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ADVOCATING FOR BEHAVIORAL HEALTH
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August 31, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1633-P: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Short Inpatient Hospital Stays; Transition for Certain Medicare-Dependent, Small Rural Hospitals Under the Hospital Inpatient Prospective Payment System

***NOTE*: Our comments focus on "PARTIAL HOSPITALIZATION CY2016 RATES"**

Dear Acting Administrator Slavitt,

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-1633-P) titled "Hospital Outpatient Prospective Payment…." [CY2015 Payment Rates] as published in the July 8, 2015, *Federal Register*.

We are specifically providing comments on the proposed **partial hospitalization** payment rates for CY2016.

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 800 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*, nearly half (45.6%) of all NAPHS members responding offered psychiatric partial hospitalization services for their communities, and approximately one-third (33.2%) 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 report on *Medicare Psychiatric Patients & Readmissions in the Inpatient Psychiatric Facility Prospective Payment System*, The Moran Company noted that some patients received partial hospitalization services following an inpatient psychiatric facility (IPF) stay. According to their analysis, time to readmission for these Medicare beneficiaries was 131 days (vs. 59 days for those who did not participate in PHP programs between admissions).

However, in recent years, the payment system for partial hospitalization has been 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.

"OPPS: PARTIAL HOSPITALIZATION" COMMENTS

NAPHS appreciates the extensive analysis CMS did of the claims and cost data from the 2014 calendar year claims. This work included provider service usage, coding practices, and the ratesetting methodology.

To help NAPHS develop our comments for this proposed rule, we engaged the firm Dobson/Davanzo to review the CMS cost and claims data as well as the methodology to calculate the payment rates. The Dobson/Davanzo analysis focused on three goals:

- To validate the payment rates CMS published in the NPRM by replicating their cost calculation with the 2014 claims data
- To determine the impact of the CMS trimming methodology upon payment rates
- To explore the utilization patterns within the claims

The Dobson/Davanzo study included the following findings:

Payment rates published in the proposed rule are consistent with the geometric mean of the costs found in the database using the CMS methodology.

The "trimming" methodology used by CMS identified several providers with outlier data. These providers comprised roughly 5 percent of charges and 50 percent of untrimmed costs, and have cost-to-charge ratios that appear to be unreasonable.

Overall, service utilization seems to have stabilized in both the Community Mental Health Centers (CMHCs) and the Psychiatric Hospitals (PHPs) after several years of decrease.

The distribution of primary diagnoses also seems to be fairly consistent with the exception of a slight increase in the proportion of schizophrenic disorders in the CMHCs.

Based on these findings we agree with CMS that the "trimming" methodology removes some of the aberrant data reported by a few providers.

We support the CMS plan to reduce or eliminate the impact of including aberrant data received from a few CMHCs and hospital-based providers by using a +2 standard deviation trim for CMHCs and excluding hospital-based PHP services where the cost-to-charge (CCR) is greater than five. **We think this methodology will meet our overarching goal of mitigating inappropriate fluctuations in the payment rates.**

We support the CMS recommendation that CMHCs and hospital-based PHPs review their accounting and billing processes to ensure that they are following these procedures with the goal of obtaining greater accuracy in setting the PHP rates. NAPHS will work with its members to this end.

We note that the utilization of PHP services seems to be stabilizing in both CMHC and hospital-based programs. This had not been the case for many years and we thank CMS for the work it has done in its payment policies to address the historic instability in partial hospitalization rates.

Going forward NAPHS pledges to continue to work with CMS to ensure that the payment rates are adequate to meet the needs of the Medicare beneficiaries, and that these rates remain stable over time.

NAPHS recommends that CMS take the following actions:

- Implement the proposed trimming methodology and monitor its effect on access to this level of care by Medicare beneficiaries and to continue to review the trimming methodology each year to ensure that payment rates remain adequate and predictable.

CONCLUSION

In recent years, the payment system for partial hospitalization has been 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. We believe that the proposed "trimming" changes included in this rule is an important step in responding to the unstable rate structure over the past several years.

We are committed to working with CMS to track and continue 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