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August 26, 2010

Donald M. Berwick, MD, MPP, FRCP  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, DC 20201

**RE: CMS-1504-P: Medicare Program: Proposed Changes to the Hospital Outpatient PPS and CY 2011 Payment Rates**

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

Dear Dr. Berwick,

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 2011 Payment Rates...." as published in the August 3, 2010, *Federal Register*.

We are specifically providing comments on the proposed **partial hospitalization** payment rates.

#### **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, addiction treatment facilities, 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 (51.8%) all NAPHS

members responding offered psychiatric partial hospitalization services for their communities, and more than a third (33.6%) 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 the CMS proposal to establish four separate PHP APC per diem rates – two for community mental health center (CMHC) PHPs and two for hospital-based PHPs – and using only CMHC data for setting the CMHC PHP rates and hospital-only data for the hospital-based PHPs.

In 2008, an independent study sponsored by NAPHS and the American Hospital Association had two key findings, among others:

- 1) PHP rates should be based on hospital data because it is reliable, predictable, and national and scope; and
- 2) CMHC PHPs are primarily located in a few southern states, while hospital-based PHPs operate in the vast majority of the states.

These two findings were very important because (prior to calendar year 2009) PHP per diem payments were based on the combined median costs of CMHC PHPs and hospital-based PHPs, which resulted in declining per diem payments due to decreasing CMHC PHP median costs driving payments below hospital-based PHPs' actual costs. This phenomenon had the potential of reducing access to PHPs for many Medicare beneficiaries. In CY2009 CMS responded by establishing a two-tiered payment system based on hospital data only.

It is our strong view that the latest CMS proposal – which builds on the current two-tiered per diem system by now proposing to create four separate per diem rates specific to each type of setting (CMHC and hospital-based) and calculating the per diem payments based on the specific setting's median cost – will result in stabilizing the hospital-based PHP programs that now serve hundreds of thousands of Medicare beneficiaries across the country. This proposal also recognizes the clear difference in cost structures between CMHC PHPs and

hospital-based PHPs. One major reason that there are cost differences between these types of settings is that hospitals have to meet the requirements of federal and state regulatory structures (such as Medicare and Medicaid), national accreditation (e.g., The Joint Commission), and state licensing, among others. This increases the administrative costs of the hospital-based PHP programs. On the other hand, CMHC PHPs do not have similar federal or state regulatory requirements, resulting in lower administrative costs. Also, hospital-based PHPs must meet the Medicare direct supervision requirement, while CMHC PHPs must meet the general supervision requirement – a less costly standard.

NAPHS also strongly supports the CMS proposal to use the hospital-based PHP APC 0176 (4 or more units of service) as the daily payment cap for non-PHP hospital-based outpatient mental health services. Longstanding CMS policy has held that total payments for discrete mental health services provided on an outpatient basis should not exceed the hospital-based PHP per diem rate for four or more units of service. The rationale is that PHP is the most intensive outpatient service, so discrete mental health services provided during a single day should not be more costly than a PHP day. Also, we support the CMS proposal to use the hospital-based PHP APC for 4 or more units of service as the payment cap because only hospitals can offer hospital-based outpatient mental health services. CMHCs are only able to offer PHP services.

NAPHS totally concurs with CMS statements that it is critical to ensure hospital-based PHPs are not paid below their actual costs, as this could lead to hospital-based programs closing and possible access problems. Also, the 2008 NAPHS/AHA-sponsored study had a similar conclusion to the CMS statement in the proposed rule that “we need to continue to protect hospital-based PHPs from receiving inadequate payments, given that they offer the widest access to PHP services because they are located across the country.”

Because the proposed reimbursement structure reduces payment for CMHCs by 42 percent in a single year, we recommend that CMS consider a phase-in of the rate reduction as it has done in the face of significant changes to other payment rates.

## **RECOMMENDATIONS:**

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

- Establish a four-tiered per diem payment system for PHPs (two tiers for CMHC PHPs and two tiers for hospital-based PHPs), based on the median costs of each specific PHP setting.
- Use the hospital-based PHP APC 0176 (4 or more units of service) as the daily payment cap for non-PHP hospital-based outpatient mental health services.

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  
President/CEO