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March 9, 2009

Secretary Robert M. Gates
Office of the Secretary of Defense
c/o Federal Docket Management System Office
1160 Defense Pentagon
Washington, DC 20301-1160

RE: TRICARE: Outpatient Hospital Prospective Payment System (OPPS) [DOD-2007-HA-0048; RIN 0720-AB19], 32 CFR Part 199

Dear Secretary Gates,

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 "TRICARE: Outpatient Hospital Prospective Payment System (OPPS): Delay of Effective Date and Additional Opportunity for Public Comment" as published in the February 6, 2009, *Federal Register* [DOD-2007-HA-0048; RIN 0720-AB19]. We thank you for reopening the comment period before implementing the final rule. In this final rule (with a delay of effective date and opportunity for public comment), TRICARE is adopting Medicare's prospective payment system for reimbursement of hospital outpatient services currently in effect for the Medicare program as required under the *Balanced Budget Act of 1997*. The final rule with delay of effective date delays implementation until May 1, 2009.

We are specifically providing comments on the impact of the TRICARE final rule on 1) partial hospitalization programs (PHP) and 2) other 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. These services are paid for by all types of payers, including TRICARE, as well as commercial insurers, Medicare, Medicaid, states, and others.

"PARTIAL HOSPITALIZATION" COMMENTS

The final rule states that the TRICARE and OPPS partial hospitalization reimbursement systems are "similar" with only "subtle differences" between the two payment methodologies. In fact, as we will describe below, the two systems are fundamentally different and, in many cases, incompatible with each other. This complicates the direct and immediate transition from TRICARE rates to Medicare rates.

We support (and have submitted official comments on) the December 30, 2008, proposed rule that recommends that TRICARE no longer impose its unique certification standards upon hospital-based psychiatric PHPs. In the proposed rule, TRICARE approval of a hospital would be sufficient to establish the hospital as an authorized provider of its PHP services to TRICARE beneficiaries. Our comments in this letter are predicated on the finalization of this rule and the resultant decrease in provider burden in complying with the additional, detailed, unique TRICARE certification requirements.

CONCERNS AND COMMENTS

Definition of a day of service

TRICARE reimbursement is based on the intensity of the program as defined by the length of the treatment day. A *half day* is defined as one greater than three hours but less than six hours of service. A *full day* is six hours or more of service. Different levels of reimbursement are provided for each type of treatment day. TRICARE requires that a day include a psychotherapy service, and the requirements are not specific regarding the number or mix of other services furnished within the day.

MEDICARE reimbursement is based on a per diem payment with a required number of units of service. A day must include, at a minimum, three units of service that include at least one psychotherapy service with the others chosen from activities therapy and/or education and training. The number of units of service is expected to vary upwards from the minimum, depending on the identified needs of the patient. The units are reported as line items and packaged into APC 0172 (Level I Partial Hospitalization—3 services) and APC 0173 (Level II Partial Hospitalization—4 or more services) for payment. The current levels of service distinctions were implemented as of January 1, 2009, with the rates for 2009 of APC 0172 at $204.78, and APC 0173 at $161.05.

CONCERN: Currently, TRICARE and Medicare days of service are not comparable in terms of their length, clinical structure, or provider mix. It is impossible to compare the cost of a direct transition from the TRICARE payment structure to the Medicare structure. Many providers are at risk of experiencing a significant decline in their PHP reimbursement levels based on the level of service they provide.

Basis on which the reimbursement for a day of service is calculated

Under TRICARE, a full-day program (more than six hours) is currently reimbursed at 40% of the average TRICARE inpatient per diem. A half-day program (more than three but less than six hours) is paid a per diem of 75% of the rate for full-day partial hospitalization.

MEDICARE reimbursement for a day of partial hospitalization is a bundled rate. The rate is set annually through the Outpatient Prospective Payment Rule based on cost data submitted to the Centers for Medicare and Medicaid Services (CMS).

CONCERN: The bases for calculating the reimbursement rates for TRICARE and Medicare are completely different. TRICARE is based on the average TRICARE inpatient per diem. The Medicare PHP rate is based on cost as reported to CMS via the cost report. Transitioning from one base rate to another could cause significant change in reimbursement and disruption of services.

Setting of service

TRICARE PHP services must be provided in a freestanding or hospital-based program. They cannot be provided in a community mental health center (CMHC).

MEDICARE PHP services may be provided in a freestanding, hospital-based, or CMHC setting. CMS stated in the CY08 Outpatient PPS Rule that, "We believe the most appropriate payment rate for PHPs is computed using both hospital-based and CMHC PHP data." This data has historically been averaged (even though CMHC data were excluded from calculations for the CY08 rate), and historically the rate was established that is the same for all sites of service

CONCERN: The historical Medicare PHP rate is significantly driven by the cost of providing services in CMHCs because a majority of days of care are provided by CMHCs. CMHC costs have fluctuated widely through the last several years, contributing to the significant instability in the PHP per diem rate. The Medicare PHP rate is established based on inclusion of CMHCs. However, in CY08 CMS used hospital-only data to address this concern.

TRICARE does not permit CMHCs to be certified providers. Therefore, the historical Medicare rate calculation is not a good proxy for TRICARE partial hospitalization programs because TRICARE does not include CMHCs as providers, but Medicare median costs rely heavily on CMHCs cost structure. CY08 is the only year in which both TRICARE and Medicare PHP rates are based only on hospital data. Care must be taken in future years to ensure that only comparable data are evaluated

RECOMMENDATIONS

1) We urge the Department of Defense (DoD) to reissue the final rule with changes that would implement the TRICARE OPPS as budget neutral to the current TRICARE OPPS payment amount for hospital outpatient services. This would be consistent with the way Medicare implemented OPPS and would not decrease the payment to hospitals that care for military dependents and retirees. In future years, payment

rate reductions required to merge the TRICARE and Medicare OPPS payment systems should occur through a well-constructed and fiscally sound transition policy.

2) We recommend that DoD bridge the transition to the TRICARE OPPS by limiting the amount reimbursement can fall annually in the years following the initial budget-neutral implementation year. This could be done by applying an adjustment to the OPPS conversion factor. We suggest the conversion factor be no more than 10 percent until the final TRICARE OPPS payment rates are achieved.

3) We recommend that DoD pay special attention to TRICARE providers located in areas with high concentrations of military families and retirees. In this time of war and national fiscal upheaval, beneficiary access to services is extremely critical. Provider organizations serving large TRICARE populations who cannot adapt to significant changes in reimbursement levels will be forced to discontinue providing services to TRICARE beneficiaries.

CONCLUSION

Thank you for your consideration of our comments. We look forward to continuing to work with the Department of Defense to ensure that TRICARE beneficiaries continue to have access to necessary mental health services.

Sincerely,

Mark Covall
Executive Director