NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS
ADVOCATING FOR BEHAVIORAL HEALTH
900 17th Street, NW, Suite 420, Washington, DC 20006-2507 | Ph 202/393-6700 | Fx 202/783-6041 | naphs@naphs.org | www.naphs.org

SUBMITTED ELECTRONICALLY: www.regulations.gov

September 2, 2014

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-1613-P: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Physician-Owned Hospitals: Data Sources for Expansion Exception; Physician Certification of Inpatient Hospital Services; Medicare Advantage Organizations and Part D Sponsors: Appeals Process for Overpayments Associated with Submitted Data**
(42 CFR Parts 411, 412, 416, 419, 422, 423, and 424)

***NOTE*:** **Our comments focus on 1) "PARTIAL HOSPITALIZATION CY2015 RATES" and 2) "QUALITY REPORTING"**

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-1613-P) titled "Hospital Outpatient Prospective Payment…." [CY2015 Payment Rates] as published in the July 14, 2014, *Federal Register*.

We are specifically providing comments on 1) the proposed **partial hospitalization** payment rates for CY2015 and 2) proposed **quality reporting**.

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*, half (50.6%) of all NAPHS members responding offered psychiatric partial hospitalization services for their communities, and approximately one-fourth (26.3%) 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.

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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

In the proposed rule, CMS is recommending significant drops in 2015 Medicare rates for both hospital-based and community mental health center (CMHC) partial hospitalization programs. The proposed rates for CY15 (vs. CY14) are as follows:

	2014	2015 (proposed)	% change
HOSPITAL-BASED:			
PHP with 3 services (Level 1)	$190.15	$169.36	-10.9%
PHP with 4 or more services (Level 2)	$213.64	$181.66	-14.9%
COMMUNITY MENTAL HEALTH CENTER:			
PHP with 3 services (Level 1)	$99.04	$93.06	-6.03%
PHP with 4 or more services (Level 2)	$111.73	$109.77	-1.75%

We recognize that CMS is bound by regulatory formulas in setting rates.

However, **we have serious concerns about the unintended impact of proposed CY2015 partial hospitalization rates on Medicare beneficiaries' access to partial hospitalization.**

The payment system for partial hospitalization is unstable, which puts beneficiaries at risk. With rates for this level of care fluctuating widely over time, Medicare beneficiaries are the ones at risk as access to this level of care diminishes when providers respond to an erratic rate structure that does not allow them to forecast financials for their programs. There are many questions that need to be studied (as outlined later in this letter) to determine what factors are fueling the instability in rates. We are committed to working with CMS to better understand and to stabilize the partial hospital benefit so the Medicare beneficiaries with mental and addictive disorders can access the most appropriate services to meet their needs.

To put our comments in context, we would like to highlight several aspects of the proposed rule and provide our response.

CMS IN PROPOSED RULE:

In the proposed rule, CMS notes the following:

> *The CY 2015 proposed geometric mean per diem costs for hospital-based PHPs calculated under the proposed CY 2015 methodology using CY 2013 claims data show more variation when compared to the CY 2014 final geometric mean per diem costs for hospital-based PHPs, with geometric mean per diem costs for Level I hospital-based PHP services decreasing from approximately $191 to approximately $177 for CY 2015, and geometric mean per diem costs for Level II hospital-based PHP services decreasing from approximately $214 to approximately $190 for CY 2015. We understand that having little variation in the PHP per diem payment amounts from one year to the next allows providers to more easily plan their fiscal needs. However,* ***we believe that it is important to base the PHP payment rates on the claims and cost reports submitted by each provider type so these rates accurately reflect the cost information for these providers.***
>
> ***We recognize that several factors may cause a fluctuation in the per diem payment amounts,*** *including direct changes to the PHP APC per diem payment rate (for example, establishing separate APCs and associated per diem payment rates for CMHCs and hospital-based providers based on the provider type's costs), changes to the OPPS (for example, basing the relative payment weights on geometric mean costs), and provider-driven changes (for example, a provider's decision to change its mix of services or to change its charges and clinical practice for some services).*

NAPHS RESPONSE:

As noted in the final rule, CMS recognizes that several factors *could* cause fluctuation in per diem payment amounts. But, in fact, these factors do not apply to the CY15 partial hospitalization calculation.

Establishment of separate APCs and associated per diem payment rates for CMHCs and hospital-based providers based on the provider type's costs has been in place since 2012 and, therefore, should not have an impact on CY15 rates. This factor does not apply.

Associated payment based on CMHC/hospitals has already been separated. This should not be a factor in 2015 hospital-based partial hospitalization rates.

Basing the relative payment weights on geometric mean costs occurred in 2013. This should not affect 2015 rates.

Provider-driven changes (e.g., a change in mix of services, charges, or clinical practice) are not factors, based on data (see attachment). Our members providing partial hospitalization have reported to us no material operational or clinical protocol changes that would support such a drastic reduction in the geometric mean cost per diem. In fact, because of Medicare payment and coverage rules, only certain types of professionals are licensed and qualified to deliver the specific services required as part of a partial hospitalization program. As a result, based on our conversations with our membership, NAPHS has heard of *no change to the personnel* delivering the mix of services.

To better understand the partial hospitalization data on which the CY15 proposed rule is based, NAPHS and the American Hospital Association contracted with Dobson DaVanzo & Associates, LLC, to analyze CMS Medicare data from 2010 to 2013.[1] A copy is attached to these comments.

[1] Dobson DaVanzo & Associates, LLC. Vienna, VA. Analyses conducted for the American Hospital Association and National Association of Psychiatric Health Systems. Included in NAPHS comment letter to CMS September 2, 2014. (Attached)

According to the Dobson DaVanzo & Associates study, **the mix of services has not changed.** See Slide 23.

According to the Dobson DaVanzo & Associates study, there has been **no change in the patient population being served.** Consistently, primary diagnoses in all four partial hospital APCs fall into two categories: episodic mood disorders and schizophrenia. See Slide 16.

As defined by the law, those beneficiaries eligible for partial hospitalization would otherwise be hospitalized if they could not access partial hospitalization. In effect, this group is the same patient population that is seen in inpatient hospitals – only with a different (i.e., lesser) acuity level.

CMS IN PROPOSED RULE:

In the proposed rule, CMS asks the following:

> *We are inviting public comments on what causes PHP costs to fluctuate from year to year*.

NAPHS RESPONSE:

Hospital-based PHP rates have been substantially reduced. It is unclear what is driving the dramatic fluctuation.

However, we know what is *not* driving the change. As noted in the Dobson DaVanzo & Associates study cited above, the factors CMS outlined in the proposed rule as potentially impacting the rate (such as the mix of services provided and the diagnoses of the patients seen) have – based on our analyses (and as described above) – remained constant and would not have created significant cost fluctuations year to year.

There are a myriad of variables that could potentially be factors, and we would be happy to work with CMS to explore these further. Some areas of potential CMS study may include:

- **The major shift of services from CMHCs to hospital-based PHPs.**
- **A different mix of providers within the hospital category.** This may be occurring because of the high demand for (and limited availability of) psychiatric services.
- **Other types of hospitals (such as rehabilitation or long-term care hospitals) newly offering partial hospitalization.**
- **Volume.**
- **The size of hospitals and the size of partial hospital programs.**

More research needs to be done.

But in the meantime, we need to protect the PHP benefit while that research is ongoing.

As CMS noted in the RY2008 final rule and in other regulations:

> *While the guidelines have allowed a minimum of three services per day, this was intended to be a floor, not the norm.*

In other words, CMS intent has been to focus in on the PHPs that are meeting the highest acuity needs of Medicare patients and to find ways to make sure that these programs can continue to meet their critical needs.

Congressional intent is also to have an intensive benefit. As authorized by Congress, Medicare beneficiaries eligible for PHP are individuals who would require inpatient psychiatric care in the absence of partial hospitalization. Moreover, CMS in subsequent interpretive guidelines and program memorandum have stated that partial hospitalization programs are designed to treat patients who exhibit

severe or disabling conditions related to an acute psychiatric condition or an exacerbation of a severe and persistent mental disorder. CMS also has stated that partial hospitalization may occur in lieu of either admission to an inpatient hospital or a continued inpatient hospitalization. At the time of admission, and regularly thereafter, a physician must certify that the patient admitted to the partial hospitalization program would require inpatient hospitalization if the PHP services were not provided. Clearly, the intent was to provide a highly structured, clinically intensive PHP for patients who either were stepping down from hospital care or were using PHP as a diversion from hospital care.

Yet the disruption to this critical benefit in recent years has been dramatic as evidenced by the significant decline in PHP services over multiple years.

Over a four-year period, there has been a 60.2% decline in total PHP days of service (using claims data from 2010, 2011, 2012, and 2013. Total partial hospitalization days of service went from 1,664,000 in 2010 to only 661,000 by 2013. See Slide 9.

During this period, the number of CMHCs offering Medicare partial hospital services declined from 203 in 2010 to 77 in 2013. See Slide 15.

In this environment, unpredictability in rates is a great concern to providers of PHP services. It is not only the steep decline in rates in 2014 and in 2015 that is a concern, but the significant fluctuation in rates from year to year over time is also a problem. As a provider organization, if you can't reasonably predict what the rate will be, you are less likely to continue the service in order to ensure fiscal viability.

CMHC PHP days of service plummeted 89% during the same period (going from 1,326,000 days of service in 2010 to only 145,000 days by 2013.) Although not specifically addressed in the Dobson study, we believe that the steep decline in CMHC PHP volume has resulted from increased CMS scrutiny of CMHC activities and payments, as well as the decrease in Medicare reimbursement for CMHC PHP services.

While total partial hospitalization days of service have dramatically declined (with days cut by nearly 60%), **hospital-based PHP days of service increased by 52.2%** between 2010 and 2013 (from 339,000 in 2010 to 516,000 by 2013), helping to offset part of the major decline in CMHC services. Hospital-based days have leveled off (from 534,000 in 2012 to 516,000 in 2013) as reimbursement rates have continued to decline. See Slide 10.

Most of the hospital-based increase between 2010 and 2013 was in PHP programs offering four or more services. See Slide 11.

CMS has clearly – and repeatedly – stated its intent to focus on PHPs that meet the highest acuity needs of Medicare beneficiaries. As CMS noted in the RY2008 final rule and in other regulations:

> *While the guidelines have allowed a minimum of three services per day, this was intended to be a floor, not the norm.*

Hospital-based programs have not only maintained – but expanded – their programs to respond to Medicare beneficiaries' need for partial hospitalization that serve the higher acuity level (as CMS urged). Hospitals have had a long-term commitment to delivering partial hospitalization programs. Hospital-based programs have historically and continue to be geographically distributed across the states.[2,3]

Yet – in direct correlation to the decrease in partial hospitalization rates – access to hospital-based services is also leveling off. The total number of hospital-based days is down (from 534,000 in 2012 to 516,000 in 2013). With an additional 15% cut proposed for hospital-based programs offering four or more

[2] Dobson DaVanzo & Associates, LLC. Vienna, VA. Analyses conducted for the American Hospital Association and National Association of Psychiatric Health Systems. Included in NAPHS comment letter to CMS September 2, 2014. (Attached)

[3] Wellington Group (Rossiter, D) analyses of three years of data (including data from 2003, 2004, and 2006). Conducted for the American Hospital Association and National Association of Psychiatric Health Systems. Included in NAPHS comment letter to CMS on August 26, 2009.

services (the most intensive PHP level), programs are no longer likely to be paid their costs, creating a significant fiscal viability issue.

CMS IN PROPOSED RULE:

In the proposed rule, CMS asks the following:

> *The proposed CY2015 geometric mean per diem costs for the CMHC and hospital-based PHP APCs are shown in Table 44 of this proposed rule. We are inviting public comments on these proposals.*

NAPHS RESPONSE:

As CMS has stated in the proposed rule:

> *…we believe that it is important to base the PHP payment rates on the claims and cost reports submitted by each provider type so these rates accurately reflect the cost information for these providers.*

Yet, according to the Dobson DaVanzo & Associates analysis conducted for NAPHS and AHA, the change between the geometric mean and the proposed payment rate is the highest difference in the last four years. The percent difference between the payment rate and geometric mean cost was 0% in CY2012; -2.8% in CY2013; -0.4% in CY2014; and is proposed to be -4.5% in CY2015. See Slide 8.

Almost one-third of the overall proposed CY15 partial hospital rate cut can be explained by the proposed -4.5% adjustment for PHPs in CY15.
We recognize that this adjustment is a way to calibrate all the various APCs so that the overall hospital OPPS is budget neutral. This budget adjustment for the entire APC structure has a disproportionate impact on PHPs because these beneficiaries have no alternative service available other than hospital care, which is more costly and may not be appropriate (when partial is available).

The -4.5% geometric mean reduction has nothing to do with hospitals' actual PHP costs.

CMS has the authority and flexibility to consider a variety of approaches to ensure fairness and access. In the past, for example, CMS decided to break out hospital-based and CMHC programs because of major differences in cost structures, thereby establishing different rates for different groups. Historically, the hospital OPPS was based on median costs, but CMS changed to a geometric mean, thereby changing how the rate is calculated.

CMS has the ability to make adjustments to try to perfect the rate so that it more accurately reflects overall average costs.

NAPHS recommends that – at a minimum – CMS freeze PHP rates at the CY14 level so that rates in CY15 will more closely reflect what costs are.

CMS IN PROPOSED RULE:

In the proposed rule, CMS states:

> [In the CY2011 PPS final rule]: *We also were concerned that paying hospital-based PHPs at a lower rate than their cost structure reflects could lead to hospital PHP closures and possible access problems for Medicare beneficiaries because hospital-based PHPs are located throughout the country and, therefore, offer the widest access to PHP services.*

NAPHS RESPONSE:

We believe that historic trends and proposed further cuts in CY15 rates pose a broad access challenge for Medicare beneficiaries.

In recent years, as partial hospitalization program visits have declined precipitously overall (see data above), Medicare beneficiaries face a significant access issue because they do not have alternative sites for services. When partial hospitalization is not available, the only alternatives may be more costly hospitalization or outpatient care (that – by Medicare's own partial hospitalization definition[4] – are insufficient for their needs). This can lead to higher costs or rehospitalizations.

Lack of access to partial hospitalization creates a major disequilibrium in the system. We don't have a range of services in Medicare in these less intensive levels. Partial hospital programs prevent hospitalization, but without PHP these patients' illnesses will become more acute, leading to hospitalization and/or ED visits. Our experience indicates that the decline in partial hospitalization means either that people are not getting services at all, or people are instead going to emergency departments (EDs) which have seen an increase in behavioral health visits. EDs are reporting problems with boarding of psychiatric patients (when no beds – or no alternative such as partial hospitalization – are available) and longer wait times for all ED services.[5]

Wide variability in partial hospitalization rates from year-to-year does not allow quality providers to plan for and to maintain services in any predictable way. When rates go down, fewer organizations participate in delivering partial hospitalization.

While declining payment rates are a mathematical issue, the impact on access to care is a major clinical concern.

It is time for CMS to take a comprehensive look at the overall mental health system – and the critical role of partial hospitalization within that system – for Medicare beneficiaries. It is not enough to look at individual levels of care in a vacuum.

Nationwide the demand for all types of behavioral health services has been outstripping the capacity. According to The Treatment Advocacy Center[6] report titled "No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals," the number of state psychiatric beds decreased by 14% from 2005 to 2010 (from 50,509 state psychiatric beds in 2005 to 43,318 in 2010). The per capita state psychiatric bed population by 2010 plunged to 1850 levels. "In 1850, at the beginning of the movement to provide more humane care by treating seriously mentally ill persons in hospitals, there were 14 beds per 100,000 population. In 2010, the supply was virtually identical at 14.1." Thirteen states closed 25% or more of their total state hospital beds from 2005 to 2010. New Mexico and Minnesota closed more than 50% of their beds; Michigan and North Carolina closed just less than 50%. Completed or announced bed eliminations *since* 2010 will eliminate 4,471 additional beds.

Jails are becoming de facto treatment sites, according to research by The Treatment Advocacy Center.[7] When appropriate services are unavailable, some may find themselves on the streets or worse.

Medicare beneficiaries as a group have significant and complex mental health, substance use, and medical conditions – particularly those that are dually eligible for Medicare and Medicaid.

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[4] Partial hospitalization Local Coverage Determination. "Psychiatric partial hospitalization is a distinct and organized intensive psychiatric outpatient treatment of less than 2 hours of daily care, designed to provide patients with profound or disabling mental health conditions an individualized, coordinated, intensive, comprehensive, and multidisciplinary treatment program not provided in an regular outpatient setting.

[5] Urgent Matters Policy Brief. "Volume 1, Issue 2: Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions." The George Washington University School of Medicine & Health Sciences. June 2014. See http://smhs.gwu.edu/urgentmatters/sites/urgentmatters/files/Psychiatric%20Boarding%20in%20U.S.%20EDs%20A%20Multifactorial%20Problem%20that%20Requires%20Multidisciplinary%20Solutions.pdf.

[6] Treatment Advocacy Center. "No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals." July 19, 2012. See http://tacreports.org/bed-study.

[7] Treatment Advocacy Center. "More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States." May 2010. See http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.

According to the Medicare Payment Advisory Commission (MedPAC)[8] [9], more than nine million Americans are enrolled in both the Medicare and Medicaid programs ("dual eligible"). Two-thirds of dual-eligible beneficiaries are low-income and elderly, and one-third are younger than 65 and are disabled. **Mental disorders disproportionately affect the dual-eligible population.** Dual eligibles are more likely to have cognitive impairment and mental disorders than non-dual eligibles. In addition, more than half of dual eligibles who are under the age of 65 and eligible due to a disability have mental or cognitive impairments. According to the Kaiser Commission on Medicaid (Fact Sheet: Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries, May 2011), people dually eligible for both Medicare and Medicaid (Medicare-Medicaid enrollees) are among the sickest, most vulnerable individuals covered by these programs. They often have complex, chronic illnesses, as evidenced by the fact that half are in fair or poor health, more than twice the rate of others on Medicare. They also have very low incomes (55% have annual incomes below $10,000 vs. 6% for the rest of the Medicare population). The nine million dual eligibles – and especially those with serious mental and /or addictive disorders – need to have access to and coverage for a coordinated and integrated set of services, from acute inpatient care, to outpatient care, to long-term supports. Partial hospitalization is a critical part of the continuum of services needed by this Medicare population.

Among Medicare beneficiaries using the partial hospitalization benefit, two primary diagnoses predominated in all four APCs for partial hospitalization: episodic mood disorders and schizophrenia, according to Dobson DaVanzo & Associates. See Slide 16.

Medicare is a safety net for some of the nation's most vulnerable individuals, and Medicare policy should focus on the critical role of partial hospitalization as part of the continuum of care that is necessary to support its beneficiaries.

This is not the time to jeopardize the progress the Administration and the nation are making to institute system-wide changes (such as parity, the *Affordable Care Act*, and Medicaid expansion).

NAPHS Recommendation:

Partial hospitalization is a covered service under Medicare that is now diminishing – creating an access problem for beneficiaries.

We recommend that CMS freeze rates at current levels.

Because we have never seen this much instability in the industry – to ensure continued beneficiary access to hospital-based PHP services – **we recommend that CMS set the payment rates for CY2015 at the CY2014 rate.** We believe that this will help to stabilize access to these critical services and give CMS sufficient time to assess the implications for access to care and determine whether any changes (legislative or regulatory) need to be made to the PHP.

Instability is creating difficulties predicting payment rates, resulting in providers being less willing and able to keep providing this service. Without CMS finding ways to better stabilize the rates, the spiral we have been experiencing will continue and access to this critical service will continue to be dramatically diminished.

"QUALITY REPORTING" COMMENTS

NAPHS has been a leader in quality measurement. With our partners in both the public and private sectors, NAPHS played a major role, for example, in developing hospital-based inpatient psychiatric services (HBIPS) measures that are now part of the hospital accreditation process and the CMS quality

[8] Medicare Payment Advisory Commission (MedPAC). Chapter 3: "Dual Eligible Beneficiaries: An Overview." June 2004. See http://www.medpac.gov/publications%5Ccongressional_reports%5CJune04_ch3.pdf.

[9] Medicare Payment Advisory Commission (MedPAC) DataBook: Beneficiaries Dually Eligible for Medicare and Medicaid." December 2013. See http://www.medpac.gov/documents/Dec13_Duals_DataBook.pdf

reporting requirements. These hospital measures, which have been broadly supported by stakeholders and proven to provide actionable data for improving direct patient care, were developed and tested over a decade. We are committed to accountability and quality improvement, and we want to work with CMS (and all others) on this important step within the hospital outpatient PPS benefit.

However, we believe discussion of imposing quality measure reporting on partial hospitalization and within the hospital OPPS is premature.

Below we respond to your specific questions.

CMS REQUEST:

In the proposed rule, CMS specifically requests public comment on three partial hospital program (PHP) measures submitted to the MAP for consideration as part of the ''MAP Pre-Rulemaking Report: 2014 Recommendations on Measures for More than 20 Federal Programs'' (*http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx* (formerly referred to as the ''List of Measures Under Consideration'')):

- **30-Day Readmission;**
- **Group Therapy;** and
- **No Individual Therapy**.

These measures are included in the Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) developed under the Comprehensive Error Rate Testing (CERT) Program claims-based measures.

NAPHS RESPONSE:

As we have outlined in our comments related to the proposed partial hospitalization rates for CY15, the partial hospitalization benefit is under threat (with closures of programs as rates continue to plummet and significant access issues for beneficiaries).

This is not the time to impose quality measures on partial hospitalization. If CMS does anything, we suggest that CMS do more work to understand what is depressing the partial hospitalization rates below costs, where patients are going when partial hospitalization is not available (Are they receiving no care? Are they hospitalized? Are they in EDs?).

Far more study is needed to understand which measures are relevant to partial hospitalization. For example, PEPPER target areas (30-Day Readmission; Group Therapy; and No Individual Therapy) were developed as *auditing tools* – not as quality measures. Their purpose was to "summarize Medicare claims data statistics for individual PHPs in areas that may be at risk for improper Medicare payments." PEPPER compares a PHP's Medicare claims data statistics with aggregate Medicare data for the nation, Medicare Administrative Contractor (MAC) jurisdiction, and the state. They are, according to the PEPPER program, "not intended to direct PHPs how to administer their programs or how they deliver patient care." Also, "The PHP PEPPER is not intended to set a standard for services provided to a Medicare beneficiary."

We are unaware of any research to suggest a "right mix" between individual and group therapy in partial hospitalization. Quality measures should be based on research aimed at improving patient care and should not be based on utilization data. They should be specified and tested in clinical settings with the support of the field. Reporting data to the public on areas that have not been developed as measures of quality is not consistent with the goals of informed decision-making and quality improvement

Readmission is a measure that addresses a course of treatment, which ultimately requires a look beyond a single setting. Partial hospitalization is a subset (only one of many types of outpatient treatment). The current data being collected for the PEPPER target area on readmission is a count of all index (first) episodes of care ending in the report period for which a resumption of care occurred within 30 days to the same or to another partial hospitalization program. Given the challenges facing the delivery of partial hospitalization services in the current environment, we need to better understand the patterns of readmission from a clinical perspective before we apply this as a measure of quality for PHP programs.

We recommend that no measures be imposed at this time on partial hospitalization.

We recommend that CMS stop to look at the issues related to the partial hospitalization benefit overall in a more comprehensive way – or else it will be too late (as providers cannot afford to sustain this essential level of care). Imposing any kind of payment reduction for PHP programs that fail to meet Outpatient Quality Reporting (OQR) requirements would further destabilize the PHP rate and the inherent threats to access. We offer to work with you and others to identify and develop appropriate measures for PHP quality reporting.

CMS REQUEST:

CMS also requests public input on **other possible quality measures for partial hospitalization services for inclusion in the Hospital OQR Program in future years**.

NAPHS RESPONSE:

It is premature to impose additional quality measures.

As stated above, far more work needs to be done to identify, define, test, and educate providers on the use of measures that can ultimately improve patient care in the partial hospital setting.

CMS REQUEST:

In addition to PHP measures, CMS states that it is considering **other measures specific to behavioral health in the outpatient setting, including measures addressing depression and alcohol abuse.** "Because of the prevalence of depression and alcohol abuse and their impact on the Medicare population," says the proposed rule, "we believe that we should consider measures in these and other behavioral health areas for use in future Hospital OQR Program payment determination years. Therefore, we invite public comment on measures applicable to these areas that would be suitable for the Hospital OQR Program."

NAPHS RESPONSE:

It is premature to impose behavioral health quality measures throughout the hospital OPPS.

As stated above, far more work needs to be done to identify, define, test, and educate providers on the use of behavioral health measures that can ultimately improve patient care in the hospital outpatient setting.

SUMMARY OF RECOMMENDATIONS:

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

- Freeze partial hospitalization rates at the CY2014 level until CMS can better explain the fluctuations in the geometric mean costs of PHP providers.
- We recommend that CMS stop to look at the issues related to the partial hospitalization benefit overall in a more comprehensive way – or else it will be too late (as providers cannot afford to sustain this essential level of care).
- We recommend that no action be taken on quality measures at this time.

CONCLUSION

The payment system for partial hospitalization is unstable. With rates for this level of care fluctuating widely over time, Medicare beneficiaries are the ones at risk as access to this level of care diminishes when providers respond to an erratic rate structure that does not allow them to forecast financials for their

programs. There are many questions that need to be studied (as outlined in this letter) to determine what factors are fueling the instability in rates.

We are committed to working with CMS to better understand and to stabilize the partial hospital benefit so the Medicare beneficiaries with mental and addictive disorders can access the most appropriate services to meet their needs.

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

ATTACHMENT: Dobson DaVanzo & Associates report ("An Analysis of CY2015 Notice of Proposed Rule Making for Partial Hospitalization")