American Hospital Association

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

March 18, 2011

Donald M. Berwick, M.D., M.P.P.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1346-P
P.O. Box 8010
Baltimore, MD 21244–1850

RE: CMS-1346-P, Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System – Update for Rate Year Beginning July 1, 2011 (Rate Year 2012); Proposed Rule (Vol. 76, No. 18), January 27, 2011

Dear Dr. Berwick:

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) proposed rule for rate year (RY) 2012. We are generally supportive of the proposals in this rule; our specific comments follow.

PAYMENT RATE UPDATE PERIOD

CMS proposes to switch the IPF PPS payment year from a RY that runs from July 1 through June 30, to coincide with the federal fiscal year (FY) of October 1 through September 30. The agency states that this change would allow the consolidation of Medicare publications by aligning the IPF PPS update with the annual update of the ICD-9-CM codes, which take effect on October 1 of each year.

To make the transition, CMS proposes that RY 2012 run for 15 months, from July 1, 2011 through September 30, 2012. For RY 2013 and thereafter, the rate update period would begin October 1 and end September 30. **The AHA supports CMS' proposal to transition the IPF PPS from a RY to a FY update period.**

MARKET BASKET

Since RY 2007, IPF PPS payments have been updated using a market basket that includes inpatient rehabilitation facilities (IRFs), IPFs and long-term acute care hospitals (LTACHs), which is known as the RPL market basket. CMS did not create an IPF-specific market basket due to the small number of facilities and limited data. In the proposed rule, CMS solicits comment on the viability of creating two separate market baskets to replace the current RPL market basket, one of which would include freestanding IPFs and freestanding IRFs. The other market basket would be an LTACH-only market basket. Depending on the outcome of the research, CMS may propose a rehabilitation and psychiatric (RP) market basket in the next update cycle (RY 2013).

While the AHA generally supported use of the RPL market basket at the time of its implementation, 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 explore the creation of an RP market basket.**

Currently, the IPF portion of the RPL market basket reflects only freestanding IPF data. In considering different types of market basket structures in this proposed rule, CMS explored the observed differences in costs and cost structures between hospital-based and freestanding IPFs, but noted that it was not able to sufficiently understand the differences. Therefore, the agency said it was not appropriate at this time to incorporate data from hospital-based IPFs with those of freestanding IPFs in the market basket.

From 2005 through 2008, the number of freestanding IPFs increased by 11.5 percent, while the number of hospital-based IPFs decreased by 10.3 percent. We fear that this trend in facility closures will continue, and likely accelerate given that, in 2009, freestanding IPF margins were *positive* 14.4 percent, while hospital-based IPF margins were *negative* 14.1 percent. Hospital-based facilities, which account for more than 75 percent of facilities and 61 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. **Thus, we urge CMS to continue to explore the reasons behind the differences in the costs and cost structures between freestanding and hospital-based providers.**

IPF PPS TEACHING ADJUSTMENT

The IPF PPS includes a teaching adjustment that 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.

CMS proposes to allow a temporary increase in the FTE resident cap when the teaching IPF increases the number of FTE residents it trains due to the acceptance of displaced residents from a closed IPF or a closed IPF medical residency training program. The proposed policy, which is similar to the policy used for acute care hospitals, provides the following:

- CMS proposes to apply the IPF PPS temporary cap adjustment only to residents that were still training at the IPF at the time it closed or at the time the IPF ceased training residents in the residency training program(s);
- Residents who leave the IPF before the closure of the IPF or medical residency training program, for whatever reason, would not be considered displaced residents for purposes of the IPF temporary cap adjustment policy; and
- Medical students who match to a program at an IPF, but the IPF or medical residency training program closes before the individual begins training at that IPF, will not be considered displaced residents for purposes of the IPF temporary cap adjustments.

The AHA supports CMS' proposed policy to allow an increase to the temporary resident cap adjustment. However, we are generally concerned about caps on the number of FTE residents that can be used to calculate the teaching status adjustment. We are specifically concerned that the current cap is based on a snapshot of activity, essentially "freezing" the status of residency education at a random point in time – 2004.

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 began to retire in 2010. Further, the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* was designed to improve access to and 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 today's psychiatrist shortage to a crisis.

While we will continue to advocate for a substantial increase in the total number of residency training positions supported by the federal government, allowing a temporary resident cap adjustment will help maintain access for beneficiaries who suffer from mental health and substance use disorders.

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

Sincerely,

Rick Pollack
Executive Vice President