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December 22, 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–FC** and **CMS-1656-IFC:** Final rule with comment period & interim final rule with comment period: "**Medicare Program: Hospital Outpatient Prospective Payment** and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; …..Electronic Health Record (EHR) Incentive Programs; Payment to Nonexcepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing (VBP) Program; Establishment of Payment Rates Under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital" **RIN 0938–AS82 (42 CFR Parts 414, 416, 419, 482, 486, 488, and 495)**

NOTE: **Our comments focus on CY2017 PARTIAL HOSPITALIZATION** and the **20-HOUR/WEEK MINIMUM REQUIREMENT FOR PARTIAL HOSPITALIZATION SERVICES**

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') final rule with comment period (CMS-1656-FC) and interim final rule with comment period (CMS-1656-IFC) on the "Medicare Program: Hospital Outpatient Prospective Payment…System" as published in the November 14, 2016, *Federal Register.*

Please note that our comments focus on 1) CY2017 partial hospitalization and 2) the 20-hour-a-week minimum requirement for partial hospitalization 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 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.

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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 COMMENTS ON PARTIAL HOSPITALIZATION

In the Medicare Program: Hospital Outpatient Prospective (OPPS) Rule, CMS asked for comment on several specific areas. Our comments, which are specific to partial hospitalization, are outlined below.

20-hour-a-week requirement for partial hospitalization.

We acknowledge the partial hospitalization program (PHP) requirement that patients must be able to cognitively and emotionally participate in the active treatment process and to tolerate the intensity of a PHP program. We acknowledge that these patients require an intensive level of services of at least 20 hours per week **as evidenced in their plan of care.** We acknowledge that PHP is not an appropriate program for patients who need less intensive mental health services.

However, we also know through extensive experience that appropriately certified patients – with high levels of commitment to the program, with intensive and individualized plans of care, and with demonstrated clinical progress – are occasionally not able to fully participate in the weekly requirement of 20 hours of service for many reasons. Examples of these reasons include:

- Patient is ill and cannot come to the program for a day or becomes ill and must leave before the end of the day.
- Patient's condition is such (e.g., acute emotional distress) that individual time with a provider is the appropriate intervention. This may be provided by a professional who cannot bill for a covered service (such as a registered nurse or social worker).
- Patient must leave a program day early for an appointment that cannot be scheduled any other time and is essential to treatment (e.g., securing Social Security benefits).
- An emergency arises in the patient's personal life that cannot be handled by anyone else.
- Weather, transportation emergencies, or holidays (both civil and religious) impact the patient's ability to attend.

We maintain that PHP regulations state that a patient's acuity must *require* 20 hours per week of programming, as evidenced in their plan of care, but do not state that a patient must *attend* 20 hours per week as a condition of payment.

While we have not conducted a formal survey, our members report that the number of beneficiaries who do not meet the 20-hour-per-week requirement is between 10% and 20%.

Our members have, in many cases, developed PHP schedules that make available significantly more than 20 hours a week of programming to accommodate a wide range of patient needs. Despite their best efforts, they have not always been able to deliver 20 hours of billable services to each PHP patient because of individual patient needs and choices—not lack of programming.

If CMS works to more strongly tie a beneficiary's receipt of at least 20 hours per week of partial hospitalization services to payment, we strongly recommend that it take the factors we have outlined (and others as appropriate) into consideration. We think documentation in the medical record of the reason why a patient has not received the services outlined in the plan of care is reasonable. We think it is important that providers monitor the number of patients who are not receiving 20 hours of service and develop appropriate strategies to assist these patients. We **strongly oppose** the proposal made (and

subsequently suspended--SE 1607) that PHPs be required to bill on a weekly basis and that failure to provide 20 billable services would lead to reimbursement for the entire week being denied.

The requirement tying payment to 20 hours per week of PHP services is inconsistent with MM8048 ("Enforcing Interim Billing for Partial Hospitalization Services"). In addition, the preamble to the 2009 OPPS/ACS final rule describes **program availability of 20 hours of programming in a week as evidenced by the patient's plan of care,** but recognizes that there may be reasons why patients are not able to meet the 20-hour framework in a given week. The preamble states, "We are clarifying that the patient eligibility requirement that patients require 20 hours of therapeutic services is evidenced in a patient's plan of care rather than in the actual hours of therapeutic services a patient receives." The requirement is also inconsistent with the local coverage determination that allows for exceptions to the 20-hour programming week, which could include such situations as physical illness, weather, holidays, transportation, or medically necessary absences. Special attention also needs to be paid to bills that represent the first and last days of a course of treatment. Depending on how frequently a provider submits a claim (and we recommend there be flexibility in this requirement), some weeks may have fewer days and therefore not meet the 20-hours-per-week benchmark.

Twenty Hours of Service and Payment (CY2018 rulemaking).

CMS specifically requests comment on the advantages, disadvantages, and potential challenges of strengthening the tie between payment and furnishing of at least 20 hours of services per week to eligible beneficiaries for development of the CY2018 rulemaking. CMS states in the 2017 OPPS rule, "PHP services can be extremely beneficial to eligible patients and, at the same time, can provide a more cost-effective method for providing care outside of an inpatient setting. We are working to protect vulnerable beneficiaries with MH condition by helping to ensure that eligible beneficiaries receive the level of care that is appropriate to the PHP setting."

We note the CMS intent to monitor PHP claims, beginning January 2017, to determine whether PHP beneficiaries are receiving at least 20 hours of partial hospitalization services. CMS has closely monitored this benefit and the associated data for many years. As noted before, NAPHS supports the significant value of this benefit and acknowledges the requirements that come with it. We have noted throughout our comments that patients in PHP are required to have a plan of care that reflects the need for an intensive level of intervention without which inpatient hospitalization might be the only alternative. PHP patients are acutely ill. We recognize patients' challenges in receiving services and the challenges faced by professionals in providing those services.

However**, we are very concerned about the effects of overly-rigorous monitoring of an intense and complex benefit through evaluation that is so focused on 20 billable hours of service**. This could easily result in claims being denied for services that meet every intent of the benefit yet occasionally, through no fault of the provider or the beneficiary, fall short of the 20-hour mark. Providers have also noted that billing codes allow a range of times for services, and strictly counting units of service fails to account for services that may be longer and, in sum, contribute significantly to 20 hours of service. Significant resources on both the part of providers and CMS contractors will go into this effort. The result could very easily be the continued decline in the number of PHP programs and the lack of beneficiary access to this most important level of care. This decline in access is being seen in an environment where the need for behavioral health services is documented daily. Providers are clearly discouraged from providing services that are unnecessarily regulated using criteria that appear to be bureaucratically-driven and detached from patient needs and the reality of the clinical setting.

We recommend a level of oversight that is in proportion to the problem. There has not been evidence of widespread misuse of the PHP benefit. The role of CMS and its contractors is to protect the beneficiary and the Medicare Trust Fund. We recommend continued education of the field about the requirements of the benefit. Before claims are denied, programs should be required to demonstrate that a treatment plan for 20 hours of service was developed and implemented and to document the reasons why a patient was not able to participate in the full 20 hours of service. The goal should be to help programs understand the requirements of the benefit, identify patients who are appropriate candidates for this level of care, and

help patients and providers maximize the PHP benefit. The goal should not be to deny claims based on levels of oversight that are not warranted. **We recommend flexibility the auditing process you are developing.**

Hospital-based PHPs not required to become CMHCs.

We appreciate CMS's decision in the final rule that allows hospital-based partial hospitalization programs to remain as such and not be required to become CMHCs. However, we are very concerned that nonexcepted PHP programs will not be able to remain financially viable and provide services at the payment that has been set (equal to the CMHC rate of $121.48). The existence of these programs is at risk. This leads directly to concerns about beneficiary access to this statutorily-mandated benefit. New hospital-based programs may not be opened in areas where there is documented need for services. This reduces the ability of programs to meet the clinical needs of patients.

Mental Health Composite.

The current policy regarding the outpatient mental health treatment cap limits the maximum payment for a day of individually billed outpatient mental health services to the highest hospital-based PHP APC per diem, and is derived from the most recent provider claims and cost data. The final rule is silent on how the mental health services composite (APC 8010), with a current reimbursement rate of $207.27, will be applied in the nonexcepted outpatient services. If CMS applies the 50 percent of the OPPS rate to nonexcepted PHPs, the payment rate for APC 8010 would be less than the maximum payment for these services (which is set at the CMHC rate of $121.48). We request clarification of this policy and the reimbursement rate.

CMS is seeking comment on their plan to monitor whether the frequency of providing 3-service days increases now that the payment incentive to provide 4 or more services per day has been removed.

We note the extensive work CMS has done to monitor the number of days paid under the former Level 1 services for both Hospitals and Community Mental Health Centers (CMHCs). We note also that the geometric mean per diem costs for providing Level 1 PHP services has approached the geometric mean per diem costs for providing Level 2 PHP services. The trend is less clear for CMHCs but the data still show the cost difference narrowing between the two tiers. There has been a steady movement toward programs providing higher levels of service. This information should give both CMS and the field confidence that, even in the presence of a combined reimbursement rate for Level 1 and Level 2 services, practice patterns have migrated to higher levels of service and should be expected to stay there.

CMS also continues to emphasize the requirement that patients have a plan of care that documents the need for 20 hours of service per week. We think it is important that facilities have the flexibility to be paid for the situation when the patient receives 3 services in a day. We are confident that programs are designed around higher levels of intensity and will continue to be so. If 3-service days are anything more than a rare occurrence, it is virtually impossible to achieve the 20-hour requirement.

CMS asks for comment on which facility types, treatment patterns, and other indicators are most important to monitor. We do not have specific recommendations about possible patterns of use, but we are confident that CMS has the tools to monitor the number of services being billed and to identify changes in patterns efficiently.

CMHC claims for PHP services set the nonexcepted rate for hospital-based services.

We are concerned that a relatively small number of CMHC claims for PHP services set the nonexcepted rate for hospital-based services.

The payment rate set for nonexcepted PHP services (hospital-based off campus PHP programs opened after November 2, 2015) is equal to the CMHC payment rate (for CY2017, $121.48). We understand that CMS must comply with Section 603 of the *Bipartisan Budget Act of 2015*. However, the way CMS has chosen to apply an applicable payment system to hospital-based programs sets the hospital-based nonexcepted program reimbursement rate at the CMHC rate for all new programs going forward with no financial justification. We are very concerned that this rate was based on an analysis of 46 CMHC programs (106,757 claims) in the 2017 rate-setting modeling. A total of 52 CMHCs submitted claims in 2015. Five programs were excluded for trimming. By comparison, hospital-based PHP rates were based on claims from 482 programs with 395 programs (463,721 claims), remaining after trimming.

The low number of CMHC programs that bill CMS for the PHP benefit has a very powerful effect on the rate. In addition, CMS has closely watched the CMHC cost report data through many years and has raised questions about its accuracy. The fact that PHP is the only Medicare-reimbursable service a CMHC can deliver adds great challenge to accurate cost reporting.

As recently as CY2016, CMS implemented trimming processes for both hospital-based and CMHC PHP programs to increase the accuracy of the PHP per diem costs. This was in response to the finding of significant outlier claims. On one hand, there were excessive CMHC charges resulting in CMHC geometric mean costs per day, in some claims, that were approximately the same or more than the daily payment for inpatient psychiatric facility services. On the other hand, some CMHCs reported costs of less than $25 per day. The trimming methodology is very new and untested.

In addition, CY2017 will be the first year for implementation of the combined Level 1 and Level 2 PHP APCs for CMHCs. We support this combination to provide more predicable per diem costs, but it is a newly-implemented change for which we have no data.

CMS acknowledges the decrease in the number of PHPs, particularly CMHCs, at various places throughout the final rule. It notes, “with a small number of providers, data from large providers with a high percentage of all PHP service days and unusually high or low geometric mean costs per day will have a more pronounced effect on the PHP APCs geometric mean costs, skewing the costs up or down.” CMS used this as a primary reason for combining Level 1 and Level 2 PHP APCs with a single APC by provider type and for implementing trimming.

We support the CMS goal of paying appropriately for partial hospitalization services based on each provider type’s data. **However, the combination – of low numbers (46 CMHCs), very recent implementation of trimming processes, combining of Level 1 and Level 2 APCs, and the very wide fluctuation of CMHC cost data – leads us to the strong recommendation that further work needs to be done on the rate setting for nonexcepted off-campus hospital-based PHP programs. The continued viability of this statutory benefit is at stake.**

CMS has consistently stated its position that a patient’s plan of care must demonstrate the need for 20-hours-per-week as a minimum requirement and that a typical PHP would include 5 to 6 hours per day. It is very difficult to understand how an off-campus hospital-based PHP program that began after November 2, 2015, (and therefore subject to the nonexcepted provisions) could be viable at the payment rate of $121 per day. The level of professional staff required to provide the required number of therapeutic services, complete the required documentation, and manage the clinical program is such that we are extremely concerned that services are being placed in jeopardy. We recognize that the basic service provided in a CMHC and a hospital-based PHP program is guided by the same regulatory standards. However, our members who provide hospital-based PHP services tell us that the number of patients they receive immediately upon discharge from acute psychiatric services is high (more than 60%). We are not aware of how this compares with the number of patients admitted to CMHC programs directly from acute hospitalization. This may help to account for differences in data reported on cost reports that are indicative of resource utilization.

Geometric mean per diem costs are used to calculate payment. How will costs of nonexcepted providers be calculated and used in the rate-setting process? If the nonexcepted programs are reported in the

hospital cost report, will there be a way to distinguish their costs from grandfathered programs? Will only CMHC data be used to determine the nonexcepted rate with the risk of failing to capture all the costs of delivering nonexcepted PHP services?

CMS is seeking comment on whether there should be a separate cost center for PHP services.

NAPHS does not have a definitive recommendation on whether there should be a separate cost center in the Medicare cost report for PHP services. CMS notes, from its extensive data analysis, the existence of coding errors that were inappropriately removing costs from rate setting and aberrant data from several providers that were affecting the calculation of the proposed PHP geometric mean per diem costs. These factors need to be better understood and solutions identified.

Our recommendation is that CMS continue its efforts to educate the field about the appropriate use of the existing cost center (including instructions to include all costs) so that the data used for calculation of the cost of the PHP benefit for both hospital-based and CMHC programs is accurate.

Frequency of individual services.

CMS expressed concern in the final rule about the low frequency of individual therapy. CMS noted that it is not seeing individual therapy services provided by physicians, clinical psychologists, clinical nurse specialists, nurse practitioners, and physician assistants at the frequency they would expect to see them within a PHP program. These services can be billed separately as professional services, and costs for these professional services are not considered to be partial hospitalization services.

While the majority of the services compromising the partial hospitalization program are group therapies, we acknowledge the important role of individual therapy for patients determined to need it as part of their interdisciplinary care plan. We understand CMS is looking for a certain variability of treatment modalities. However, we note, there is no professional benchmark for the “right” number of individual therapy sessions. A greater understanding of the current status of individual therapy needs to be developed before a judgment can be made about the appropriate indications, frequency, and billing procedures. It is important that CMS and the field assure themselves that they are capturing all the individual therapies that are being delivered, including those being done by staff employed by the program who are working within their scope of practice and who are not billing as independent practitioners (such as social workers).

NAPHS IS AVAILABLE TO ASSIST CMS.

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