



March 11, 2003

BY FAX AND MAIL

Thomas A. Scully, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 443-G
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Scully:

The National Association of State Mental Health Program Directors (NASMHPD) represents the \$23 billion public mental health system serving 4.6 million people annually in all 50 states, four territories, and the District of Columbia. NASMHPD members are responsible for the administration and management of nearly 250 state-operated psychiatric hospitals, which serve as critical safety net providers for individuals with the most severe mental illnesses and, often, with the fewest resources.

In April, 2002, we wrote to you about the process currently underway at the Center for Medicare and Medicaid Services (CMS) to develop an interim prospective payment system (PPS) for inpatient psychiatric services provided under Medicare. In light of CMS' plans to publish a Notice of Proposed Rulemaking within the next few months, we are again writing to emphasize that any PPS must adequately and fairly reimburse state psychiatric hospitals for the services they provide to Medicare patients. Specifically, the PPS should be guided by the following principles:

1. To the greatest extent possible, the PPS should be based on the appropriate resource needs of patients receiving services, rather than on historic facility payments that may reinforce inequities or inefficiencies among providers.

Government-owned psychiatric hospitals currently are reimbursed under TEFRA's cost-based methodology at an average rate much lower than is provided to either privately-owned psychiatric hospitals or distinct part units of general hospitals. There is no consensus as to why government-owned hospitals report lower costs despite serving the most severely ill and needy patients, and analysis is

complicated by the fact that many of these hospitals bill Medicare based on an all-inclusive per diem rate that does not capture clinical procedure coding related to individual patient costs. Nonetheless, a preliminary analysis of Medicare cost reports conducted by the National Association of Reimbursement Officers (NARO) and shared with NASMHPD suggests that the costs of providing *direct patient care* are comparable in government-owned and privately-owned freestanding facilities. Differences in reported costs between these categories of facilities generally are attributable to such areas as capital expenditures and administrative costs.

The Balanced Budget Refinement Act of 1999 (BBRA) requires CMS to develop a per diem PPS that includes “an adequate patient classification system that reflects the differences in patient resource use and costs ...” In a Report to Congress (RTC) submitted August, 2002, CMS noted that a sound PPS meeting the requirements of the statute would result in the appropriate targeting of greater prospective payments to providers treating more costly resource-intensive patients using statistically objective criteria. (RTC at p. 4) The RTC acknowledged that such criteria are not currently available and described the importance of two CMS-sponsored research projects designed to identify patient characteristics and modalities of treatment that are predictive of appropriate resource use.

Nonetheless, the RTC suggested that an interim PPS based on existing administrative data could be developed, but acknowledged that a significant shortcoming of this approach is that it would result in a payment system “more reflective of the historical costs of the facilities, rather than one more closely linked to the medical characteristics and clinical resource needs of the patients.” (RTC at p. 45) Despite the fact that such a bias is inherent in the PPS methodology suggested in the RTC, we are aware that some analysts and interest groups have advocated for adjustments to the PPS to link it even more directly to historic payment rates and reported costs, rather than to the objective costs of providing services.

We understand the difficulty of developing a budget-neutral PPS without data that is adequate to identify appropriate patient resource use and costs. If an interim PPS cannot be delayed until CMS-sponsored research projects are completed, we urge you to continue to pursue a PPS that bases payment rates, to the greatest extent possible, on the appropriate resource needs of patients receiving services, rather than on historic payment rates or reported costs. Further, as discussed in the RTC, we urge you to continue to work toward a flexible PPS that can easily be updated, as information becomes available, to accommodate risk adjusters independent of the type of facility in which treatment occurs.

2. The PPS methodology should minimize the administrative burden placed on hospitals.

As discussed above, the collection and analysis of clinical and patient case-mix data is essential to the development and implementation of an equitable and effective PPS methodology. However, significantly increasing the administrative burden on hospitals to collect new data, revise billing, claims, and cost reporting forms, and modify computer software and hardware would strain hospital budgets already facing severe shortfalls. This is an especially important issue in state hospitals for which Medicare is only a small portion of revenues. In these facilities, the costs of additional paperwork can be

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allocated among only a few patients, resulting in increased operating losses for hospitals providing services to Medicare recipients. Therefore, we urge you to minimize, to the greatest extent possible, any new data collection or reporting requirements and to emphasize flexibility for facilities serving only a small number of Medicare recipients.

Thank you for considering our views on this matter. If you have questions or need additional information, please don't hesitate to contact us.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert W. Glover". The signature is fluid and cursive, with a long horizontal stroke at the end.

Robert W. Glover, Ph.D.
Executive Director

cc: The Honorable Nancy L. Johnson
The Honorable Pete Stark
Charles G. Curie