August 12, 2011

Submitted via www.regulations.gov

Administrator Donald Berwick
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445–G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Request for Comments, Medicare Program: Conditions of Participation (CoPs) for Community Mental Health Centers, 76 Fed. Reg. 117 (June 17, 2011); File Code CMS–3202–P.

Dear Administrator Berwick:

The National Council for Community Behavioral Healthcare is a not-for-profit, 501(c)(3) association of 1,950 behavioral healthcare organizations that provide treatment and rehabilitation for mental illnesses and addictions disorders to nearly six million adults, children and families in communities across the country. The National Council and its members are committed to providing comprehensive, quality care that affords every opportunity for recovery and inclusion in all aspects of community life. The National Council advocates for policies that ensure that people who are ill can access comprehensive healthcare services and offers state-of-the-science education and practice improvement resources so that services are efficient and effective.

Our members are traditional Community Mental Health Centers (CMHCs) recognized by the state mental health authorities and the federal Community Mental Health Services Block Grant. A majority of our members are non-profit organizations that overwhelmingly depend on Medicaid and other public funds to serve people with the most chronic mental health conditions.

The National Council and its members take great interest in the proposed Conditions of Participation (CoPs) for Community Mental Health Centers (CMHCs) that provide Partial Hospitalization (PHP) services. A small number of our member organizations provide PHP services, and there are other member organizations that are interested in providing PHP. These CMHCs have an obvious interest in the proposed CoPs. However, the proposed CoPs are of interest to all of our members, whether or not they currently provide or intend to provide PHP services. In an effort to provide some consistency, the federal Medicaid program and/or state governments may adopt these CoPs for all CMHCs, regardless of whether they are PHP providers. For this reason, all of our 1,950 behavioral health organizations are grateful for the opportunity to provide comments.

The National Council appreciates the agency's effort to establish CoPs for PHP services. Like CMS, we and our members are committed to delivering quality services for people living with mental illnesses. In addition to our practice improvement initiatives, the National Council is supporting the creation of a new statutory definition for Federally Qualified Behavioral Health Centers (FQBHC). Such a definition would establish federal status for community-based mental health and addiction providers that volunteer to meet the standards for an FQBHC and would provide clearly defined treatment objectives and the minimum core services required. A provision creating a definition for FQBHCs was included in the House version of healthcare reform; however, it was not included in the final version of the Affordable Care Act enacted in March 2010. In the last Congress, stand-alone bills that would both establish the FQBHC definition and provide for cost-based reimbursement for FQBHCs were introduced in the House by Reps. Doris Matsui and Eliot Engel (HR 5636) and in the Senate by Sen. Debbie Stabenow (S. 4038). Both bills will soon be reintroduced in the current Congress.

Although CoPs are Needed, Proposed Regulations Significantly Underestimate the Burden on CMHCs and Threaten PHP and Safety Net Services

Although the National Council supports the establishment of CoPs, we have serious concerns about the proposal at hand. Our greatest concern is that the proposed CoPs, while written for PHP services, would apply to *all* of the services provided by the participating CMHCs. This does not make clinical or fiscal sense, and CMS makes erroneous assumptions about both. For our non-profit CMHCs, their PHP programs are very small relative to the outpatient services they provide. For example, one member organization has an eight-bed PHP but over *10,000* active clients in its outpatient program. Based on reported revenue sources, the share of Medicare patients at a typical National Council member organization is about *four percent.*[1] By its very definition, a PHP program serves clients who would otherwise require hospitalization; these individuals are experiencing an acute episode of mental illness and require the most intensive level of services CMHCs provide. In contrast, outpatient mental health programs serve people with a wide range of needs, from short-term marital counseling to long-term services for individuals with chronic but stable conditions. Our members would simply be unable to provide PHP services if Medicare requires the same treatment and staffing conditions for PHP programs as for outpatient services.

Based on our experience, the proposed CoPs make assumptions about certification/licensure that are not accurate for non-profits. CMS states that "no regulatory basis exists to ensure basic levels of quality and safety for CMHC care." 76 Fed. Reg. 117 at 35684. Although there are currently no CoPs for CMHCs, non-profit CMHCs are regulated at both the state and federal level because of their reliance on Medicaid and state funding. Medicaid and state funding provide approximately 80% of our members' revenue.[2] At both the federal and state levels, Medicaid provides very specific requirements for services to be reimbursed. As state mental health budgets have dwindled, CMHCs have adapted their

[1] This figure is based on the funding sources reported by National Council member organizations in the 2011 Salary Survey. Executive Summary available at http://www.thenationalcouncil.org/galleries/resources-services%20files/BH%20Salary%20Survey%20FINAL%20exsumm.pdf.

[2] National Council Salary Survey.

programs to conform to Medicaid reimbursement rules. To the extent that the Medicare PHP CoPs increase the number of personnel required to perform a task or undergo additional training or require higher credentials as compared with Medicaid and state law, this significantly increases the burden on CMHCs without providing additional revenue streams.

Perhaps most alarming, CMS' assumptions and methodology for determining the burden of the proposed CoPs are not accurate based on our members' experiences and available data. The National Council surveyed our members who provide PHP services and retained the services of Avalere Health[3] to evaluate the assumptions contained in the proposed CoPs. See Attachment A.[4] Whereas CMS estimates the financial burden of all proposed CoPs to be approximately $18,304 per CMHC in the first year of implementation, Avalere demonstrates that the actual burden to be approximately *$2.8 to $19.1 million per CMHC*, depending on the organization's size. See Attachment A at 1-2.

Avalere's estimates differ greatly from CMS' estimates for several reasons:

- the actual number of patients per CMHC to whom the CoPs apply, pursuant to the requirements of the proposed CoPs themselves,
- inaccurate assumptions by CMS regarding Standard Medical Practice (SMP),
- a methodology, based on the size of the CMHC, for determining the number of direct care staff who will be subject to seclusion and restraint training,
- National Council member data regarding the length of time needed to complete a comprehensive assessment,
- average length of stay (LOS) data and its impact on the frequency of updates to both the comprehensive assessment and active treatment plan, and
- a conservative estimate of staff turnover based on nursing industry data.

The data and analysis provided by Avalere reveals that the proposed CoPs woefully underestimate the real costs to providers. Based on this information, CMS must review and recalculate all of its estimates to more accurately reflect the actual burden to providers.

The implications of implementing the proposed CoPs are dire. National Council non-profit PHP providers report that they are barely covering their PHP costs at the current Medicare reimbursement rates. One provider estimates that the CoPs would cost their center an additional $75,000 in salary just for their PHP program—a program that serves an average of six people at a time. All providers note that current Medicare reimbursement rates for PHP are inadequate to support the proposed CoPs. As one CMHC stated, if the interdisciplinary treatment team requirements are implemented as written, "We will discontinue this service as a PHP Medicare provider…We barely cover costs as it is, and we have no margin. Any additional salary costs would cripple the program." This provider is just considering the application of the CoPs to their PHP program and not to their entire CMHC. Application of the proposed CoPs to all clients of

[3] Avalere Health is a Washington DC-based advisory services firm dedicated to delivering practical solutions to complex healthcare problems. A multidisciplinary team of experts partners with organizations across the healthcare sector to elevate performance and drive success.

[4] The Avalere report contained in Attachment A is hereby incorporated by reference into the National Council comments.

participating CMHCs would be catastrophic, virtually eliminating the safety net for people with mental illnesses nationwide.

The only way to prevent this catastrophe is to reevaluate CMS' proposal to apply the CoPs to all programs of participating CMHCs. With the proper application of proposed CoPs to CMHCs and specific CoPs to PHP services and other important changes, revised CoPs could address CMS' legitimate concerns about client care without placing an undue and unintended burden on CMHCs. Such revisions could ensure continuation of both safety net services and PHP in the continuum of services.

The CoPs Should be Divided Into Two Categories: Those that Apply to Participating CMHCs Generally and Those that Apply Only to PHP Services

We propose that the CoPs be divided into two categories: those that apply to participating CMHCs generally and those that apply specifically to PHP services.

CoPs That Should Apply to Participating CMHCs Generally

The CoPs that should apply to participating CMHCs as a whole are those that make clinical and fiscal sense regardless of the types of services provided. We recommend that the following CoPs apply to participating CMHCs, with specific exceptions and concerns discussed below:

- Sec. 485.902 Definitions
- Sec. 485.904 Personnel qualifications
- Sec. 485.910 Client rights (except for subsection (f) regarding staff training)
- Sec. 485.917 Quality assessment and performance improvement
- Sec. 485.918 Organization, governance, administration of services

Sec. 485.902 Definitions

The only concern that the National Council has with the Definitions section is the requirement that all volunteers meet the standard training requirements under §485.918(d). Although it is appropriate that CMHCs provide all volunteers with "an initial orientation…that addresses the specific duties of his or her job," §485.918(d)(2), it is unreasonable to require CMHCs to provide the specific training and competency assessments required under §485.918(d)(1) and (3) for regular employees. Volunteers can include a wide range of commitment levels and services, such as providing one-time assistance with beautification projects or fundraising that may not involve client care.[5] An initial orientation tailored to the actual work a volunteer will be doing ensures that volunteers will receive the information and guidelines they need from CMHCs without imposing an unnecessary and impractical barrier to using volunteers.

Sec. 485.904 Personnel qualifications

[5] We do not know of any data source to determine the number of volunteers at CMHCs or the kinds of services they perform. CMS does not provide such data nor does the agency provide evidence that lack of training for volunteers is a problem that needs to be addresses via CoPS. CMS provides no estimates regarding the financial burden of volunteer orientations or training.

The National Council and its members have several concerns about the proposed personnel qualifications. Sec. 485.904(a) requires that "All professionals who furnish services directly…must be legally authorized (licensed, certified or registered) in accordance with applicable Federal, State and local laws, and must act only within the scope of their State licenses." Most states allow individuals with masters level degrees, such as social work and psychology, to provide services under the supervision of a licensed professional. In fact, a period of supervision is required for these professionals to receive licenses. In addition, many peer educators and bachelors level professionals do not have a process for becoming licensed or must work in a supervised position for a certain number of hours to obtain certification. We do not believe that CMS intends to impose a barrier to master level clinicians becoming licensed or to limit the advancement opportunities of peer educators and bachelors level staff. We propose that this Section be rewritten as follows:

> All professionals who furnish services directly…must be legally authorized in accordance with applicable Federal, State and local laws and must act only within the scope of these laws.

The same issue regarding certification and/or licensure is raised by the personnel qualifications for "mental health counselors." Sec. 485.904(b)(4). The proposed CoPs require that these counselors be "certified and/or licensed by the State." Id. Most states allow unlicensed mental health counselors to practice under the supervision of a licensed practitioner. This subsection should be modified to ensure that mental health counselors who are on the path to certification or licensure should be able to provide services under the supervision of a licensed professional.

The National Council is also concerned about the proposed qualifications for "psychiatric registered nurses." Sec. 485.904(b)(7). The proposed CoPs require that a psychiatric RN have "at least 2 years of education and/or training in psychiatric nursing." Id. Non-profit CMHCs face fierce competition for professional staff and cannot always offer salaries as high as those offered by other providers, such as hospitals. CMHCs in rural areas have an added hurdle to recruiting and retaining clinicians. One way CMHCs can attract staff at the salaries they are able to pay is by offering recent graduates the opportunity to gain more experience working in community behavioral health. It is unclear whether the two-year education and/or training requirement would disqualify recent nursing school graduates from working at non-profit CMHCs. (e.g., What does two years of education require in terms of credit hours?) If it does, CMHCs can expect to pay significantly higher salaries. This subsection should be clarified to include approved nursing school graduates who have "education and/or training in psychiatric nursing," without specifying a length of time.

Sec. 485.910 Client rights

With one major exception, the client rights section of the proposed CoPs contains provisions that are already standard practice for CMHCs. CMHCs routinely inform clients of their rights and provide for a grievance process. The seclusion and restraint standards outlined in Sec.

485.910(e) should be standard practice for CMHCs, and we understand that they are included pursuant to the Children's Health Act.

However, the National Council strongly questions the attention the CoPs devote to staff training on seclusion and restraint in Sec. 485.910(f) and is concerned that the proposed training components may have the opposite effect of what CMS intends. As CMS notes, "we believe restraints or seclusion are *rarely, if ever,* used in a CMHC setting and that there are very few deaths *(if any)* that occur due to restraints or seclusion in CMHCs." 76 Fed. Reg. 117 at 35688 (emphasis added). We are not aware of any CMHCs using seclusion or restraint in their outpatient programs and are certainly not aware of any deaths that have resulted from their use. Many of our members report that state law prohibits CMHCs from using seclusion and restraint in any program. As a result, many of our members no longer train staff on these prohibited practices. Instead, CMHCs train staff in de-escalation techniques and crisis management.

Even if CMS were to determine that such training were necessary, CMS underestimates the actual cost of training staff on seclusion and restraint techniques. CMS estimates that seclusion and restraint training would involve an annual cost of $2,248 per CMHC. 76 Fed. Reg. 117 at 35700. CMS underestimates the number of direct care staff per CMHC and does not take into account staff turnover. Analysis by Avalere shows that CMHCs vary greatly in size, whether measured by staff, patients served, or annual budgets. Attachment A, Table 2. In Avalere's analysis of training costs, a small CMHC would incur approximately $9,000 in annual costs for staff-wide training; a large CMHC would incur $30,000 annually. Id., Table 1. CMS underestimates the annual cost of seclusion and restraint training by as much as $27,000 per large CMHC.

There is no evidence that CMHCs' use of seclusion or restraint is a concern, but Avalere's report provides ample evidence that the training and reporting requirements would be a tremendous administrative and financial burden. It is sufficient to impose the standards outlined in Sec. 485.910(e) and to require reporting of any adverse events as proposed in Sec. 485.910(g). It would be contrary to best practices and state laws to train staff to use seclusion and restraint when they are not now engaging in these practices and may be legally prohibited from doing so. Sec. 485.910(f) should be removed from the CoPs, and all staff training (including training in de-escalation techniques and crisis management) should be addressed by Sec. 485.918.

Sec. 485.917 Quality assessment and performance improvement

The National Council is committed to supporting its members to develop better data systems and to use that data to improve service quality and efficiency. In fact, the National Council has been leading quality improvement initiatives for a number of years. Because of our commitment to quality improvement, we have no objection to the CoPs requirement for CMHCs to develop, implement and maintain a quality assessment and performance improvement (QAPI) program.

Sec. 485.918 Organization, governance, administration of services

The National Council has both concerns and comments to offer on this section of the CoPs. Although this section does not address deeming authority, it appears to be the appropriate place

to discuss the topic. In the proposed CoPs, CMS is "not proposing to amend our regulations at 42 CFR 488.6 to grant deeming authority for CMHCs to accrediting organizations…[but they] are specifically soliciting public comment regarding this issue." 76 Fed. Reg. 117 at 35685. The National Council encourages CMS to defer to the states regarding deemed status, by recognizing deeming authority for CMHCs in those states that allow deeming.

Provision of Services

Sec. 485.918(b) states that a CMHC "must be primarily engaged in providing the following care and services to *all* clients served by the CMHC…" (emphasis added). As written, this requirement appears to contradict the section of the CoPs which rightly demands that treatment plans be individually tailored to each client. One of the listed services is occupational therapy (OT). Sec. 485.918(b)(xi). Although occupational therapy may be appropriate for some clients, particularly those in PHP programs, it is not a necessary service for all CMHC clients. In some instances, OT is not even a reimbursable service under Medicaid. The National Council recommends modifying Sec. 485.918(b) to qualify that the required services are available to all clients "for whom they are clinically appropriate and necessary."

Forty Percent Rule

Sec. 485.918(b)(1)(v) of the CoPs requires CMHCs to provide "at least 40 percent of its items and services to individuals who are not [Medicare] eligible." For National Council members, this standard is not difficult to meet. Medicare-eligible clients typically represent just four percent of their overall client base.[6] Although the CoPs propose to measure this by using the "total revenues received by the CMHC that are payments from Medicare versus payers other than Medicare," (Sec. 485.918(b)(1)(v)) CMS acknowledges that this could be measured in a variety of ways and seeks comment on methodology as well as whether the agency should require attestation or verification auditing. See 76 Fed. Reg. 117 at 35693-4. Although National Council members did not provide a consensus as to a preferred methodology, providers did emphasize that uncompensated care should definitely be included in any calculation using a revenue-based methodology. As one provider commented, "a cost is associated with service delivery" even if it is uncompensated.

Other providers raised concerns about using a methodology based on the percentage of clients within certain eligibility categories— specifically, how clients who are dually eligible for Medicaid and Medicare would be counted. Although Medicare is billed for PHP services for dual eligibles, Medicaid is the par for the more prevalent outpatient services. Counting all dual eligibles as Medicare clients would misrepresent the percentage of actual "items and services" delivered to people who are Medicare eligible because they are receiving those services based only on Medicaid eligibility.

Non-profit CMHCs exceed the 40 percent requirement to such a degree that attestation should suffice. Subjecting CMHCs to verification audits could involve significant staff time and resources—an unnecessary burden when the end result is not in question.

[6] National Council Salary Survey.

Staff Training

Section 485.918(d) requires staff training, initial orientation, and a staff assessment. Annual training is a standard practice for CMHCs. As discussed above regarding Sec. 485.902, we take exception to including volunteers in the staff education component described by Sec. 485.918(d)(1) and recommend that any reference to volunteers in this section be removed.

Section 485.918(d)(3) requires that CMHCs "assess the skills and competence of all individuals furnishing care…" It is not clear what such a skills and competency assessment would contain, and how much time it would take to develop and administer such assessments for each position within every CMHC. CMS does not provide burden estimates, assuming that these are "usual and customary business practices." 76 Fed. Reg. 117 at 35697. Contrary to CMS' assertions, the National Council has not encountered such a practice among our members. The ultimate determination of how well staff are performing lies with the QAPI. If staff fail to deliver quality services, that will be reflected in the QAPI. Because the QAPI is the appropriate vehicle for determining staff performance and identifying weaknesses that require additional training and personnel or policy changes, the National Council recommends eliminating this vague requirement from Section 485.918.

CoPs that Should Apply Only to PHP Programs

The CoPs that should apply only to PHP programs are those that make clinical and fiscal sense for the intensive, short-term services that PHPs provide. We propose that the following CoPs be made specific to PHPs and not CMHCs as a whole, with specific exceptions and concerns discussed below:

- Sec. 485.910 Client rights (subsection (f) only, regarding staff training on seclusion and restraint)
- Sec. 485.914 Admission, initial evaluation, comprehensive assessment and discharge or transfer of the client
- Sec. 485.916 Treatment team, client-centered active treatment plan, and coordination of services

Initial Evaluation

There are two areas of concern regarding the initial evaluation component of the CoPs: allowable personnel to conduct the assessment and CMS' assumptions regarding costs. The Avalere analysis provides clear support for applying these CoPs only to PHP programs.

Sec. 485.914(b)(1) states that the initial evaluation must be conducted by a psychiatric RN or clinical psychologist. Although this may be standard medical practice (SMP) for PHP units, it is not SMP for outpatient programs. Under Medicaid and state law, CMHCs are allowed a wide range of staff to provide initial evaluations, from unlicensed, masters level practitioners (under supervision of a licensed professional) to licensed masters level clinicians, including social workers and counselors. Because CMS assumes that the proposed CoPs are SMP CMHC-wide, the agency assumes there is no financial burden for CMHCs. 76 Fed. Reg. 117 at 35701. Avalere estimates that the cost of applying the initial evaluation requirements to CMHCs as a

whole would result in annual costs ranging from $68,000 to almost half a million dollars per CMHC. Attachment A, Table 1. In addition to a tremendous increase in cost, applying this requirement to CMHCs as a whole would require most states to change their policies. For these reasons, the initial assessment CoPs should apply only to PHP admissions.

Under state law, many PHP programs are allowed greater flexibility regarding credentials required for initial assessments. Although states may require a physician to sign off on the initial evaluation—to attest to the need for PHP to avoid hospitalization as stated at Sec. 485.914(b)(2)(vi)—most states and Medicare allow LCSWs to perform the initial assessment for PHP admissions. Because it is standard medical practice and a comprehensive assessment will be completed by an interdisciplinary team within three working days of the admission, the National Council recommends that LCSWs be added to the list of clinicians who may perform initial assessments for PHPs.

Comprehensive Assessment and Interdisciplinary Treatment Team

The proposed CoPs state that a comprehensive assessment must be completed by a "CMHC physician-led interdisciplinary treatment team, in consultation with the client's primary health care provider." Sec. 485.914(c)(1). Although Sec. 485.914 does not specify the composition of the "interdisciplinary treatment team," (IDT) the required staff members are listed in the treatment planning section at Sec. 485.916(a). The comprehensive assessment and the treatment plan must be updated "no less frequently than every 30 days." Sec. 485.914(d)(2), 485.916(d).

Based on our member data and the studies by Avalere, CMS assumptions regarding the comprehensive assessment and the treatment plan do not take into account current policies and practices mandated or allowed by federal and state requirements. For example, the CoPs' interdisciplinary treatment team requires a minimum of five licensed professionals—physician, psychiatric RN, clinical social worker, clinical psychologist, and occupational therapist—to perform comprehensive assessments. Although CMS states that the IDT composition is "Standard Medical Practice" (SMP), the number of staff and the level of credentials far exceed what most states and Medicaid require for outpatient CMHC services and indeed, may even exceed what is reimbursable under Medicaid. In addition, CMHCs report that their states have very different requirements for PHP and CMHC assessments and treatment plans. Given the variability in state laws, CMS cannot reasonably conclude that the proposed make-up of the IDT is SMP for CMHCs.

CMS also underestimates the time required for performing a comprehensive assessment. Although CMS' calculations estimate just 20-30 minutes per team member for conducting and recording a comprehensive assessment, (76 Fed. Reg. 117 at 35701), National Council members' experience indicates that the time spent on comprehensive assessment is about 60 minutes per team member per client. Avalere used the 60 minute figure in their cost calculations.

Because CMS erroneously concludes that comprehensive assessments as outlined in the CoPs are SMP, the agency does not include a cost estimate. If the proposed CoPs regarding comprehensive assessments were applied to all CMHC clients, Avalere estimates annual costs of

$643,000 for small CMHCs and over $4 million for large CMHCs. Attachment A, Table 1. The cost of applying the CoPs for treatment plan development to all CMHC clients is equally daunting. Avalere estimates annual costs of $550,000 for small CMHCs and as much as $3.7 million for large CMHCs. Id. These cost estimates do not even include the 30-day updates required by the CoPs.

When estimating the burden of updating every comprehensive assessment and treatment plan every 30 days, CMS does not take into account length of stay (LOS) data. CMS estimates that each client will have his or her treatment plan updated just once per year.[7] Using Medicare claims data for 217 PHP providers, Avalere determined that the average LOS for PHP patients was 98 days. Attachment A at 5. This would require three updated comprehensive assessments, as well as three updates to the treatment plan, per client. [8] CMS' projections regarding the financial burden of updating comprehensive assessments and treatment plans are just *one-third of the actual cost per client.*

If the 30-day update requirement is applied to CMHC outpatient services, CMS estimates are even more grossly understated. Although LOS for outpatient clients varies, data from National Council members who provide PHP show that outpatient LOS is consistently at least twice as long as that for PHP clients—and in some cases averages more than a year. Furthermore, National Council members report that updating comprehensive assessments and treatment plans every 30 days is not standard medical practice for outpatient clients. Most of these clients are stable, and their treatment goals and services do not change as frequently as every 30 days. Applying these requirements across the board at CMHCs is neither clinically necessary nor financially feasible.

When applying the CoPs IDT standard to PHPs, National Council members who are PHP providers are concerned that the list of professionals is too narrow. "[P]hysician led" does not recognize that some states allow some categories of nurses to perform services that are almost identical to physicians. The Social Security Act explicitly states that "individual and group therapy" may be conducted by "other mental health professionals to the extent authorized under State law." Sec. 1861(ff)(2)(A). National Council members encourage CMS to ensure that the CoPs are consistent with the Social Security Act in providing this flexibility to PHP programs.

Section 485.916(e) of the CoPs requires CMHCs to provide care coordination by "ensur[ing] that the interdisciplinary treatment team maintains responsibility for directing, coordinating, and supervising the care and services provided." According to the CoPs definition of an IDT, this means that care coordination must be provided by one of the following licensed professionals: physician, psychiatric RN, clinical psychologist, clinical social worker or occupational therapist. See Sec. 485.916(a). Contrary to CMS assertions that this is consistent

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[7] Per Table 2, CMS assumes 112 Medicare clients per average CMHC. 76 Fed. Reg. 117 at 35698. When determining the cost of providing 30-day updates to these clients' treatment plans, CMS estimates 15 minutes per update for a total of 28 hours per CMHC. Id at 35702. Twenty-eight hours accounts for only 112 treatment plan updates.

[8] CMS concludes that there is no additional burden associated with comprehensive assessment updates because CMHCs are required under current payment rules to recertify a Medicare client's eligibility for PHP. 76 Fed. Reg. 117 at 35701. This assertion does not take into account the proposed CoPs application to all CMHC clients, not just those in PHP programs.

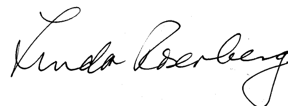
with CMHC practice, it is common under Medicaid rules for lower level staff to provide care coordination. Whereas CMS does not estimate the burden to CMHCs to provide care coordination to all clients with the personnel designated by the CoPs, Avalere estimates the annual cost to be approximately $35,000 for small CMHCs and $238,000 for the largest CMHCs. Because the care coordination process required by the proposed CoPs deviates from what is allowed under Medicaid and imposes a significant burden on CMHCs, this provision should apply only to PHP programs.

Conclusion

Although our concerns and proposed revisions are extensive, the National Council supports fair and reasonable rules for CMHCs that provide PHP services as part of a continuum of care. National Council members are actively working to improve access to care and the quality of services to people with mental illnesses and addictions disorders. Conditions of Participation (CoPs) must make clinical and fiscal sense and should not impose unnecessary and undue burdens on CMHCs for no gains in client care. Applying appropriate CoPs to all CMHC services and limiting specific CoPs to PHP programs is the only way to ensure that PHP remains a viable option for those who need it.

We greatly appreciate the opportunity to provide comments.

Sincerely,



Linda Rosenberg, MSW
President & CEO

To: National Council for Community Behavioral Health

From: Joanna Young
Brychan Manry

Date: August 11, 2011

Re: Financial Impact on Community Mental Health Centers Associated with the Medicare's Conditions of Participation

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Summary

The National Council for Community Behavioral Health (NCCBH) requested Avalere Health to estimate the financial impact on community mental health centers (CMHCs) associated with CMS' proposed rule, published in the *Federal Register* on June 17, 2011, establishing six conditions of participation (CoPs) in the Medicare program.[1] The proposed CoPs would apply organization-wide at CMHCs billing Medicare for partial hospitalization program (PHP) services; nevertheless, CMS developed the cost burden estimates based only on the number of PHP clients at those CMHCs. In addition, there is a concern that states might incorporate similar CoPs in their certification requirements for all not Medicare-certified CMHCs providing behavioral care services to Medicaid patients but that CMS' CoPs may not be applicable to the entire universe of CMHCs. Avalere estimated the cost burden for a typical member organization of the 1,800+ represented by the NCCBH based on all of their patients as opposed to CMS' estimation. We have estimated the costs associated with the selected requirement areas related to the three CoPs:

- ''Admission, initial evaluation, comprehensive assessment, and discharge or transfer of the client'', specifically §485.914(b) regarding initial evaluation, §485.914(c) regarding comprehensive assessment, and §485.914(d) regarding comprehensive assessment update
- "Treatment team, active treatment plan, and coordination of services'', specifically §485.916(b) regarding development of the active treatment plan, §485.916(d) regarding review of the active treatment plan, and §485.916(e) regarding coordination of services
- ''Client rights", specifically §485.910(f) regarding restrain/seclusion staff training

We estimate the annual cost of meeting these three CoP requirements with respect to all patients served to be on average between $2.8 million and $19.1 million per CMHC (depending on the CMHC size) assuming the lowest required staff level and a conservative rate of staff turnover throughout the year. Our estimates in Table 1 are broken down by the organization size as reflected by the CMHC's annual operating budget.

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[1] http://www.gpo.gov/fdsys/pkg/FR-2011-06-17/pdf/2011-14673.pdf

Table 1: Estimated annual costs of selected CoP requirements based on CMHC operating budget

Annual Operating Budget (Million $)	*0 – 9.9*	*10 – 19.9*	*20 – 29.9*	*30 – 39.9*	*40+*
Estimated Cost per CMHC, in Thousands of Dollars					
Initial Evaluation	68	168	205	366	459
Comprehensive Assessment	643	1,600	1,954	3,483	4,364
Comprehensive Assessment Update	964	2,400	2,931	5,225	6,546
Active Treatment Plan Development	550	1,368	1,671	2,979	3,732
Active Treatment Plan Update	550	1,368	1,671	2,979	3,732
Coordination of Services	35	87	107	190	238
Restraint Training	9	11	16	18	30
TOTAL	**2,818**	**7,004**	**8,554**	**15,239**	**19,099**

CMS projects the overall financial impact of all proposed CoPs to be approximately $4.1 million in the first year of implementation. CMS also estimated the impact on 224 Medicare-certified CMHCs, suggesting the average cost burden per CMHC could be around $18,304. Our estimates differ from CMS' estimates for three reasons: the number of patients per CMHC; the amount of financial resources needed to comply with the CoP provisions; and staff turnover.

- CMS' estimation is based on only PHP patients even though CoP requirements will be applicable to all patients served by a given organization. We included all CMHC patients in our estimates.
- CMS assumed that the requirements in the first two CoP areas (§485.914 and §485.916) are standard medical practice and that the only financial burden to CMHCs will be associated with the documentation and update requirements. The assessment- and treatment plan-related activities described in those CoPs may be standard medical practice with respect to PHP services but not all other outpatient services provided by CMHCs. Many of CMHCs are currently not well-equipped to carry out those activities. We estimated the financial burden associated with performing the assessment- and treatment plan-related activities at the CMS-described level for the entire CMHC client population.
- Finally, CMS' estimates do not appear to take into consideration staff turnover throughout the year which would lead to increased costs associated with restraints training that will have to be provided to new employees. We have assumed a modest amount of staff turnover (14 percent), based on average annual turnover rates for registered nurses reported in the recent study on hospital nursing labor costs.

Background

CMHCs lost their federal designation upon the passage of the Omnibus Budget Reconciliation Act of 1981 as they were no longer able to receive the direct federal funding. Since there is no federal designation of a CMHC, every state has its own licensing or certification requirements, which often leads to varying definitions of a CMHC as well as varying scope of services provided. The typical NCCBH member, all of whom are considered CMHCs, usually provide

outpatient services to mentally ill adults and children such as individual or group therapy, medication management, and 24 hour-a-day emergency care services. Given the patient mix, Medicaid fee-for-service (FFS) is the primary source of payment for most of these CMHCs.

Some CMHCs provide partial hospitalization services directly reimbursable by Medicare. To be able to bill and receive payments from Medicare for those services, an organization needs to be certified as a Medicare CMHC provider. Until now, there have been no CoPs and CMHCs simply had to meet applicable licensing or certification requirements in the State in which they were located and provide specific core services described in §1913(c)(1) of the Public Health Service Act. [2] However, many locations that are considered CMHCs provide Medicare patients with services other than partial hospitalization and bill Medicare via special submission on physician office claims. These organizations are not defined as CMHCs from the Medicare billing perspective.

The proposed Medicare CoPs are directed only at a small group of CMHCs billing Medicare for partial hospitalization services (224 centers). Nevertheless, other payers, notably state Medicaid programs, may follow CMS' footsteps and start incorporating the requirements outlined in the CoPs in their own licensing or certification processes. As a consequence, all CMHCs currently billing Medicaid for mental health and substance abuse services would potentially have to meet similar CoP requirements or else risk losing the largest source of their revenues.

Data Sources

We used the following data sources to develop our estimate:

- The Centers for Medicare and Medicaid Services (CMS)' Medicare Program: Conditions of Participation for Community Mental Health Centers, Proposed Rule, June 27, 2011
- Bureau of Labor Statistics (BLS), salary estimates, 2009
- Medicare 5% standard analytic files (SAFs) representing services for a sample of 5 percent of the Medicare fee-for-service population at the hospital outpatient setting, 2009
- The National Council for Community Behavioral Healthcare (NCCBH), Behavioral Health Salary Survey, 2011[3]
- KPMG's 2011 U.S. Hospital Nursing Labor Costs Study, June 8, 2011[4]
- Unpublished, proprietary data for a sample of 217 CMHCs provided by the National Council for Community Behavioral Healthcare
- Estimates provided directly by CMHC members of the NCCBH to Avalere Health

[2] https://www.cms.gov/manuals/downloads/som107c02.pdf
[3] http://www.thenationalcouncil.org/galleries/resources-services%20files/BH%20Salary%20Survey%20FINAL%20exsumm.pdf
[4] http://natho.org/pdfs/KPMG_2011_Nursing_LaborCostStudy.pdf

Assumptions and Methodology

- **Total Number of CMHC Patients:** Determining the total number of patients who receive services at a CMHC is an important factor in estimating the burden imposed by the proposed CoPs. If implemented, the CoP requirements will apply not only to Medicare patients but to all patients at participating CMHCs. CMS acknowledges this but notes that due to the lack of the data it only included the number of Medicare patients at each CMHC in its impact analysis (112 beneficiaries, on average).

  To estimate the full financial impact on CMHCs, Avalere calculated the cost of expanding CoP requirements to all patients. We used the data collected by NCCBH for a sample of 217 CMHCs to divide the centers into five size categories based on their total annual operating budget. For each size category, we estimated the average number of patients served by a CMHC (see Table 2). We then applied these averages to the per-patient cost estimates to produce an estimate of the total financial burden for each CMHC.

  The estimates of the total number of patients seen by NCCBH's member organizations are disproportionately larger as compared to the average number of Medicare beneficiaries served by a Medicare-certified CMHCs (112 patients). The main reason for this difference is that the share of Medicare patients at a typical member organization is only about 4 percent as indicated by the funding sources reported by the NCCBH's salary survey respondents. The vast majority of the patients are indigent and their services are paid for by Medicaid or via the State grants. CMHCs also serve private insurance and uninsured patients.

- **Direct Care Staff:** There is limited information available on the exact make-up of the "direct care staff" within CMHCs. CMS acknowledges this limitation in the proposed CoP when it estimates the number of staff that would be required to be trained on proper use of restraints. CMS' assumption of eight staff members could be accurate for very small organizations, but based on our analysis may not reflect the number of direct care staff who will need to be trained at larger CMHCs.

  We used the data collected by NCCBH for a sample of 217 CMHCs to estimate the average number of staff at a CMHC for each size category. To estimate the number of "direct care staff" we used BLS statistics on the makeup of the staff in the healthcare industry as a whole. We estimated that professions associated with patient care (i.e. physicians, nurses, social workers, etc.) account for approximately 60 percent of the healthcare industry workforce.[5] The remaining 40 percent consists of management, financial, office and administrative support occupations, etc. Therefore, we applied 60 percent estimate to the total number of staff at each CMHC to calculate the number of "direct care staff" that could be required to undergo restraints use training under the proposed CoPs (see Table 2 below).

[5] Employment of wage and salary workers in healthcare, 2008, http://www.bls.gov/oco/cg/cgs035.htm

Table 2: Estimations based on the self-reported data for a sample of 217 CMHCs

Annual Operating Budget Range (in millions)	0-10	10-19.9	20-29.9	30-39.9	40+
Number of CMHCs	69	57	33	24	34
Average Number of Patients	2,503	6,230	7,608	13,562	16,990
Average Number of Staff	96	205	365	447	937
Average Number of Direct Care Staff	58	123	219	268	562

- **Staff Hourly Rates:** To the extent possible, we used CMS' estimates computed based on the annual base salaries and benefits (worth 30 percent of the base salary) collected from the BLS and converted into hourly rates using an 8 hour workday. For staff members not included in the CMS' impact analysis, we used the BLS salary estimates (occupational therapist) and the NCCBH's salary survey (psychiatrist). See Table 3.

Table 3: Estimated staff hourly rates

Hourly Rate	CMS' estimate	Avalere's estimate
Psychiatric Nurse (PRN)	$36	$36
Clinical Psychologist(CP)	$48	$48
Clinical Social Worker(SW)	$28	$28
Psychiatrist (MD)	No estimate	$104
Occupational Therapist (OT)	No estimate	$41

- **Comprehensive Assessment Duration:** CMS estimates that each member of the interdisciplinary treatment team would need 20-30 minutes per patient to complete a comprehensive assessment. The NCCBH members' experience indicates that the time spent on the comprehensive assessment is about 60 minutes per staff member per patient. We used the latter number in our cost estimation.

- **Frequency of Updates to Comprehensive Assessment and Active Treatment Plan:** CMS incorporates one annual update to the comprehensive assessment and the active treatment plan per CMHC patient. This stems from the assumption of a length of stay (the period in which a beneficiary receives partial hospitalization services) of approximately 30 days. However, the service period lasting longer than 30 days, would require more frequent revisions of the assessment and the treatment plan since CoPs require regular updates, no less frequently than 30 days.

  Avalere analyzed Medicare outpatient claims data for a sample of 1,455 beneficiaries who received partial hospitalization services in 2009. Those beneficiaries received services from 188 CMHCs. The average length of stay (time period between the first date and the last date of the treatment) was 98 days. Based on this finding, we assumed that three updates would be necessary to meet CoP requirement for regular updates. This brings the total estimated time needed annually for the comprehensive assessment update to 90 minutes per patient (as opposed to 30 minutes) and for the active treatment plan update to 45 minutes per patient (as opposed to 15 minutes).