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August 31, 2016

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-1656-P: "Medicare Program: Hospital Outpatient Prospective Payment** and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; … Payment to Certain Off-Campus Outpatient Departments of a Provider; etc." **RIN 0938–AS82 (42 CFR Parts 416, 419, 482, 486, 488, and 495).** Proposed rule in 7.14.16 *Federal Register*.

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 Centers for Medicare and Medicaid Services' (CMS') proposed implementation of § 603 of the Bipartisan Budget Act, Social Security Act § 1833(t)(1)(B)(v); (t)(21).[1] To summarize our comments, we are urging that CMS adopt a clear policy that the provisions of § 603 and CMS' implementing regulations do not apply to partial hospitalization programs (PHPs), including PHPs that may open after November 2, 2015 (non-excepted PHPs). Absent such an exemption, CMS risks placing a moratorium on new PHP programs, which have no comparable "physician office" service and are a critical and cost-effective level of care for Medicare beneficiaries living with mental illness. As we will explain in greater detail in this letter, we believe that there are sound policy reasons for our position. We also believe that CMS has the clear legal authority to adopt this policy and, in fact, is obligated to adopt this policy.

Background on 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

[1] 81 Fed. Reg. 45,604, 45,681-91 (July 14, 2016).

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*, about one-third (31.8%) of all NAPHS members responding offered psychiatric partial hospitalization services for their communities, and more than 20% (20.5%) 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, for a very vulnerable population, an important intermediate service between outpatient, office-based visits and inpatient psychiatric care. It remains a critical, cost-effective level of care for persons living with mental illnesses.

Patients who meet the admission criteria for partial hospitalization services are in need of an intensive, highly structured day of therapeutic services. They receive at least three and usually four or more interdisciplinary professional services (either individual or group sessions) individualized to meet the goals of their specific treatment plan. The therapies are designed to provide a highly integrated approach to treatment, with each intervention supporting the overall needs of the individual patient. Patients typically attend the program four to five days a week for an episode of care that averages about 12 treatment days.

Policy Request

We respectfully request that CMS clarify that partial hospitalization programs (PHPs), including PHPs that may open after November 2, 2015, are exempt from the application of § 603. As we explain below, there is a clear policy rationale for our request, and CMS has a clear legal basis to grant it.

Policy Rationale

In describing the implementation of § 603 in the proposed rule, CMS begins by noting "the increased trend toward hospital acquisition of physician practices, integration of those practices as a department of a hospital, and the resultant increase in the delivery of physician's services in a hospital setting."[2] CMS notes that under these arrangements, "the total payment amount for

[2] *Id*. at 45,681.

the services made by Medicare is generally higher" than when services are provided in a physician's office.[3] Clearly, the intent of the site-neutral payment policy is for Medicare to not pay more for the same service based on the type of setting. However, with respect to PHPs, there is no comparable service provided in a physician office or any other setting. Also, there is no other appropriate payment mechanism other than the OPPS for this service. Absent a carve-out in the final rule for PHPs from § 603, we are gravely concerned that the final regulation will have the unintended consequence of undermining a statutory Medicare benefit that has been effective in reducing hospitalization and lowering the overall cost of caring for Medicare beneficiaries living with mental illnesses.

CMS acknowledges that the proposed rule would effectively end the existing PHP billing model as we know it, but the proposed solution is for non-excepted off-campus PHPs to enroll and bill as Community Mental Health Centers (CMHC) under OPPS.[4] As CMS is aware, CMHCs require separate certification, operate under separate conditions of conditions of participation, and operate in a way that is distinctly different from an off-campus provider-based department. There are also distinct advantages offered by hospital-based PHPs (over CMHC PHPs) which CMS itself has identified. According to a report commissioned by CMS, hospital-based PHPs (1) offer better continuity of care to patients who have been discharged from an inpatient unit from the same provider; (2) are better at information sharing; (3) typically have easier access to more support staff, nutritionists, nurses, and psychiatrists; and (4) have the "obvious" advantage in timely and safe re-admission to an inpatient unit.[5] In other words, the proposed solution -- that these entities transition to a different provider type -- ignores both the inherent structure of hospital-based PHPs, as well as their inherent benefits.

Rather than crafting a new payment system for hospital-based PHPs (or rather than forcing hospital-based PHPs into a payment system that was not designed for that purpose), we strongly believe that public policy necessitates excluding hospital-based PHPs from § 603 and any final regulations, so as to permit new, non-excepted PHPs to bill under OPPS.

First, as discussed above, there is no "physician-based" alternative to PHPs. Indeed, the very point of the PHP benefit is to serve as an intermediate service between outpatient, physician-based visits and inpatient psychiatric care. Thus, by definition, PHP services are not and cannot be physician office-based services. So, too, CMHC-based PHPs are designed to address a unique community need and operate under their own conditions of participation, and are separate and distinct from the hospital-based PHP benefit.

Second, rather than generating cost-savings, application of § 603 to PHPs would result in cost growth. The regulations specifically state that the physician must certify that the patient admitted to the partial hospitalization program "would require inpatient psychiatric hospitalization if the partial hospitalization services were not provided."[6] Without partial hospitalization as an option,

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[3] *Id*.

[4] *Id*. at 45,690.

[5] Leung M, Drozd E, Maile J, "Impacts Associated with the Medicare Psychiatric PPS: A Study of Partial Hospitalization Programs," Prepared for CMS by RTI International (February 2009).

[6] 42 C.F.R. § 424.24(e).

one could imagine even more patients in overcrowded emergency departments.[7] There is much evidence that emergency department care is an inefficient and very expensive way to care for patients experiencing a mental health crisis. Moreover, 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. 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 inpatient psychiatric facility (IPF) services through a partial hospitalization program.[8] 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.

We are confident, to the extent that Congress was attempting to curtail wasteful program expenditures in enacting § 603, those concerns were not presented by hospital-based PHP billing.

Legal Rationale

While we do not believe Congress ever intended for § 603 to apply to the PHP benefit, even if a strict interpretation of the statute were to include PHPs, CMS would still have the legal authority to adopt our request through its broad equitable adjustment authority in § 1833(t)(2)(E). This subparagraph permits CMS to "establish … other adjustments as determined to be necessary to ensure equitable payments." We respectfully submit that permitting hospital-based PHPs (existing and new) to bill under HOPPS is an adjustment "necessary to ensure equitable payments" under HOPPS, especially given the critical and cost-effective care provided by hospital-based PHPs.[9]

CMS has in the past used this authority to make similar adjustments where failure to make a change would result in a negative impact for both beneficiaries and the program as a whole. For example, as recently as the FY 2016 HOPPS final rule, CMS utilized its authority at § 1833(t)(2)(E) to impact the ways it pays hospital-based PHPs so that it was not paying less for Level 2 days, than it was for Level 1 days.[10] CMS' use of this authority has also been much more broad, particularly in cases where the agency seeks to redirect resources that are in the best

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[7] *See* Joint Commission, "Alleviating ED boarding of psychiatric patients," Quick Safety Issue 19 (Dec. 2015) (noting that "the dramatic rise in emergency patients with chronic psychiatric conditions is a national crisis"). *See also* Abid Z., *et al*, "Psychiatric Boarding in U.S. EDs: A multifactorial problem that requires multidisciplinary solutions", George Washington University Urgent Matters Policy Brief (noting the need for additional sources of outpatient mental health services in the community) (June, 2014).

[8] "Medicare Psychiatric Patients & Readmissions in the Inpatient Psychiatric Facility Prospective Payment System," Prepared for NAPHS by The Moran Company (May 2013).

[9] We would also note that such an adjustment is shielded from judicial review under Social Security Act § 1833(t)(12)(A). *See also* Amgen v. Smith, 357 F.3d 103 (2004).

[10] 80 Fed. Reg. 70,298, 70,459 (November 13, 2015).

interest of Medicare beneficiaries and high quality care. For example, in the FY 2007 HOPPS final rule, CMS used this authority to take its first step toward value-based purchasing in OPPS, citing § 1833(t)(2)(E) as the basis for varying payment based on quality.[11] So too, here, should CMS use this broad authority to exempt hospital-based PHPs from § 603 to ensure that this critical and cost-effective benefit is not phased out.

PHP Payment Rate

NAPHS is very concerned about the dramatic and unexplainable significant decrease in the median cost calculated by CMS to be used as the basis for the 2017 PHP APC payment rate. As we noted earlier in this comment letter, NAPHS advocates for 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 and is comprised of both large multi-behavioral health systems and standalone freestanding psychiatric hospitals that operate PHP programs.

In response to the CMS proposed PHP rate decrease in 2017, NAPHS members were queried to provide any qualitative and/or empirical reasons that they have encountered in their respective organizations that would have driven the median PHP cost down by 13% over the prior year. In general, our membership was not able to provide any substantive justification for such a significant cost decrease in the PHP median cost.

As members have developed recent past financial forecasts and operating budgets for their respective PHP programs, the cost of operating a PHP continues to increase. Labor costs are one of the largest cost drivers of the PHP program and those costs have increased at a minimum of at least 2% to 3% per year. While we understand that other factors will contribute to a change in the median PHP cost, our members have not seen the cost decrease that CMS is using as the basis for 2017 PHP rate setting.

While we have no direct evidence of any cost report anomalies, we do believe that the lack of a required standardized Partial Hospitalization Program cost center on the Medicare cost report may be creating some cost finding nuances in the cost report itself (e.g., inaccurate stepdown of overhead cost allocations to the PHP program, diluted cost to charge ratios by the commingling of PHP and outpatient psychiatric services on the cost report, etc.) may have contributed to this decreased PHP median cost. As such, the cost decrease may not be a "real" cost decrease, but rather just a Medicare cost-accounting-driven decrease.

In light on this unexplained median cost decrease and the potential impact it could have on the continued financial viability of such a critical and cost-effective Medicare program benefit, NAPHS recommends that CMS use the median PHP cost from the 2016 rate year as the basis for the 2017 rate year.

If this freeze of the median cost is not acceptable to CMS, then NAPHS recommends a median cost phase-in of at least three years to allow PHP providers to assess their respective PHP programs and make operational changes as they deem appropriate to keep the programs in service.

[11] 71 Fed. Reg. 67,960, 68,190 (November 24, 2006).

Other Issues: Relocation and Rebuilding of Excepted Outpatient Sites

In this comment letter we have asked that Partial Hospitalization Programs be exempted from the provisions of the BiBA for the reasons listed above. The comments below relate to the non-PHP outpatient services provided in HOPDs.

NAPHS recommends that CMS recognize situations when relocation of HOPDs is essential and should not trigger payment cuts for facilities operating before or after the BiBA enactment date (November 2, 2015). Examples of such situations (not intended to be an exhaustive list) are things such as:

- Any situation in which the current building is determined to be unsafe.

- Relocation of a facility that has been destroyed or damaged by a natural or man-made disaster such as a fire, hurricane, flood, tornado, etc.

  A current example is the hospital-based outpatient providers that are in "limbo" after the August 2016 Louisiana floods. We have member-organizations that will never be able to return to their current locations (both hospitals and HOPDs) because of buildings that cannot be salvaged. Moving vital services will result in their losing their excepted status. They know beneficiaries need services yet hesitate to commit to an unknown payment model.

- Relocating because a provider ended or lost its lease. We have heard from members who can move to more clinically suitable, geographically appropriate, and cost-effective space yet will lose excepted status if they do so. We have also been told by members that negotiating new leases will be more difficult if the owner knows moving puts the provider at payment risk and has little alternative but to stay—at any cost.

- Psychiatric outpatient services are often located in rural and underserved locations. Providers being restricted in establishing, expanding, or relocating services based on changing population needs potentially decreases beneficiary access and puts provider stability at risk.

These are situations that must be dealt with in a timely, efficient way without lengthy approval processes. We recommend that organizations be required to notify CMS that they meet one of the approved exceptions (with regional offices being able to act on other exceptions) through the established mechanisms they use to update their enrollment information.

We also note with concern that PHPs are wholly omitted from the listing of clinical families in Table 21 of the Proposed Rule. Unless CMS revises the listing of clinical families to include PHPs or does away with the notion of clinical families and non-excepted items and services, CMS' proposal could essentially eliminate all off-campus PHPs. Even excepted PHPs that had been fully operational prior to November 2, 2015, would be considered "non-excepted" services under the Proposed Rule, forcing hospitals to relocate PHPs from their community-based locations to the main hospital campus, to cease operating them as PBDs and re-enroll them as CMHCs, or to terminate off-campus PHPs altogether.

Conclusion

In conclusion, we respectfully urge CMS to clarify that non-excepted hospital-based PHPs will continue to retain provider-based status and be permitted to continue to bill under HOPPS after January 1, 2017. We believe that there are sound policy and legal justifications for our request.

If, despite the clear policy reasons and legal justifications provided in this letter, CMS believes it is unable to grant the relief sought, we would urge CMS to delay the effective date of these regulations until the agency is able to create and implement a payment system that adequately reimburses and captures the services provided by hospital-based PHPs. We believe there is no way the field could produce the data that is required within the timeframe given in the proposed rule and no way to set up the reporting mechanism. The delivery system would be placed in an impossible situation.

Should you have any questions, please feel free to contact me at 202-393-6700, ext. 100, or our counsel on this matter, Thomas R. Barker of Foley Hoag, LLP, at 202-261-7310.

Sincerely,

/s/

Mark Covall
President/CEO