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ADVOCATING FOR BEHAVIORAL HEALTH
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September 6, 2013

Ms. Marilyn Tavenner, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: **CMS-1601-P: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program; Organ Procurement Organizations; Quality Improvement Organizations; Electronic Health Records (EHR) Incentive Program; Provider Reimbursement Determinations and Appeals** (42 CFR Parts 405, 410, 412, 416, 419, 475, 476, 486, and 495)

***NOTE*: Our comments focus on "PARTIAL HOSPITALIZATION CY2014 RATES"**

Dear Ms. Tavenner,

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 (CMS-1601-P) titled "Hospital Outpatient Prospective Payment…." [CY2014 Payment Rates] as published in the July 19, 2013, *Federal Register*.

We are specifically providing comments on the proposed **partial hospitalization** payment rates for CY2014.

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 700 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 (51.5%) of all NAPHS members responding offered psychiatric partial hospitalization services for their communities, and approximately a third (31.3%) 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 intermediate service between outpatient, office-based visits and inpatient psychiatric care.

The benefit continues to have a very important place as inpatient 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.

The current implementation of healthcare reform places ever-more emphasis on the importance of the care continuum. Essential to reform implementation is the creation of a system that makes it possible for patients to receive treatment at the most appropriate, cost-effective level with well-coordinated transition to the next level of care. We think partial hospitalization is critical for helping the mental health system meet its goal of a robust continuum of services.

Partial hospitalization also has been shown to have an impact on time to readmission. For example, in a recent report on *Medicare Psychiatric Patients & Readmissions in the Inpatient Psychiatric Facility Prospective Payment System*, The Moran Company noted that some patients received inpatient psychiatric facility (IPF) services through a partial hospitalization program. Time to readmission for these Medicare beneficiaries was 131 days (vs. 59 days for those who did not participate in this program between admissions), according to their analysis.

"OPPS: PARTIAL HOSPITALIZATION" COMMENTS

Future Initiatives to Improve Long-Term Stability and Payment Accuracy

The proposed rule states that, "…we are considering a number of possible future initiatives that may help to ensure the long-term stability of PHPs and further improve the accuracy of payment for PHP services." We totally agree with the goals of this statement: 1) to ensure the long-term stability of PHPs and 2) improve accuracy of payments for PHP services.

Over the years, NAPHS has recommended ways to address these two goals, including the creation of two levels of PHP (using hospital-based cost data to determine hospital-based rates and CMHC cost data to determine CMHC rates). We believe this change to the PHP payment structure has been a positive step in addressing the twin goals of ensuring long-term stability and improving accuracy of payments. However, the proposed PHP rates in this year's rule for CY14 show again that payment rates continue to materially fluctuate from one year to another. For example, for hospital-based PHPs in CY14, Level 1 (three or more services) will increase by 13.3 percent, while Level 2 (four or more services) will decrease by 9.2 percent. Clearly, further monitoring of rate fluctuations is needed.

As part of trying to achieve long-term stability and payment accuracy, the proposed rule states that CMS is interested in receiving public comments on whether payment methodologies for PHP should change to an episode-of-care methodology or a per-diem similar to the inpatient psychiatric facility (IPF) prospective payment system (PPS). CMS is asking whether this would result in more appropriate payment for PHP services than the current payment structure.

We are not aware of any substantive payment research that has been conducted on episode-of-care or per-diem systems for PHP at this point, so it would be premature to comment on whether these approaches would accomplish the goals discussed above.

However, before any research is conducted on episode-of-care or per-diem systems (such as an IPF PPS-type methodology) for PHP, we would suggest that a full review of the Medicare mental health and substance use benefit structure be conducted.

The current Medicare behavioral health benefit is extremely limited. It covers only inpatient psychiatric hospital care, partial hospitalization, and outpatient office-based services. The Medicare benefit is not in line with what is commonly covered by private health insurance plans. Medicare does not cover the full continuum of behavioral health services, such as intensive outpatient care, residential treatment, psychosocial

rehabilitation, and care management. Also, the current PHP benefit is very narrowly defined. As a result, it is really only available for the most acutely ill patients who would be hospitalized if not for the PHP program.

We point this out because more changes to the PHP payment structure will not address the broader problem, which is the lack of flexibility in the Medicare benefit design. Medicare's behavioral health benefit makes it hard to provide the right care, at the right level, at the right time for Medicare beneficiaries.

We recognize that changes to the behavioral health benefit under Medicare must be done through the legislative process. In that regard, we welcome a recent open letter to the behavioral health community from Senate Finance Committee Chairman Sen. Max Baucus and Ranking Member Sen. Orrin Hatch asking for suggestions on ways to improve the Medicare and Medicaid programs to better serve individuals who are dealing with mental and substance use disorders. Also, the Administration has called for a national dialogue on mental health in the aftermath of the tragedy at Sandy Hook.

NAPHS has been active in this national dialogue, and we will be submitting formal comments to the Senate Finance Committee in response to the Committee's request.

We believe that public understanding of mental illnesses and substance use disorders is improving, and this provides an excellent opportunity to engage all stakeholders in a broad discussion about the future of the delivery and payment of mental and substance use disorders.

PHP is a very important benefit within the continuum of care, but it is only a part of the continuum. **We would suggest that any changes to the PHP payment methodology should only be done as part of a broader redesign of the Medicare behavioral health benefit structure.**

Certification/Recertification

We have no reason to recommend changes to the requirements for initial certification for PHP services at the time of admission, recertification by day 18, and continued recertification at intervals established by the program but no longer than 30 days We have not seen this to be a problem in the field and know of no best practices that would suggest the need for a revision.

Written Plan of Care With Focus on Discharge

We support patients being given a list of medications, prescriptions, etc. and details about their next scheduled appointment. We have difficulty with the inclusion of a requirement for a "confirmed place to live in a stable environment with support services." In order for patients to meet the Admission Criteria for PHP (intensity of service) as laid out by the Local Coverage Determinations (LCDs) for Partial Hospitalization Services, they must "have an adequate support system to sustain/maintain themselves outside the partial hospitalization program." While a PHP program can reasonably help a patient maintain and enhance this stable environment, it cannot provide it or keep a patient in PHP until it can be established. Patients are at times living in transitional situations while attending partial. If the person's living situation deteriorates to the point that they are no longer able to sustain and maintain themselves and this impacts their illness sufficiently, it might be an indication for hospitalization—since partial is in lieu of acute hospitalization.

Quality Measures / Performance Measures

We have actively supported and partnered in developing quality measures (currently required by CMS) for the hospital level of care for psychiatric patients. We support quality measurement throughout the continuum of care. We suggest beginning to look at the applicability for PHP of select measures approved for public reporting under the Inpatient Psychiatric Facility Quality Reporting (IPF QR) program. With appropriate modification, these measures hold promise for application to PHP programs.

In particular, we suggest that the first emphasis be on two paired sets of measures from the Hospital-Based Inpatient Psychiatric Services (HBIPS) core measure set, HBIPS 4/5 (multiple antipsychotics) and HBIPS 6/7 (continuity of care).

HBIPS 4 requires the identification of patients who are discharged on two or more antipsychotic medications. HBIPS 5 reports the number of patients discharged on multiple antipsychotic medications with appropriate

justification. CMS stated in the 2013 final inpatient rule[1] (CMS-1588-F) that, "We believe that lower rates (of antipsychotic use) are indicative of higher quality of care because reducing the use of multiple antipsychotics reduces the potential risks of harmful side effects to patients." Reducing the number of antipsychotics a person is on cannot always be completed during a brief hospitalization because there is often a need to taper drugs. This process needs to be continued in outpatient treatment. PHP is an appropriate place to continue tapering medication with the goal of decreasing the number of patients who are discharged from partial hospitalization on multiple antipsychotics without appropriate justification.

HBIPS 6 measures whether a post-discharge continuing care plan is created. HBIPS 7 measures whether the post-discharge continuing care plan is transmitted to the next level of care provider. In the 2013 final inpatient rule[2] (CMS-1588-F), CMS states that, "for a seamless transition from one treatment setting to another, providers need to know information regarding the patient's treatment during hospitalization, recommendations for post-discharge care and any medications the patient was discharged on. A discharge plan facilitates this transition of information from one setting to another and has been shown to have positive effects on readmissions." We believe the transmission of relative information is important whenever a patient changes level of care and that communication between the partial hospitalization program and outpatient care is equally important.

Outlier Payments for CMHCs

We have no reason to suggest changing the current approach to designating outlier payments.

RECOMMENDATIONS:

To summarize, **NAPHS recommends** that CMS take the following actions:

- Partial hospitalization is a very important benefit within the continuum of care, but it is only a part of the continuum. We would suggest that any changes to the PHP payment methodology should only be done as part of a broader redesign of the Medicare behavioral health benefit structure.

- We suggest beginning to look at the applicability for PHP of select measures approved for public reporting under the Inpatient Psychiatric Facility Quality Reporting (IPF QR) program, particularly HBIPS 4/5 (multiple antipsychotics) and HBIPS 6/7 (continuity of care).

- No changes should be made to either certification/recertification timelines or to outlier payments for CMHCs.

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,

/s/

Mark Covall
President/CEO

[1] CMS-1588 –F. "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers." Published in the 8/31/12 *Federal Register*. See http://www.gpo.gov/fdsys/pkg/FR-2012-08-31/pdf/2012-19079.pdf.

[2] Ibid.