style with a large, stylized 'M' and 'C'.

Mark Covall
President/CEO