National Association for Behavioral Healthcare

Access. Care. Recovery.

SUBMITTED VIA: www.regulations.gov

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

24 September 2018

Re: CMS–1695–P: Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Requests for Information on Promoting Interoperability and Electronic Health Care Information, Price Transparency, and Leveraging Authority for the Competitive Acquisition Program for Part B Drugs and Biologicals for a Potential CMS Innovation Center Model; RIN 0938–AT30

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) "Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Requests for Information on Promoting Interoperability and Electronic Health Care Information, Price Transparency, and Leveraging Authority for the Competitive Acquisition Program for Part B Drugs and Biologicals for a Potential CMS Innovation Center Model" (CMS–1695–P) published in the *Federal Register* on July 31, 2018.

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 (SUD). Our members are behavioral health provider organizations that own or manage more than 1000 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.

Background: NABH and Partial Hospitalization Programs

NABH members have provided partial hospitalization programs (PHP) for years. Currently, 55 percent of NABH members offer psychiatric partial hospitalization services and more than 42 percent offer partial hospitalization addiction services. These NABH members have consistently offered patients partial hospitalization services either as a transition from a hospital program, or as an alternative to inpatient care.

NABH has strongly supported Medicare's partial hospitalization benefit and helped in the legislative process that eventually established the benefit in the late 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 a less intensive, "step-down" programs. And, also 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

900 17th Street, NW, Suite 420
Washington, DC 20006-2507

Phone: 202.393.6700
Email: nabh@nabh.org
Web: www.nabh.org

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 need 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) that are tailored 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 lasts, on average, about 12 treatment days.

Comment: Partial Hospitalization Programs

As NABH has stated in previous letters to CMS, we agree that PHPs should be required to demonstrate that they have developed and implemented a treatment plan for 20 hours of service for patients, and, document the reasons why a patient was not able to participate in the full 20 hours of service. However, we do not think payment should be contingent upon a patient's ability to participate in all 20 hours of programing. We thank CMS for not pursuing that policy in this year's rule.

CMS developed the 20 hours-per week metric to measure clinical intensity, but there are no data or studies to indicate this metric is an ideal or appropriate proxy for clinical intensity in a PHP.

Properly certified patients — namely those with intensive and individualized plans of care who have stayed committed to the program and demonstrated clinical progress — are not always able to participate fully in the weekly requirement of 20 hours of service. There are many reasons for this, including patient illness, which would require a patient to leave before the end of the day.

Additionally, many patients experience difficulty adjusting to a new medication, a common occurrence in PHPs. This adjustment might make 20 hours of intense therapeutic services clinically sub-optimal for the patient, and he or she may be best served initially by not attending the full 20 hours. Ultimately, a provider can only make this determination based on a patient's individual treatment plan.

For these reasons – as well as the lack of widespread misuse of the PHP benefit – we thank CMS for not instituting a code edit for 20-hours per week. NABH welcomes further discussion of this issue and we would be happy to work with CMS on convening a meeting of experts from the field to discuss, develop, and recommend ideas on how best to ensure the appropriate clinical intensity in PHPs.

Comment: Site Neutral Payments for PHPs

In previous comment letters, NABH urged CMS to adopt a clear policy that the provisions of Section 603 of the *Bipartisan Budget Act of 2015* and the law's subsequent regulation do not apply to the PHPs. In those letters we explained that absent such an exemption, CMS risks placing a moratorium on new 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 and SUD. There are sound policy reasons for our position and CMS has the clear legal authority to adopt this policy.

900 17th Street, NW, Suite 420
Washington, DC 20006-2507

Phone: 202.393.6700
Email: nabh@nabh.org
Web: www.nabh.org

National Association for Behavioral Healthcare

Access. Care. Recovery.

Given the ongoing opioid crisis and suicide crisis, we are compelled to provide additional details on this issue and reiterate that failure to make this technical correction will have a negative impact on drug overdoses rates, which are at an all-time high, as well as suicides rates, which are at a 30-year high.

Unlike other services paid under OPPS, the PHP regulations state specifically 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."[1] The point of the PHP benefit is to serve as an intermediate service between outpatient, physician-based visits and inpatient psychiatric care. Therefore, by definition, PHP services are not and cannot be physician office-based services.

CMS' solution to this issue of a physician-based equivalent to PHPs is for these programs to enroll themselves and be reimbursed as Community Mental Health Centers (CMHC) under OPPS. CMHCs require separate certification, operate under separate 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) that CMS 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.[2] In other words, the proposed solution – that these entities transition to a different provider type – ignores both the structure of hospital-based PHPs, as well as their benefits.

We are also very concerned that the rate for these hospital-based PHPs will be based on an analysis of the 44 CMHCs in the PHP claims data file. By comparison, hospital-based PHP rates were based on claims from nearly 400 programs. The low number of CMHC programs that bill CMS for the PHP benefit has a very powerful effect on the rate. CMS itself has noted that "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."

An effective response to the opioid epidemic requires payment for the full continuum of care and partial hospitalization is included in the American Society of Addiction Medicine's (ASAM) treatment continuum. But, CMS' current approach puts at risk the continued viability of this level of care, which is a statutory benefit for Americans on Medicare. NABH is concerned that if this level of care is eliminated, individuals with SUD will no longer be able to enter treatment at their clinically appropriate level of care. The scientific literature on SUD treatment is clear that different levels of care are not clinically interchangeable. If patients do not receive the level of care they need, they will likely drop out of services, relapse, overdose, or even die. There is little room for error in this opioid epidemic. Simply put: bad policies can result in death. This policy approach is in opposition to federal HHS and congressional approaches to assure the availability of every and all relevant and necessary levels of care to treat individuals with opioid use and other SUDs.

---

[1] 42 C.F.R. § 424.24(e).

[2] 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).

900 17th Street, NW, Suite 420
Washington, DC 20006-2507

Phone: 202.393.6700
Email: nabh@nabh.org
Web: www.nabh.org

In addition, without partial hospitalization as an option, NABH expects to see an increase of patients in overcrowded emergency departments and inpatient treatment.[3] Partial hospitalization has proven to have a positive impact on readmission rates. For example, in a report on *Medicare Psychiatric Patients & Readmissions in the Inpatient Psychiatric Facility Prospective Payment System*, the Moran Company noted that for Medicare beneficiaries who received services though a PHP, the time to readmission was 131 days, versus 59 days for those who did not participate in this program between admissions.[4]

While we do not believe Congress ever intended for section 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." 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.[5]

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 asserted its authority at § 1833(t)(2)(E) to impact the ways the agency pays hospital-based PHPs so that it was not paying less for Level 2 days than it was for Level 1 days.[6] CMS has exercised this authority more broadly particularly in cases where the agency seeks to redirect resources that are in the best 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.[7] CMS should use its authority here to exempt hospital-based PHPs from section 603 to ensure that this critical and cost-effective benefit is not phased out.

Comment: Site Neutral Payments Overall

When Section 603 became law, Congress made clear the distinction between hospital outpatient departments (HOPDs) that were billing under the OPPS at that time and all new HOPDs. Congress reaffirmed that distinction by passing Section 16001 of the 21st Century Cures Act in 2016, which allowed HOPD in the process of being built prior to the passage of Section 603 to receive grandfathered status. Furthermore, the language from Section 16001 demonstrates that Congress sought to have the grandfathering status apply to the HOPD facility and not to the line of services provided to beneficiaries. The proposed rule attempts to change this intention

---

[3] *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).

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

[5] 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).

[6] 80 Fed. Reg. 70,298, 70,459 (November 13, 2015).

[7] 71 Fed. Reg. 67,960, 68,190 (November 24, 2006).

900 17th Street, NW, Suite 420
Washington, DC 20006-2507

Phone: 202.393.6700
Email: nabh@nabh.org
Web: www.nabh.org

National Association for Behavioral Healthcare

Access. Care. Recovery.

Most notably, CMS has proposed to pay the "PFS-equivalent" (Physician Fee Schedule) rate for evaluation and management (E&M) services furnished at such facilities, contrary to congressional intent regarding the grandfathered status of facilities. Furthermore, CMS is proposing to reduce payment to 40 percent of the current HOPD rate for grandfathered HOPDs that furnish a new service not offered prior to November 1, 2015. This policy unfairly penalizes facilities that expand services to meet the changing needs of their patients. We ask that that CMS ensure these facilities be treated as Congress intended and, therefore, protected from these proposed cuts.

Comment: Interoperability and Electronic Healthcare Information

The ultimate goal of widespread adoption of health information technology — to save American lives through improved care coordination — is particularly relevant to persons with mental and SUDs. Individuals with serious mental illnesses die, on average, 25 years earlier than other Americans due to a high incidence of untreated co-occurring chronic medical conditions in this patient population that include cancer, hypertension, diabetes, asthma, heart disease, and cardio-pulmonary conditions. However, behavioral healthcare providers were excluded from the *American Recovery and Reinvestment Act of 2009*, which included about $20 billion in health information technology (HIT) funding.

This lack of HIT incentives for behavioral healthcare providers has left little or no incentive for electronic health record (EHR) vendors to develop behavioral healthcare-specific platforms. Consequently, behavioral healthcare providers have been slow to adopt EHRs.

If CMS is committed to removing fundamental barriers to interoperability and health information exchange, the agency should extend health information technology incentives to behavioral healthcare providers. There is bipartisan, bicameral legislation from Sens. Rob Portman (R-Ohio) and Sheldon Whitehouse (D-R.I.) and Reps. Lynn Jenkins (R-Kansas) and Doris Matsui (D-Calif.) that would authorize a behavioral health IT demonstration program at CMS. While we applaud their efforts, we understand legislation is not necessary to do this. CMS' Innovation Center could devise a program similar to the one outlined in the legislation that would extend EHR incentives to psychiatric hospitals, community mental health centers, accredited residential or outpatient mental health treatment facilities, clinical psychologists, and clinical social workers. Each of these groups was left out of the *HITECH Act*.

Thank you for your consideration of our comments. 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,

Mark Covall
President and CEO

900 17th Street, NW, Suite 420
Washington, DC 20006-2507

Phone: 202.393.6700
Email: nabh@nabh.org
Web: www.nabh.org