

June 1, 2004

Ms. Brenda Aguilar, OMB Desk Officer
Office of Management and Budget
OMB Human Resources and Housing Branch
Executive Office Building
Room 10235
Washington, DC 20503

RE: File Code CMS-10107 (OMB #0938-NEW)

Dear Ms. Aguilar:

On behalf of our more than 5,000 member hospitals and health systems, including more than 1,330 freestanding psychiatric hospitals and general hospitals with distinct part psychiatric units, the American Hospital Association appreciates the opportunity to comment on the **Instrument/Tool for Refinement of a Prospective Payment System for Patients in Inpatient Psychiatric Hospitals and Units: a Pilot Test**; *Form No.:* CMS-10107 (OMB #0938-NEW).

A patient classification system used in the research and development of an inpatient psychiatric prospective payment system (PPS) should be administratively simple, rely on commonly available data, have a manageable number of categories, and focus on data needed for payment purposes. The study by the Centers for Medicare & Medicaid Services (CMS) using the University of Michigan Case Mix Assessment Tool (CMAT) fails on these criteria. We urge the Office of Management and Budget to reject CMS' request to pilot test the CMAT tool with psychiatric facilities. The CMAT is not useful in accounting for differences in the cost of psychiatric patients and is inadequate for refinement of the Psychiatric PPS.

The Proposed Pilot Test is an Unnecessary Burden

Before testing the CMAT instrument for its reliability, CMS must determine if this instrument can be a useful component of its psychiatric hospital PPS. In commenting on the proposed inpatient psychiatric PPS rule, the AHA and other organizations urged CMS not to use the CMAT in the psychiatric PPS because it will not effectively account for differences in psychiatric patients.

CMS' intended purpose for the tool is to refine the case-mix adjustment for inpatient psychiatric PPS; however, the University of Michigan CMAT was derived from a clinical

management/monitoring tool developed for use in Canada. Using the CMAT tool to refine the existing Medicare case-mix system is a starkly different purpose from that for which it was developed. Data collection tools developed for one purpose are rarely well suited for a distinctly different purpose.

In this case, the CMAT fails to account for the acute nature and short lengths of stay of psychiatric services. Many of the instrument's data items would force hospitals to collect information on each patient that has no direct relationship to cost or payment. For example, the CMAT asks for data on tearfulness, insight, constipation, ability to prepare meals and white blood count. Collecting this data is administratively burdensome. Further, the information has no substantiated relationship to the costs incurred to care for patients; therefore, it should have no impact on payment.

The Data Gathering Burden will far Exceed the Estimate

The assessment tool's length – 37 questions, many requiring detailed patient information – would create a tremendous administrative burden on caregivers in psychiatric facilities.

OMB estimates that the overall burden to each pilot facility's staff will be 61.6 minutes per patient record. This estimate is built on faulty assumptions. OMB's estimate assumed that "all of the information is in the medical record or otherwise already known and available." Given the short lengths of stay in psychiatric facilities, the episodic nature of the illnesses, and the transient life experiences of many severely and persistently mentally ill patients, many facilities may find it challenging to gather the data requested on each patient. In fact, nurses participating in the University of Michigan's own pilot study commented that "it was sometimes difficult to gather information about events occurring before the subject entered the hospital." Nurses also indicated they had difficulty finding ICD-9 codes. The current practice is for medical record coders to assign ICD-9 codes after patients are discharged and records are closed. ICD-9 codes are not available in an open record and not readily known by frontline caregivers. However, the CMAT data are expected to be taken from the record before it is closed.

The burden that facilities perceive from the CMAT data collection is captured in the contractors' own pilot study. Seven out of 11 sites (64 percent) approached refused to participate. Two of the four sites that agreed to participate "held close ties with a member of the project team." Within the three sites that did agree to the pilot test, 33 percent of the 69 patients recruited to participate refused. "The nurse assessors indicated their impression that paranoid patients and patients who were refusing all care were less likely to consent to the study." This is indicative of the challenges facing inpatient psychiatric providers – challenges that are not present in nursing home or general health care populations for whom the original instruments were developed.

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Based on the information collected by the contractors during the first pilot, we project completion of the CMAT survey would require a minimum of 80 minutes per patient record (plus significant hours for initial training, orientation of new staff, and ongoing re-orientation) would become a permanent burden on inpatient psychiatric facilities. This is a significant – and unnecessary – burden.

The Use of Information Technology is Problematic

OMB indicates that, for the purpose of this test, “the contractors are proposing to administer the CMAT using an automated instrument.”

The difficulty that the contractors had in gaining participation for their pilot test (as described above) reflects the limited resources available within behavioral health care facilities to deliver data electronically. Configuring systems to collect data will add significant costs, in hardware and human capital, at a time when many facilities lack sufficient financial and human resources.

Recommendations

The AHA recommends that:

- OMB ask CMS to show how each item collected is related to the cost of caring for patients before it is included in the instrument to be tested and validated.
- Prior to testing any instrument, CMS examine all available methods for refining the psychiatric facility PPS to adequately account for case-mix, including the research from RTI, and ensure that the method that is brought forward for further testing is able to reliably accomplish the desired goal and is not burdensome for hospitals to administer.

If you have questions or concerns about our comments, please contact Nancy Foster, senior associate director of policy at (202) 626-2337 or nfoster@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

cc: Mark McClellan, M.D., Administrator, Centers for Medicare & Medicaid Services

Carolyn Rimes, Ph.D., Centers for Medicare & Medicaid Services