NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS
ADVOCATING FOR BEHAVIORAL HEALTH
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Ms. Seema Verma
Administrator, Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Sent via e-mail; hard copy to follow.

Dear Ms. Verma:

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') "Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs" (CMS–1678–P) published in the Federal Register on July 20, 2017.

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 has long been a level of care offered by NAPHS members: nearly 45% of NAPHS members offer psychiatric partial hospitalization services and more than 35% offer partial hospitalization addiction services. Throughout the years, these NAPHS members have been a stable group of providers offering patients the use of partial hospitalization either as a transition from a hospital program, or as an alternative to inpatient care. NAPHS is a major supporter of the Medicare partial hospitalization benefit and worked closely with Congress on crafting the legislation that created the benefit.

Patients who meet the admission criteria for partial hospitalization services need intensive, highly structured therapeutic services and 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. However, we maintain that the 20 hours per week requirement should not be based on attendance, it is not an appropriate measure of "clinical intensity," and CMS should convene an expert panel to examine multifaceted ways to measure "clinical intensity."

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. In the preamble to the 2009 OPPS/ACS final rule CMS states "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." As NAPHS has stated in previous letters to CMS, these 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.

CMS created the 20 hours per week metric for the purpose of measuring clinical intensity, but there are no data or studies to indicate this CMS devised metric is an ideal or even appropriate proxy for clinical intensity in a PHP. Properly certified patients – with high levels of commitment to the program, with

intensive and individualized plans of care, and with demonstrated clinical progress – are not always able to fully participate in the weekly requirement of 20 hours of service. There are many reasons for this, including a patient is ill and cannot come to the program for a day or becomes ill and must leave before the end of the day. Nearly 70 percent of individuals diagnosed with a mental health conditions have a co-occurring medical diagnosis and more than half have one or more chronic diseases. Therefore, a patient may miss a day and fall short of 20 hours for medically necessary reasons that are in their clinical best interest.

An additional example of why 20 hours per week is a poor proxy for clinical intensity, is that many patients experience difficulty adjusting to a new medication, a common occurrence in PHPs. This difficulty cognitively adjusting to the new medication might make 20 hours of intense therapeutic services clinically suboptimal for the patient and they may be best served initially by not attending for the full 20 hours. However, this determination cannot be made until a treatment plan is designed and implemented for the patient.

In these examples, the existing CMS standards were met, the patients benefited, and the PHP offered the clinically appropriate services but 20 hours per week of attendance was not met. Clearly, this is not a good proxy for clinical intensity or a good metric for the quality of a PHP.

Given these facts and the lack of evidence to suggest widespread misuse of the PHP benefit CMS should not institute a code edit for 20-hours per week until they convene a meeting of experts from the field to discuss, develop, and recommend ideas on how best to ensure the appropriate clinical intensity in PHPs. We recommend that CMS work with the group and towards establishing an appropriate and multifaceted determination of clinical intensity within a PHP.

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,

Mark Covall
President and CEO