American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

June 22, 2009

Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1495-NC, Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2009 (RY 2010); Notice and Request for Comments (Vol. 74, No. 83), May 1, 2009

Dear Ms. Frizzera:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) inpatient psychiatric facility (IPF) prospective payment system (PPS) notice and request for comments for rate year (RY) 2010. We have comments on two issues: the creation of an IPF-specific market basket and the teaching adjustment.

MARKET BASKET

Since RY 2007, IPF PPS payments have been updated using a market basket – known as the RPL market basket – that reflects the operating and capital cost structures for inpatient rehabilitation facilities, IPFs and long-term care hospitals. CMS did not create an IPF-specific market basket due to the small number of facilities and limited data. While at the time of its implementation we generally supported use of the RPL market basket, it has limitations. For instance, while all of the facilities included in the RPL market basket are paid under a PPS, there are substantial differences in a number of cost factors across these facility types. **Therefore, we urge CMS to consider creating an IPF-specific market basket.**

In its request for comment, CMS also stated that the intent of an IPF-specific market basket would be to combine data from freestanding and hospital-based IPFs; currently, only freestanding data are included in the RPL market basket. **We believe that including hospital-based IPF data in the market basket, as well as pursuing a greater understanding of the differences between freestanding and hospital-based providers, are worthy undertakings.**

From 2005 through 2007, the number of freestanding IPFs increased by 1.0 percent, while the number of hospital-based IPFs decreased by 1.4 percent. We fear that this trend in facility closures will continue, and likely accelerate. In 2007, freestanding IPF margins were *positive* 6.4 percent, while hospital-based IPF margins were *negative* 9.8 percent. Hospital-based facilities, which account for more than 60 percent of patient discharges under the IPF PPS, are a vital component in preserving access to care for patients suffering from mental illness, particularly those who have coexisting physical conditions or experience a crisis and enter the emergency department for treatment.

IPF PPS TEACHING ADJUSTMENT

The IPF PPS also includes a teaching adjustment. High-quality residency education is fundamental to ensuring a continued physician workforce that many consider the best in the world. Medicare serves as an important source of financial support for residency programs by reimbursing the program's share of the costs of residency education at teaching hospitals. The IPF PPS' teaching adjustment provides an add-on payment for teaching hospitals based on the ratio of interns and residents to average daily census. However, the system includes a cap on the number of full-time equivalent (FTE) residents that may be used to calculate the teaching status adjustment. This cap is based on the number of FTE residents reported in the IPF's most recent cost report that was filed before November 15, 2004.

We are concerned about a cap on the number of FTE residents that can be used to calculate the teaching status adjustment; specifically, that it is based on a snapshot of activity, essentially "freezing" the status of residency education at a random point in time – 2004. **We believe that it is time to substantially modify the resident cap policy in the IPF PPS.**

CMS specifically solicits information on the number of IPFs that train additional residents from a residency program that has closed and have exceeded their caps because of those residents, as well as on the number of IPFs that have been asked to train additional residents from a residency program that has closed but have not agreed because these additional residents would cause them to exceed their caps. In the inpatient PPS, when a residency program closes, CMS permits temporary upward adjustments to the resident limits of hospitals that take on and complete the training of residents from hospitals that are closing. While this effort in the inpatient PPS minimizes disruptions in residents' education, allowing permanent resident limit adjustments in these situations is critical, both in the inpatient and IPF PPS. Because these situations involve a residency program closure, allowing permanent adjustments would not increase overall resident counts nationally.

To obtain information on the impact of the IPF teaching adjustment cap, the AHA surveyed IPFs. According to the results of this survey, the cap does impact IPF training of psychiatric residents. Specifically, certain IPFs reported that they train additional residents from a closed residency program and have exceeded their caps because of those residents; other IPFs reported that that they had been asked to train additional residents

from a closed residency program but had not agreed because these additional residents would have caused them to exceed their cap. These facilities expressed concern about the limitations of the cap, particularly in light of the shortage of psychiatrists in the U.S.

Recent data project that by 2030, the number of Americans over the age of 65 will double from 35 million to 71 million. The demand for health care services will continue to rise with the growing needs of the 78 million "baby boomers," who will begin to retire in 2010. Further, the recently passed *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* will greatly improve the affordability of mental health and substance use disorder health benefits. Given that the U.S. already faces a shortage of psychiatrists, these factors could potentially elevate what is now a problem to what could be a crisis. **The AHA urges CMS to modify its IPF PPS resident limit policy and thereby help address the psychiatrist shortage and help ensure access for beneficiaries who suffer from mental health and substance use disorders and who are among the most vulnerable Americans.**

If you have any questions, please feel free to contact me or Joanna Hiatt, senior associate director for policy, at (202) 626-2340 or jhiatt@aha.org.

Sincerely,

Rick Pollack
Executive Vice President