American Hospital Association

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Dennis Smith
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: File Code CMS-1213-P

Dear Mr. Smith:

On behalf of our more than 5,000 member hospitals and health systems, including more than 1,331 freestanding psychiatric hospitals and general hospitals with distinct part psychiatric units, the American Hospital Association appreciates this opportunity to comment on the proposed Inpatient Psychiatric Facility Prospective Payment System (IPF PPS).

The mental health care system in this country is tenuous, as President Bush recognized when he appointed the New Freedom Commission on Mental Health. State budget woes have forced cutbacks in funding for state mental health care. These funding cutbacks, coupled with changes in insurance coverage for patients with mental illness, have threatened the viability of freestanding psychiatric hospitals and distinct part psychiatric units within general acute care hospitals. In fact, the number of inpatient psychiatric beds has dropped from 233,436 in 1990 to 134,770 in 2002 – a 42 percent decrease in inpatient capacity. At the same time, outpatient options and other resources for care and support are inadequate in most communities across the country.

We are gravely concerned that the proposed rule will further weaken our fragile mental health care system by substantially decreasing payments to the majority of distinct part psychiatric units within hospitals. These facilities, which provide care for approximately 50 percent of those receiving inpatient psychiatric care each year, are a vital – and often an only – resource for patients suffering from mental illness, particularly those who have coexisting physical conditions or experience a crisis and enter the emergency room for treatment.

If the IPF PPS is implemented as proposed and has the projected fiscal impact on distinct part units, it is likely that many will no longer be financially sustainable. Their closure would leave many communities without access to psychiatric care, and prevent many individuals from getting the treatment they urgently need. The loss of inpatient psychiatric units and facilities will bring with it the loss of mental health clinicians, outpatient programs, and other resources that patients rely on for both inpatient and outpatient care. **While we support a change from a cost-based system to a prospective payment system based on per diem payments, changes must be made to the rule to ensure fair and adequate payment for the facilities that are essential to maintaining access to inpatient psychiatric services.**

We have identified several changes that will minimize the negative impact of moving forward with the IPF PPS. Our recommendations, detailed below, fall into three major categories:

- Recalculation of the budget neutrality and behavioral offset factors. We believe errors were made in the underlying assumptions in each of these calculations, and urge CMS to adjust its calculations to more accurately reflect projected payments under current law.

- Additional adjustments to reflect real differences in the costs of caring for different types of patients and facilities, including:
    - Emergency department adjustment
    - Expanded list of accepted co-morbid conditions and co-occurring psychiatric conditions
    - Electroconvulsive therapy (ECT) adjustment
    - Payments for certain patients with interrupted stay
    - Adjustment for patients treated under involuntary treatment act orders
    - Retain the teaching adjustment

- Support of a four-year transition and an additional stop loss protection policy.

Our recommended changes to the rule are essential to protecting access to vital inpatient psychiatric care services in communities across our country. To demonstrate the negative impact of the rule across the country, we developed several maps (included in Appendix A) illustrating the geographic representation of hospitals with projected revenue losses under the proposed IPF PPS, based on estimates from The Health Economics and Outcomes Research Institute (THEORI) at the Greater New York Hospital Association. We also identified hospitals that are the sole psychiatric hospital in their community, both under an aerial 35-mile threshold and a less rigorous "city" level, to illustrate the vast number of communities that could lose access to their only provider of inpatient psychiatric care.

When CMS implemented prospective payment systems for skilled nursing facility (SNF) services and home health agency (HHA) services, the higher costs of patients treated in hospital-based SNFs and HHAs were not well identified, and the financial impact of the these payment systems led to closures of a substantial number of hospital-based SNFs and HHAs. The already tenuous financial status of hospitals and health systems makes it very difficult for them to

maintain such losses in specific service lines. **We believe that a similar wave of closures of distinct-part psychiatric units will result if the IPF PPS is implemented as proposed.** While there may have been additional freestanding SNFs and HHAs in the communities with hospital-based provider closures to protect access to care, there is no such capacity to absorb significant closures in inpatient psychiatric care, as freestanding psychiatric hospitals are not well distributed in communities. While they provide over half of all psychiatric inpatient days, they constitute less than 25 percent of all psychiatric facilities. **If distinct-part psychiatric units close, patients will lose much needed access to psychiatric care – CMS must take the following steps to prevent this from happening:**

RECALCULATION OF BUDGET NEUTRALITY AND BEHAVIORAL OFFSET

Recalculate the budget neutrality adjustment. We believe an error was made in the calculation to inflate costs to the mid-point of April 1, 2004-June 30, 2005, as part of the budget neutrality adjustment. CMS used the Balanced Budget Act off 1997 (BBA '97) formula that was intended to adjust facilities' payment limits rather than using the full market basket rate, which would more accurately represent the changes in the costs experienced by psychiatric facilities. Based on data made available by the National Association of Psychiatric Health Systems, 65 percent of psychiatric facilities were under their payment limit and therefore were paid based on their actual costs. Therefore, the fact that their TEFRA limit grew by less than the full market basket had no impact on what these hospitals were actually paid, and therefore, no impact on what CMS should have estimated would constitute its actual expenditure. In calculating the estimated payments that Medicare would have paid out under TEFRA, CMS substantially understated what TEFRA payments would have been.

Recalculate the behavioral offset. In the proposed rule, CMS has included an offset to account for changes in coding and length of stay that may occur as a result of the transition to a per-diem based prospective payment system. We believe the assumptions CMS made overestimate the likely impact of the changes in hospitals' behavior for several reasons. First, the accuracy of coding is already a high priority in distinct part units and in some freestanding facilities. In distinct part units, those assigning the appropriate codes to the psychiatric patients' records already are coding for many other patients for whom payment is based on the DRG to which they are assigned and the co-morbidities recorded for them. Therefore, there should not be any major changes in the coding practices by general hospitals with distinct part units, which care for 50 percent of the patients.

Second, the proposed system decreases payments for each successive day of stay, minimizing hospitals' incentive to keep patients for additional days of care. This decreasing payment, coupled with strong utilization review by many payers, makes is far less likely that stays will increase.

Third, because the prospective payment system is being phased in, and only 25 percent of the payment made for a patients' stay in the first year will be based on the IPF PPS, the incentive for behavior changes is diminished.

We urge CMS to adjust the calculations for both the behavioral offset and the budget neutrality adjustment to maintain IPF spending amounts at actual TEFRA levels.

ADDITIONAL ADJUSTMENTS TO REFLECT REAL DIFFERENCES IN THE COSTS OF CARING FOR DIFFERENT TYPES OF PATIENTS AND FACILITIES

Include an adjustment for the presence of an emergency department. The costs of caring for patients in hospitals with emergency departments (ED) is higher than the costs of caring for patients in facilities without an emergency department for a variety of reasons that should be taken into account by the IPF PPS. Psychiatric patients who are admitted through the ED often are suffering both a mental health crisis and a serious medical condition or injury. Emergency care for these patients is costly and complex, especially since many have had poor care management and preventive care. For patients of distinct part units, the emergency care costs – both psychiatric and medical – are paid through the inpatient setting. CMS' reference to these costs being paid separately through the outpatient hospital PPS applies only to ED patients that are transferred to freestanding psychiatric facilities not associated with the general acute hospital. For distinct-part psychiatric units, the cost of emergency services is wrapped into the inpatient payment and not paid separately under the outpatient PPS.

Further, hospitals incur extra costs simply by maintaining staffed and ready emergency departments; these stand-by costs of providing emergency care 24 hours each day, seven days a week must be allocated in part to the hospital's psychiatric unit (and its patients) under the provisions of the Medicare cost report methodology. Moreover, the costs of providing services to the uninsured, homeless, and indigent populations are most pronounced in the emergency department, as hospital emergency departments must screen and stabilize every patient that walks through the doors of the hospital, regardless of the patient's ability to pay. Such costs are supported by all of the other services of the hospital, including the psychiatric unit.

Hospitals' costs to maintain and treat patients through the emergency room, and the higher costs of treating psychiatric patients admitted through the ER – must be more appropriately reflected in the IPF PPS. **The AHA recommends that a facility-level adjustment to IPF PPS be created for hospitals with a fully operational emergency department.** Based on modeling done by the Greater New York Hospital Association, we believe this adjustment should increase the per diem payment by approximately 23 percent for hospitals with an ED.

Include adjustments for additional co-morbid conditions. Axis 3 of the Diagnostic and Statistical Manual (DSM) specifies medical conditions that influence the treatment protocols, and therefore the costs, of caring for psychiatric patients. However, the proposed PPS accounts for only 91 of these medical conditions in the 17 categories of comorbidities for which additional payment is provided. There is no reason that the rest of the medical conditions in Axis 3 have been excluded from the list of adjustments for the prospective payment system. **We urge CMS to include the entire list of Axis 3 medical conditions in the list of co-morbid conditions for which increases in payment will be made, to account for the additional cost of caring for these complex cases.**

Pay for provision of electroconvulsive therapy (ECT) services. In recent years, the delivery of electroconvulsive therapy has changed substantially. When the DRGs were created, ECT services were performed in a variety of facilities with differing support services. Today, the standard practice is for ECT to be performed under anesthesia, with support personnel, in a highly monitored setting, with other provisions nearby. The costs of providing ECT, therefore, are much higher than the costs for patients not receiving this specialized service, and the proposed IPF PPS does not adequately address this variation. ECT has much in common with many operating room procedures and similar resource use to operating procedures, but this is not reflected in the current coding system. **CMS should create a special and significant adjustment to increase payments for patients who are being treated with this procedure.** In the absence of a special adjustment, ECT should be considered a valid operating room procedure and included in DRG 424, other operating room procedure, because the costs of ECT procedures are similar to those for many common operating room procedures that accompany a psychiatric condition.

Adjust for patients who are admitted involuntarily. When patients are admitted involuntarily to psychiatric facilities, those facilities must incur additional costs to obtain court approval to initiate and sustain treatment for the patients. These additional costs include the lawyers' fees and court costs for obtaining consent to treat the patients and may also include additional costs of caring for the patients while awaiting the permission of the court to begin the appropriate treatment protocol. For example, if a patient that has been admitted involuntarily is considered a threat to himself or others, which is a common reason for involuntary admission, then the patient may have to be restrained and monitored until authorization for appropriate treatment has been obtained. **These additional costs need to be recognized in the payment system. We urge CMS to develop an adjustment that would be applied to any patient admitted involuntarily.**

Allow full payment for patients returning after some interrupted stays.
CMS defines an interrupted stay as one in which the patient is discharged from an inpatient psychiatric facility and returns to the same IPF within five consecutive calendar days. Under the proposed rule, interrupted stays are treated as a single stay, and facilities are reimbursed accordingly. We urge CMS to reconsider this provision in cases in which a patient is transferred from the psychiatric unit or hospital to a general acute care hospital for treatment of an acute medical or surgical condition. If a psychiatric patient experiences the need for acute medical care, it would be inappropriate for a psychiatric facility to be penalized for ensuring the patient gets the needed care and then is returned as rapidly as possible to the psychiatric facility for treatment of the mental health issue for which he or she was admitted. **We recommend that a patient being readmitted to an inpatient psychiatric facility be treated as a new admission if the patient had been transferred for treatment of an acute medical need.**

Retain the rural and teaching adjustments. We are pleased to see in the proposed rule the recognition of additional costs incurred in rural settings for the care and treatment of psychiatric patients, and we urge CMS to retain this adjustment. We also support the rule's Indirect Medical Education (IME) adjustment but recommend that CMS not impose any limits on the number of residents accepted into the program.

Consider using the Diagnostic and Statistical Manual of mental disorders-IV instead of the current inpatient DRGs. The DSM is used by the psychiatric community to diagnose a patient's illness and aid in treatment planning. While there are differences in the terminology used between ICD-9-CM and DSM, the code numbers in both coding systems are essentially the same. A recent proposal brought before the ICD-9-CM Coordination and Maintenance Committee at its December 2003 meeting brings in line the code descriptors under ICD-9-CM with the titles in DSM. If the proposal is approved, there will be no meaningful difference in the code numbers or code descriptors for both these systems.

The proposed IPF PPS could be more clinically relevant if patients are categorized for payment as they are categorized in clinical practice. The DSM provides an opportunity to do this clinically relevant categorization by essentially using the chapter headings from the DSM manual as the diagnostic groupings. Again, because the codes are nearly aligned, this does not represent a change in coding. It is, instead, a change in the way the codes are grouped to create more clinically relevant groupings.

By using these new groupings, and by including all Axis 3 medical conditions as co-morbid conditions, CMS would recognize the differences in patients and the associated costs more accurately than it would by lumping a substantial majority of patients into the current DRG 430, psychoses.

Therefore, we ask CMS to review this proposal and consider grouping patients into diagnostic groups according to the classifications from the DSM.

IMPLEMENTATION ISSUES

Preparing for implementation will require some time. The changes in payments to psychiatric facilities envisioned by this proposed rule are substantial and will require significant adjustments in the billing practices of psychiatric facilities. We have suggested many substantive changes to the proposed rule. Psychiatric facilities will need sufficient time to prepare and adapt to any changes made in the final rule. Specifically, we will need time to reprogram our computers, adapt our billing practices, and train staff, and we recognize that CMS will similarly need to train fiscal intermediaries. When other prospective payment systems were implemented, these changes typically took from to five to seven months. **Therefore, we urge CMS to provide from five to seven months between the publication of the final rule and its effective date, and that the effective date be no earlier than October 1, 2004.**

Maintain reliance on available administrative data sources. We recognize that CMS is planning to improve this PPS after implementation, as evidenced by the proposed rebasing in 2007. We applaud CMS for recognizing that refinements will be necessary and look forward to working with you to improve the system. However, we do not think that further refinements need to be based on burdensome data collection practices, such as the Michigan survey that was mentioned in the proposed rule. We strongly urge CMS to make use of the readily available administrative data to pursue future refinements.

Retain the full transition period for all facilities. The proposed rule describes a four-year transition to full implementation of the IPF PPS system. We strongly urge CMS to adhere to this timeline and *not* to allow hospitals to opt in to full IPF PPS payment prior to the fourth year. This system could have many unexpected consequences, and any budget neutral approach to allow facilities to receive full IPF PPS payment would further decrease payments to hospitals already harmed by movement to the IPF PPS. **The full four years is critical to enable psychiatric care facilities to adapt to the new payment system**.

Include a stop loss protection policy. Based on modeling of our recommended changes, we still are concerned about the significant payment losses for hundreds of freestanding and distinct-part units under the IPF PPS. While our recommended changes will minimize the payment reductions to psychiatric units from roughly $330 million to $179 million (upon full implementation), there are still many facilities that could experience significant decreases in Medicare payments. Again, these losses will create significant access gaps due to bed and facility closures. **Therefore, we recommend that CMS implement a stop loss protection for facilities with significant declines in Medicare payment.** We are very concerned about those providers that suffer declines in excess of 15 percent – which translates into an annual cut in payments of at least 3.75 percent each year. Hospital pressures are tremendous due to workforce shortages, rising drug costs, costs for information systems development, medical liability premiums and other factors beyond hospitals' control. These cost increases, coupled with IPF PPS payment reductions, will be more than most facilities can absorb – pushing psychiatric hospitals and units into financial crisis and jeopardizing patient access to care.

We also will be working with Congress to provide additional resources to help mitigate any potential disruption to the mental health delivery system that might occur from these regulatory changes.

Our key concern in recommending this stop loss protection is maintaining access. Therefore, several factors should be considered when developing a stop loss policy, including geographic isolation, occupancy of the facility and the total beds in the community, Medicare's dependence on a provider in a given community (Medicare share of business), and the impact of losing the inpatient capacity on the outpatient psychiatric resources of the community. The Medicare revenue re-captured by improving the calculations for the budget neutrality adjustments and behavioral offsets could be used specifically for purposes of the stop loss protection.

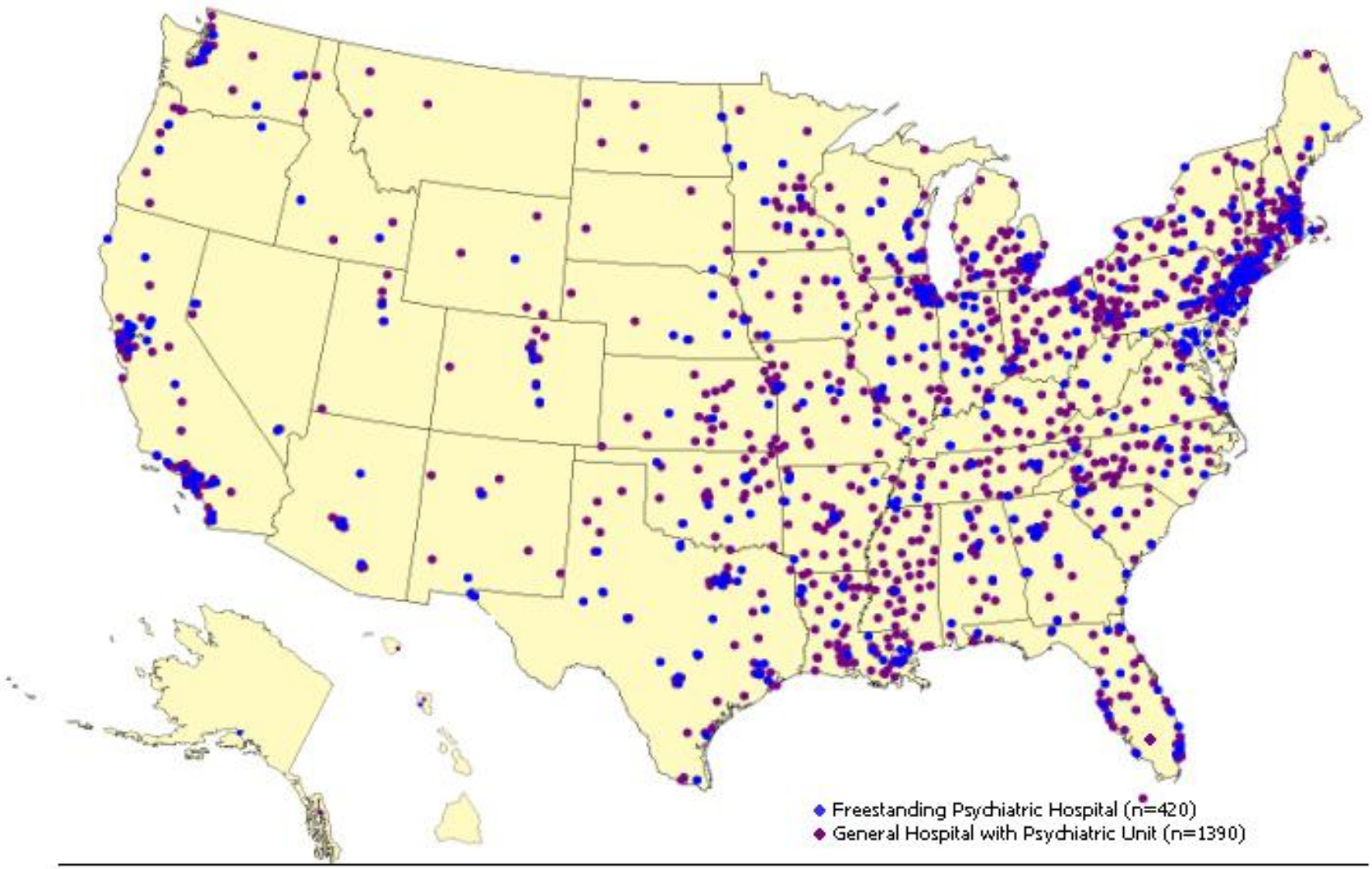
Thank you for considering these comments. Should you have any questions, please feel free to contact Don May, vice president of policy at (202) 626-2356 or Nancy Foster, senior associate director at (202) 626-2337.

Sincerely,

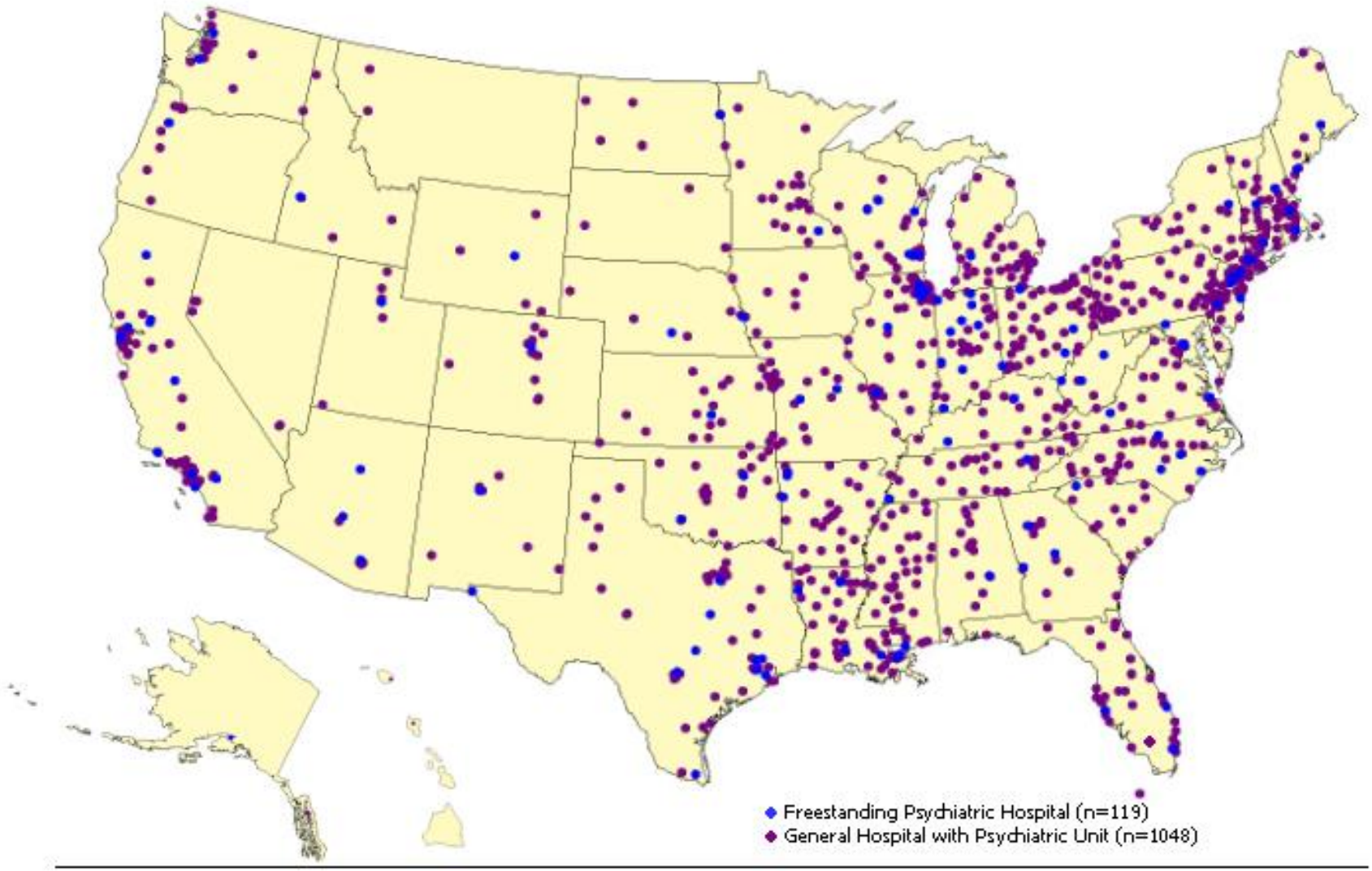
Rick Pollack
Executive Vice President

Attachment

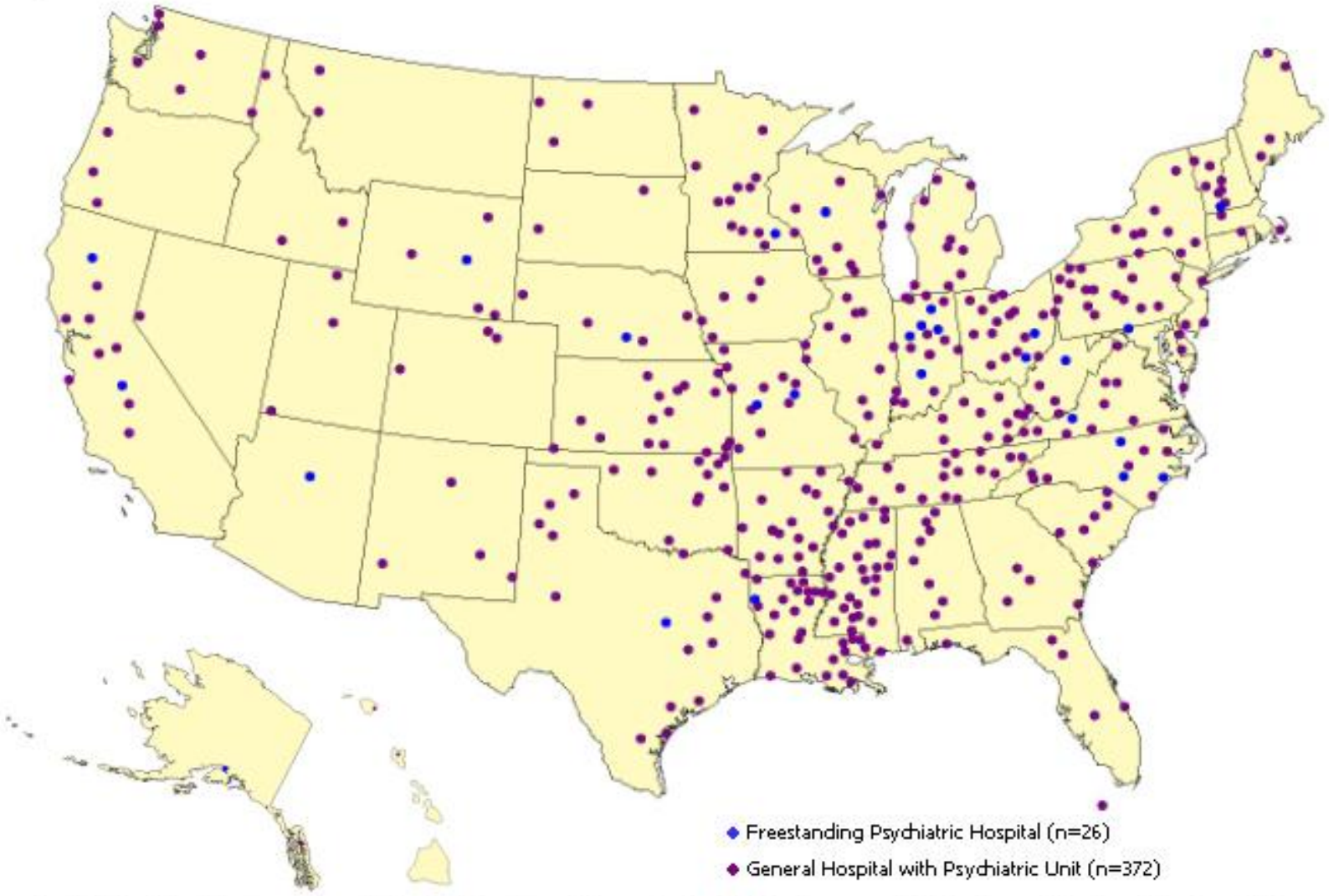
Map 1: Freestanding Psychiatric Hospitals and General Hospitals with Psychiatric Units, United States, 2002



Map 2: Freestanding Psychiatric Hospitals and General Hospitals with Psychiatric Units with Negative Financial Impact from Proposed Rule

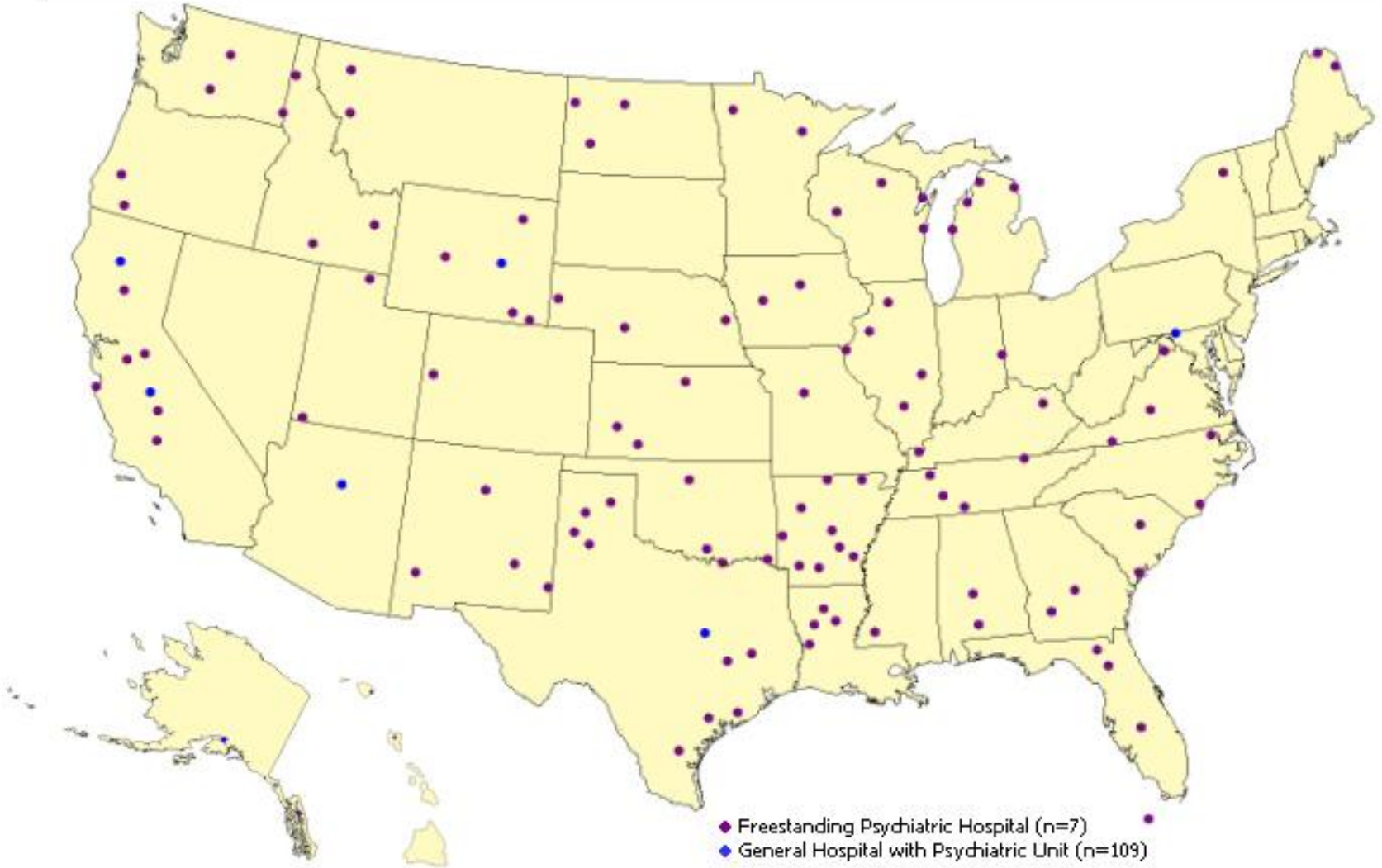


Map 3: Freestanding Psychiatric Hospitals and Psychiatric Units that are "Sole Providers" with a Negative Financial Impact from the Proposed Rule



**Sole Provider defined as rural psychiatric hospitals with no other psychiatric facility in the town and facilities that are the sole provider in an MSA.*

Map 4: Freestanding Psychiatric Hospitals and Psychiatric Units that are at Least 35 Miles from the Next Nearest Psychiatric Facility and have a Negative Financial Impact from the Proposed Rule



*Psychiatric hospitals that are located more than 35 miles (point distance) away from another psychiatric hospital.