May 31, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

SUBJECT: CMS–1769–P, Medicare Program; FFY 2023 Inpatient Psychiatric Facilities Prospective Payment System—Rate Update and Quality Reporting—Request for Information Proposed Rule, Federal Register (Vol. 87, No. 64), April 4, 2022

Dear Administrator Brooks-LaSure:

On behalf of our more than 400 member hospitals and health systems — including 84 hospitals subject to the inpatient psychiatric facility (IPF) prospective payment system (PPS) — the California Hospital Association (CHA) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) proposed federal fiscal year (FFY) 2023 IPF PPS — rate update and quality reporting — request for information. California's hospitals that provide acute psychiatric inpatient care are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, and adults with mental health and substance use disorders.

California's IPFs have been significantly impacted by the COVID-19 public health emergency (PHE). We are deeply concerned that the proposed market basket update is inadequate relative to the input cost inflation — in large part due to labor market dislocations as a result of COVID-19 — IPFs are facing. To preserve access to inpatient mental health care for all Medicare beneficiaries, CHA asks CMS to develop a methodology to calculate the market basket update that accurately reflects the recent (and anticipated continued) rapid input price inflation for labor. CHA appreciates CMS' strong commitment to reducing the conditions that result in inequitable health outcomes as demonstrated by the request for information on measuring health care quality disparities. And we greatly appreciate CMS' solicitation of comments on the various IPF PPS payment adjustments. CHA offers the following comments on specific proposals.

Market Basket Update

CMS proposes a market basket increase for FFY 2023 of 3.1%. This is then reduced by the 0.4 percentage point "productivity adjustment" required under the Affordable Care Act (ACA). The resulting proposed IPF market basket update equals 2.7% (3.2% minus 0.4 percentage points for productivity reduction).

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CHA is deeply disappointed in the proposed 2.7% market basket update as it is wholly inadequate relative to the input cost inflation experienced by IPFs. Labor-related costs — based on CMS' own forecast of the labor-related share in the proposed rule — will make up 77.4% of IPF expenses in FFY 2023.

While CHA appreciates that CMS will refresh the market basket update in the final rule using more recent data, we are deeply concerned that the revised update will still be insufficient relative to input cost inflation — particularly for labor.

Even before the application of the productivity adjustment (discussed further below), the methodology — based on IHS Global Insight data — has failed to keep up with cost growth year-over-year. Inflation has reached levels not seen in 40 years[1], which predates the implementation of the inpatient PPS in October 1983 on which the IPF PPS market basket update is modeled. It is clear, based on rapidly rising labor costs, that CMS' current method for updating the market basket is ill-suited to adequately adjusting Medicare payments in a highly inflationary environment. **Therefore, we ask CMS to consider other methods and data sources to calculate the final rule "base" (before additional adjustments) market basket update that would better reflect the rapidly increasing input prices facing IPFs.** If CMS fails to provide an adequate market basket update, CHA is deeply concerned about access to inpatient mental health services for Medicare beneficiaries.

Market Basket Update — Productivity Adjustment

The productivity adjustment required under the ACA is estimated to be -0.4 percentage points. CMS uses the total factor productivity (TFP) adjustment as calculated by the Bureau of Labor Statistics. The adjustment is calculated, as it has been in the past, as the 10-year moving average of changes in TFP for the period ending September 30, 2023, based on IHS Global Insight's fourth-quarter 2021 forecast.

CHA believes the assumptions underpinning the productivity adjustment are fundamentally flawed. As such, we strongly disagree with the continuation of this punitive policy — particularly during the PHE. The productivity adjustment to the market basket update assumes that IPFs can increase overall productivity — producing more goods with the same or fewer units of labor input — at the same rate as increases in the broader economy. However, providing care to patients in IPFs is highly labor-intensive as CMS' projection of the labor-related portion of the federal rate — 77.4% — implies in the FFY 2023 proposed rule.

This level of care must be provided on-site and has a high "hands-on" component. Therefore, IPFs cannot improve productivity using strategies like offshoring or automation that are commonly deployed in other sectors of the economy that produce goods (auto manufacturing) or services (restaurants that use automated ordering systems to reduce overall staffing count). Further, CHA notes that during the COVID-19 PHE, productivity fell[2] as a result of having to use temporary staffing resulting from high turnover rates of employed staff due to COVID-19 and the accompanying labor shortage.

Given that CMS is required by statute to implement a productivity adjustment to the market basket update, CHA asks the agency to work with Congress to permanently eliminate this unjustified

[1] https://www.npr.org/2022/02/10/1079260860/january-inflation-consumer-prices-cpi-economy-federal-reserve
[2] https://www0.gsb.columbia.edu/faculty/abartel/papers/human_capital.pdf

reduction to hospital payments. Further, we ask CMS to use its section 1135 waiver authority to remove the productivity adjustment for any fiscal year that was covered under PHE determination (i.e., 2020, 2021, and 2022) from the calculation of market basket for FFY 2023 and any year thereafter.

IPF PPS Outliers

For FFY 2023, CMS is proposing to continue to set the fixed-loss threshold amount so that outlier payments account for 2% of total payments made under the IPF PPS. For FFY 2023, CMS is returning to its historical practice of using the latest available data — in this case, FFY 2021 — to set the fixed-loss threshold. Based on an analysis of the December 2021 update of FFY 2021 IPF claims and the FFY 2022 rate increases, CMS estimates that for FFY 2022 IPF outlier payments will be 3.2% of total payments or 1.2 percentage points higher than the target of 2%. For this reason, CMS believes it is necessary to raise the fixed-loss threshold to better target 2% IPF payments as outliers. For FFY 2023, CMS proposes to increase the fixed-loss threshold from $16,040 in FFY 2022 to $24,270 in FFY 2023. CHA notes that the fixed-loss outlier threshold in the IPF PPS is 51% greater than in FFY 2022.

CHA is deeply concerned that CMS has overestimated the impact of COVID-19 on the IPF PPS outlier threshold. This will have the effect of depressing additional, necessary payments to IPFs to compensate them for the additional cost incurred when treating high-cost Medicare beneficiaries. While we appreciate CMS' effort to use trims to remove charge data from the outlier calculation that exceeds three standard deviations, clearly that strategy is not sufficient to blunt COVID-19's overstated impact on the IPF PPS outlier calculation. Therefore, we ask CMS to calculate the IPF PPS outlier threshold using the charge inflation from FFY 2018 to FFY 2019 (instead of using the charge inflation factor from FFY 2020 and 2021). Further, we also ask CMS to adjust the cost-to-charge ratios (CCRs) used in the IPF fixed-loss outlier threshold by comparing the percentage change in the national average case-weighted CCRs between the March 2019 and March 2020 updates to the provider specific file (PSF). This is the last update of the PSF prior to the PHE. **CHA notes that CMS used both of these approaches to normalize the impact of COVID-19 on the fixed-loss outlier threshold in the IPPS. We believe a similar approach would be appropriate for the IPF PPS.**

Comment Solicitation on Analysis of IPF PPS Adjustments

CMS has undertaken further analysis of cost and claims information to assess the reliability of the existing IPF PPS facility and patient-level payment adjustments. In general, the analysis finds the existing model continues to be appropriate, but suggests that certain updates could improve payment accuracy. In the FFY 2023 IPF proposed rule, CMS requests feedback on a variety of issues related to the facility and patient-level payment adjustments that it will consider when the agency elects to update the payment adjusters.

CHA greatly appreciates CMS' request for feedback. CHA believes there are opportunities to better align payment with the IPF PPS with the actual resources necessary to provide care. Below please find our specific comments.

Comorbidity Adjustments

In general, CHA strongly supports the use of a robust system of comorbidity adjustments. We would encourage the agency to expand the existing list of 17 comorbidity conditions to better account for the

full range of conditions that impact resource use when providing high-quality inpatient psychiatric care to Medicare beneficiaries. As discussed below. CHA believes that CMS should explore adding sleep apnea as its own, separate comorbidity. Further, we provide additional recommendations related to CMS' analysis of potential adjustments related to social determinants of health (SDOH).

Sleep Apnea
CHA asks CMS to analyze the additional costs associated with patients who have sleep apnea. Patients with sleep apnea require continuous positive airway pressure machines. Because the tubes and cords associated with these machines present an increased ligature risk for the patient, additional staffing resources are required to monitor these patients.

Social Determinants of Health — Homelessness
CMS' technical report[3] found that stays with Z590 (homelessness) had a significantly lower mean cost per diem of $1,045.34, which was $13.21 less costly than stays without, which had a mean cost per diem of $1,058.55. This finding is contrary to CHA's members' experience as patients experiencing homelessness require more resources per day and have longer stays due to the difficulty of discharging them to a stable environment with access to outpatient psychiatric services. This results in more costly stays relative to patients who are not experiencing issues with adequate housing.

CHA notes that under a proposed state regulation[4] — beginning on January 1, 2023 — California will require hospitals to screen patients for homelessness, and report ICD-10-CM SDOH codes (Z55-Z65) for any corresponding condition as documented in the medical record. We are uncertain as to how many other states have similar laws and when they may have taken effect. CHA also notes that both a recent CMS report[5] and the request for information in the FFY 2023 IPPS proposed rule on Z code reporting more comprehensively capture SDOH in the data set. These two items from CMS imply the agency believes that ICD-10 codes related to SDOH are underreported. Therefore, we question whether Z59.0 is consistently and accurately reported on inpatient psychiatric claims for Medicare beneficiaries. If, as suspected, homelessness is underreported on Medicare claims, it may skew any analysis of homelessness's impact on the cost of IPF care for Medicare beneficiaries. We encourage CMS to explore this issue further to ensure that the agency and its contractors are working with a complete dataset as it relates to the issue of homelessness's impact on the cost per stay. CHA provides additional comments in response to CMS' request for information related to reporting SDOH in the FFY 2023 proposed IPPS rule. We would encourage CMS staff to review those comments for additional feedback on reporting related to Z59.0.

Risk of Violent Behavior
Psychiatric units with a higher percentage of patients who are prone to violent behavior require significantly higher levels of staffing to ensure the safety of all patients and staff. However, there is no adjustment within the IPF PPS to account for the additional resources required by violent patients. CHA notes that many of its members use the Broset Violence Checklist to assess the likelihood that a patient will exhibit violent behavior during their stay in an IPF. However, there is currently no mechanism to report this risk on the patient's claim. CHA strongly encourages CMS to explore ways to allow this

[3] https://www.cms.gov/files/document/technical-report-medicare-program-inpatient-psychiatric-facilities-prospective-payment-system.pdf
[4] https://hcai.ca.gov/wp-content/uploads/2022/03/HCAI-Patient-Data-Reporting-Requirements-regulation-proposal.pdf
[5] https://www.cms.gov/files/document/z-codes-data-highlight.pdf

crucial information to be reported on claims for inpatient psychiatric services and use this information to adjust payments within the IPF PPS once it can be reliably collected. Member hospitals report that many commercial plans provide an add-on payment for patients with a documented propensity for violence to reimburse for the additional cost incurred in caring for these patients.

Source of Admission — Community Setting vs. Transfer from Hospital

Currently, in the IPF PPS, Medicare adjusts payments to IPFs with qualified emergency departments (EDs) to cover the ED costs incurred as part of an inpatient psychiatric facility stay. The ED payment adjustment takes the form of a higher payment factor applied to the first day of the psychiatric stay. To avoid creating an incentive to admit through the ED, the ED payment adjustment is applied to all admissions to IPFs with qualified EDs, with one exception. The ED adjustment is not made when a patient is discharged from an acute care hospital or critical access hospital (CAH) and admitted to the same hospital's or CAH's psychiatric unit. While CHA appreciates the facility-specific adjustment, CHA notes that it is not predicated on the patient's source of admission[6] and is intended to account for the higher standby costs associated with the operation of an ED.

CHA's members have observed that patients transferred to an inpatient psychiatric unit or facility from an acute care unit or hospital[7] typically have higher costs per case than patients admitted from the community with similar comorbidities. In many instances, the patient may have originally been admitted to the acute care facility due to an acute exacerbation of an existing comorbidity. Once the patient is transferred to the psychiatric unit or facility, the patient still consumes a higher level of resources than a patient admitted from the community, as staff continue to manage the acute exacerbation of one or more comorbidities. CHA respectfully asks CMS to analyze data related to the source of admission. If that analysis does show that patients admitted from acute facilities are more costly, we ask the agency to create an adjustment that provides adequate payment relative to the increased resources consumed by patients who are transferred to an IPF from an acute care facility.

CHA appreciates the opportunity to comment on the FFY 2023 IPF PPS proposed rule. If you have any questions, please contact me at cmulvany@calhospital.org or (202) 270-2143, or Megan Howard, vice president of federal policy, at mhoward@calhospital.org or (202) 488-3742.

Sincerely,

/s/
Chad Mulvany
Vice President, Federal Policy

[6] Unless the beneficiary is transferred from another acute care hospital or CAH.
[7] Includes CAHs.