



April 9, 2002

***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 \$6.1 billion public mental health system in all 50 states, four territories, and the District of Columbia. On behalf of NASMHPD, we are writing to express our concerns about the process currently underway to develop an interim prospective payment system (PPS) for inpatient psychiatric services provided under Medicare and to recommend that CMS adhere to certain key principles as it moves forward with this initiative.

The Balanced Budget Refinement Act of 1999 (P.L. 106-113) requires the Secretary of Health and Human Services (HHS) to take the following actions: (1) develop a per diem-based PPS system for inpatient hospital services provided under Medicare in psychiatric hospitals and distinct part units of general hospitals; (2) report to Congress a description of the system; and (3) implement a PPS system for cost reporting periods beginning on or after October 1, 2002.

We understand that the enormous complexity of this task has delayed CMS in meeting certain deadlines, but that a draft report to Congress has been completed and a Notice of Proposed Rulemaking describing an interim payment system may be issued in the next several months.

NASMHPD members are responsible for the administration and management of nearly 250 state-operated psychiatric hospitals. State hospitals, many of which are models of excellent, innovative inpatient psychiatric care, are also providers of last resort, serving many individuals with no public or private health insurance or who have exhausted the limited benefits in their insurance plans (including Medicare) and have been discharged from other hospitals. Although the amount of state hospital

revenues derived from Medicare is relatively small – approximately 3 percent as a national average – it is an essential core of their revenue base, particularly since Medicaid bars reimbursement to adults receiving services in psychiatric hospitals. Moreover, severe budget shortfalls in nearly every state have drastically reduced available state general revenue funding. In addition, many individual hospitals rely on Medicare revenues to a significantly higher degree than the national average.

Similarly, CMS reports that a relatively small percentage of Medicare reimbursement for inpatient psychiatric services is spent in public psychiatric hospitals, but this reimbursement often represents payments for services to people who are indigent and have the most severe mental illnesses. We note that patients in these public, safety net psychiatric hospitals constitute a significant proportion of Medicare patient days in inpatient psychiatric hospitals, but many of these patient days are not reimbursable to the hospital because the patients have exhausted their available Medicare Part A benefits.

CMS currently funds at least two research projects designed to understand the costs of providing effective services in different inpatient settings and to identify appropriate reimbursement methodologies. We appreciate the opportunity to have discussed implications of different PPS systems with CMS staff and researchers working on these projects. While we have some concerns about different aspects of each of the research projects, we believe that both ultimately will result in valuable data and recommendations to inform CMS' work.

**Therefore, we are concerned that CMS plans to propose an interim payment system prior to receiving findings or analysis from its own funded research.** Such an approach may lead to a policy that is inequitable and could negatively affect the public mental health system's safety net providers. Further, implementation of an interim payment system, subject to revision following completion of CMS' research projects, would require all providers to undergo two potentially costly conversions of their data collection and reporting systems.

If CMS intends to go forward with publication of an interim payment system prior to receiving its own funded research results, that payment system should, at a minimum, be guided by the following key principles:

- **State psychiatric hospitals are safety net providers that must be reimbursed fairly and adequately under a new PPS system.**

Public psychiatric hospitals currently are reimbursed under Medicare at an average rate much lower than is provided to either private psychiatric hospitals or distinct part units of general hospitals. The reasons for this are complex, but they include cost reports and claims forms that do not adequately reflect the costs of serving individuals with the most severe mental illnesses, intensive acute care needs, and the longest lengths of stay.

Thomas A. Scully  
April 9, 2002  
Page 3

A principal goal of the new PPS system must be to identify accurate costs of providing services in state psychiatric hospitals and ensuring that these costs are reflected in the new reimbursement methodology. A PPS system – even a proposed interim system – that perpetuates or worsens historic inequities is unacceptable.

- **Reliance on existing Medicare databases to develop a PPS methodology will exclude critical information about psychiatric care in state hospitals and underestimate the legitimate costs of providing services in these facilities.**

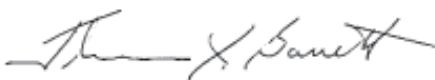
The Balanced Budget Refinement Act requires that the PPS system reflect “the differences in patient resource use and costs” among hospitals. As noted above, there is a near consensus in the field (including among CMS staff) that existing CMS forms, such as the Medicare cost report, the HCFA-1450 (UB-92), and the HCFA-1500 claims form, generally underestimate the actual costs of providing inpatient services in state hospitals. A new reimbursement system must be based on the full range of data needed to reflect accurately the costs of providing services to individuals with the fewest resources and the most severe mental illnesses.

- **The PPS methodology must minimize the administrative burden placed on hospitals.**

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 allocated among only a few patients, resulting in increased operating losses for hospitals providing services to Medicare recipients.

Thank you for considering our views on this matter. We hope to have an opportunity to meet with you and your staff developing the interim payment system to discuss our concerns and these principles in more depth. In the meantime, if you have questions or need additional information, please don't hesitate to call either of us. Tom Barrett can be reached at (303) 866-7401 and Bob Glover can be reached at (703) 739-9333, ext. 129.

Sincerely,



Tom Barrett, Ph.D.  
President



Robert W. Glover, Ph.D.  
Executive Director

cc: The Honorable Nancy L. Johnson  
The Honorable Pete Stark