National Association for Behavioral Healthcare

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SUBMITTED VIA: www.regulations.gov

Ms. Seema Verma, M.P.H.
Administrator, Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

27 September 2018

Re: CMS–1717–P: Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Proposed Revisions of Organ Procurement Organizations Conditions of Coverage; Proposed Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Proposed Changes to Grandfathered Children's Hospitals-Within-Hospitals - RIN 0938–AT74

Dear Ms. Verma:

As an association representing behavioral healthcare provider organizations and professionals, the National Association for Behavioral Healthcare (NABH) is pleased to provide comments on the Centers for Medicare and Medicaid Services' (CMS) "Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Proposed Revisions of Organ Procurement Organizations Conditions of Coverage; Proposed Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Proposed Changes to Grandfathered Children's Hospitals-Within-Hospitals - RIN 0938–AT74."

Founded in 1933, NABH represents and advocates for behavioral healthcare provider systems that are committed to delivering 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 that own or manage more than 1,000 specialty psychiatric hospitals, general hospital psychiatric and addiction treatment units and behavioral health divisions, residential treatment facilities, youth services organizations, and extensive outpatient networks. These providers deliver all levels of care, including partial hospitalization services, outpatient services, residential treatment, and inpatient care.

NABH and Partial Hospitalization Programs

NABH has supported Medicare's partial hospitalization benefit and helped in the legislative process that eventually established the benefit in the late 1980s. The benefit's original purpose was to provide Medicare beneficiaries with an alternative to inpatient psychiatric care that would allow patients to move more quickly out of the hospital into less intensive, "step-down" programs. The benefit was also meant to prevent the need for inpatient hospitalization. Before 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

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between outpatient, office-based visits and inpatient psychiatric care. It remains a critical, cost-effective level of care for persons living with mental illnesses.

Currently, 47.9 percent of NABH members offer Partial Hospitalization Programs (PHP) services and more than 32.5 percent offer PHP addiction services. These NABH members have consistently offered patients PHP services either as a transition from a hospital program, or as an alternative to inpatient care.

Decreases in PHP Programs

In 2001, the year after CMS established the per-diem payment for PHPs, there were 894 PHPs in the Medicare program.[1] The majority of those PHP programs were hospital-based (740) and the minority were Community Mental Health Center (CMHC) based (154).[2]

Nearly 18 years later, the number of PHPs has decreased by about 48 percent, with 468 PHP programs participating in the Medicare program. Of those, 427 are hospital-based, and only 41 are CMHC-based[3]. Within those programs, there has been a 43-percent decrease in hospital-based PHPs and a staggering 74 percent-decrease for CMHS-based PHPs. CMS has acknowledged the decrease in the number of PHPs, particularly CMHCs, in its previous OPPS rules.

Declines of this scale create four specific problems:

First, these declines have happened while need for these services has increased greatly. According to the American Mental Health Counselors Association, the 8 million older adults with behavioral health disorders will increase to 14 million over the next two decades.[4] In addition, older adults are already at higher risk of adverse mental health outcomes. Consider that Americans over the age of 65 make up 14 percent of the population,[5] but 17 percent of the number of suicides.[6] Meanwhile, Americans over the age of 85 have the second highest suicide rate of any age group.[7] And, an elderly suicide death occurs once every hour in the United States.[8] Decreasing services and increasing demand among an at risk population will drive progressively worse outcomes among this patient population.

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[1] Impact Associated With The Medicare Psychiatric Pps: A Study Of Partial Hospitalization Programs by Musetta Y. Leung, Ph.D. Edward M. Drozd, Ph.D. Janet Maier, RN, MPH - RTI International (February 2009).
[2] Ibid
[3] CMS–1717–P: Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Proposed Revisions of Organ Procurement Organizations Conditions of Coverage; Proposed Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Proposed Changes to Grandfathered Children's Hospitals-Within-Hospitals - RIN 0938–AT74
[4] Ibid
[5] *An Aging World* Wan He, Daniel Goodkind, and Paul Kowal - U.S. Census Bureau (March 2016)
[6] *Suicide by Age* Suicide Prevention Resource Center http://www.sprc.org/scope/age
[7] *Suicide Statistics* American Foundation for Suicide Prevention https://afsp.org/about-suicide/suicide-statistics/
[8] WISQARS Leading Causes of Death Reports – CDC https://webappa.cdc.gov/sasweb/ncipc/leadcause.html

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Second, the demand for these services is on track to outpace supply of U.S. behavioral healthcare providers. While some patients will move to lower levels of care, some patients will shift into higher levels of care, such as inpatient treatment. This should be a significant concern for CMS because the per-diem payment for inpatient services is higher than that of PHPs. Therefore, limited access to PHPs will cost CMS more money in the long run as some patients move into higher, more expensive levels of care.

Third, if decreases in the number of PHPs continues, it may become difficult to calculate the appropriate per diem. CMS noted this in a previous rule, stating "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." This scenario has played out in this current regulation.

The rates set in the proposed CY 2020 rule are not based on the most recent average cost data from the PHP program, a departure from CMS' long-standing policy. When CMS calculated the average PHP program cost for the CY 2020 proposed rule, the agency found it had decreased by nearly 15 percent for CMHCs and 11 percent for hospitals-based PHPs.

After finding this decrease, CMS reviewed the data sets and found that a single provider in the CMHC set and a single provider in the hospital-based set had such dramatically lower-reported costs that it significantly skewed the average cost for both data sets.

Because the lower average costs were the result of single providers and could significantly reduce access for beneficiaries, CMS decided to use the CY 2019 cost average as a floor for both type of PHP rates in the CY 2020 rule. If not for this change, the rate for both types of PHPs would have been significantly lower than what CMS proposed in the rule. NABH supports and thanks CMS' decision to establish this cost floor for CY 2020. This proposed policy will help ensure payment for PHPs closely approximate the cost of providing this service, and most importantly, continue to ensure Medicare beneficiaries cab access to this vital benefit. However, it is important to note that as the number of PHPs decrease the likelihood of a similar scenario in which a small number of PHPs with atypical cost skew the cost data will increase.

Fourth, changes made by CMS in recent OPPS rules make reversing the decline in PHPs very difficult. CMS has interpreted Section 603 of the *Bipartisan Budget Act of 2015* to mean that per diem for new hospital-based PHP programs after November 2015 must be set equal to the CMHC rate. We understand the need to comply with Section 603, but we do not believe this provision applies to the PHP program.

In addition, it is very difficult to understand how a hospital-based PHP could be viable at the payment rate used for CMHCs. The level of professional staff required to provide the required number of therapeutic services, complete the required documentation, and manage the clinical program make this nearly impossible. We are extremely concerned that new PHPs cannot be created under the current structure.

All this leads us to the recommendation that more work needs to be done to set the rate accurately and fairly for PHPs. As a first step, we recommend that CMS establish a task force to review and discuss improving the availability of PHPs for Medicare beneficiaries. We recommend that CMS include NABH, the Association for Ambulatory Behavioral Healthcare, the National Council for Behavioral Health, a sampling of PHP providers from the membership of each organization, Mental Health America, and the National Alliance on Mental Illness in this task force. We believe that together, CMS and these

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organizations can produce actionable steps to ensure Medicare beneficiaries continue to have the necessary and appropriate access to PHP services.

Price Transparency

NABH supports CMS' efforts to make the healthcare system more transparent and ensure that all patients have the necessary information to make the best decisions for their health. However, we have concerns with CMS' proposal in this rule to require the disclosure of payer-specific negotiated rates. NABH does not believe that CMS has the statutory authority to implement this proposal.

Furthermore, the disclosure of competitively negotiated rates does not support the interests of consumers. NABH encourages CMS to bring stakeholders together to address some of the issues regarding transparency and identify opportunities to help patients access accurate, concise, and clear cost-sharing information.

Thank you for your consideration. We look forward to working with CMS and other agencies within the Department of Health and Human Services to ensure that Medicare beneficiaries continue to have access to hospital outpatient behavioral healthcare and partial hospitalization services.

Sincerely,

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