June 5, 2023

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

SUBJECT: CMS-1783-P, Medicare Program; FFY 2024 Inpatient Psychiatric Facilities Prospective Payment System – Rate Update, Proposed Rule, Federal Register (Vol. 88, No. 68), April 10, 2023

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) 2024 IPF PPS proposed rule. 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 hospitals, including its psychiatric hospitals, continue to face unprecedented financial pressure as a result of COVID-19's impact on the labor market and the health care supply chain. From 2019 to 2022, costs per adjusted discharge rose 25%[1] (driven by increases in salary costs +22%, supply expenses +18%, and pharmaceuticals +19%). However, base payment rates for Medicare have failed to keep pace with input price inflation. Chronic underfunding by Medicare contributed to the recent closure of one hospital in California (Madera Community Hospital[2,3]), drove another into bankruptcy (Beverly Hospital[4]), and has forced many others to eliminate financially unsustainable services to ensure the facility can remain open. Unfortunately, more hospital closures are expected to follow. Kaufman Hall, a nationally renowned consulting firm, estimates that 20% of California's hospitals are currently on the financial brink.

[1] https://www.kaufmanhall.com/insights/research-report/california-hospital-financial-impact-report-april-2023-update
[2] https://calmatters.org/health/2023/01/hospital-closure/
[3] https://abc30.com/madera-commuity-hospital-remains-closed-emergency-services-residents/12922392/#:~:text=Ashraf.-,Madera%20Community%20Hospital%20closed%20its%20doors%20in%20December%20of%20last,Madera%20for%20over%20forty%20years.
[4] https://www.latimes.com/california/story/2023-04-20/beverly-hospital-in-montebello-files-for-bankruptcy-in-effort-to-avoid-closure

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The financial challenges facing hospitals threaten access to care not just for Medicare beneficiaries, but all members of the affected community. Following hospital or service line closures, patients are forced to travel farther distances for care in already overcrowded hospitals, resulting in negative outcomes. Research shows that rural hospital closures increase inpatient mortality by 8.7%, with Medicaid patients (including those dually eligible) and racial minorities bearing the brunt of negative outcomes — 11.3% and 12.6% increases in mortality, respectively. These are not abstract data points. Sadly, two individuals' deaths have already been attributed[5] to Madera's closing.

CHA is deeply concerned that the proposed 2024 IPF rule will only exacerbate these already dire circumstances for psychiatric hospitals and the patients they serve. The proposed net market basket update of +3.0% is inadequate relative to the input price inflation faced by IPFs and continues CMS' historic trend of proposing woefully inadequate payment updates. For example, in 2022, CMS finalized an unadjusted market basket update of 2.7%. However, CMS' actual market basket data for IPFs shows that costs actually increased by 5.3% (a difference of 3.6% from the final rule market basket update), resulting in a significant underpayment for psychiatric hospitals in FFY 2022. To ensure broad access to inpatient psychiatric services for Medicare patients, CHA offers the following comments on the proposed 2024 IPF PPS proposed rule:

- *Provide an Adequate Market Basket Update*: CHA respectfully asks that CMS use data that better reflects the input price inflation that IPFs have experienced and are projected to experience in 2024. Further, CHA respectfully asks that CMS make a one-time "forecast error adjustment" to account for the pandemic's impact on CMS' ability to accurately project the FFY 2022 IPF market basket update. Finally, as in prior years, CHA respectfully asks CMS to use its authority to eliminate the unjustified reduction to the market basket update as a result of the Affordable Care Act (ACA)-mandated productivity adjustment for any year covered under the COVID-19 public health emergency.
- *Revise Methodology Used to Calculate the Labor-Related Share*: CHA is concerned that the methodology CMS uses to rebase and revise the labor-related share of Medicare payments for psychiatric hospitals is premised on the flawed assumption that some categories of labor costs are not subject to geographic variation. CHA asks that CMS revise its methodology for rebasing the labor-related share to account for the geography wage variation inherent in all home office and non-clinical professional services costs.
- *Ensure Updated Psych PPS Model Is Updated for Complicating Conditions*: CHA thanks CMS for seeking input on the updated IPF PPS. Our members strongly encourage CMS to include factors ranging from homelessness to sleep apnea in its updated risk adjustment model for the IPF inpatient prospective payment system (IPPS).
- *Do Not Publicly Report Screen Positive Rate for Social Drivers of Health:* CHA is concerned that this measure may inadvertently penalize IPFs that serve high volumes of patients who screen positive for social drivers of health. Therefore, we urge CMS not to adopt it as publicly reported at this time.
- *Limit COVID-19 Vaccination Reporting Requirements:* CHA strongly supports ongoing efforts to maintain high levels of up-to-date vaccination for COVID-19 among both health care providers and the communities they serve. However, we urge CMS to consider limiting the COVID-19 vaccination reporting requirements to at least one week for each quarter, and to work with the

[5] https://www.fresnobee.com/news/local/article272712840.html

Centers for Disease Control and Prevention (CDC) to move toward a version of the measure that could be reported annually.

Below, please find CHA's specific comments on these issues.

Market Basket Update

CMS proposes a market basket increase for FFY 2024 of 3.2%. This is then reduced by the negative 0.2 percentage-point "productivity adjustment" required under the ACA. The resulting proposed IPF market basket update equals 3.0% (3.2% minus 0.2 percentage points for productivity reduction).

CHA is deeply disappointed by the proposed 3.0% net market basket update, as it is wholly inadequate relative to the input cost inflation experienced by IPFs described above. In light of this, we ask CMS to 1) recalculate the market basket update using data that more accurately reflects the growth in input prices, 2) provide a one-time "forecast error adjustment" that accounts for CMS' underpayment of IPFs in 2022, and 3) Use its exceptions and adjustments authority to provide a one-time increase in funding to account for the ill-conceived ACA productivity adjustment during the COVID-19 public health emergency (PHE).

First, while CHA appreciates that CMS will refresh the market basket update in the final rule with more recent data, we are deeply concerned that the revised update will still be insufficient relative to input cost inflation. As discussed above, costs per adjusted discharge increased 25% from 2019 through 2022. However, over the same period, the market basket update has only increased per unit payments by 6.85%[6].

Even before the application of the productivity adjustment (discussed further below), the methodology — based on IHS Global Insight (IGI) data — failed to keep up with cost growth year over year. It is clear, based particularly on rapidly rising labor costs, that CMS' current methodology for updating the market basket is ill-suited to 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 better reflects the rapidly increasing input prices facing IPFs.**

CHA asks CMS to consider using the average growth rate in allowable Medicare costs per risk-adjusted discharge[7] for IPFs between FFY 2019 and FFY 2021 to calculate the FFY 2024 final rule market basket update. Based on CHA analysis, this would yield an unadjusted market basket update of 6.14%. If CMS fails to provide an adequate market basket update, CHA is deeply concerned inadequate payments will result in reduced access to inpatient psychiatric services for Medicare beneficiaries.

Second, in prior comment letters, CHA, along with other stakeholders, expressed its concern that recent market basket updates proposed (and subsequently finalized) were inadequate relative to input price inflation. Unfortunately, that concern has been realized. Based on files recently released by CMS, the actual IPF PPS market basket update for FFY 2022 should have been 5.3%. Instead, CMS finalized a market basket update of 2.7%, resulting in IPFs being underpaid relative to inflation by 2.6 percentage points.

[6] CHA analysis of CMS market basket data.
[7] CHA analysis of CMS IPF cost report data.

In both the skilled-nursing facility (SNF) PPS and for the capital input price index (CIPI) used to update capital IPPS payments, CMS makes "forecast error adjustments" when it underestimates the market basket update. As an example, in this year's SNF PPS rule, CMS proposes a 3.6 percentage point forecast error adjustment. In FFY 2022, the finalized SNF market basket update was 2.7%. The actual increase for FY 2022 was considerably higher — 6.3% — resulting in the actual increase being 3.6 percentage points higher than the estimated increase. Therefore, CMS proposes that the FY 2024 market basket percentage increase of 2.7% would be adjusted upward to account for the forecast error adjustment of 3.6 percentage points, resulting in a SNF market basket percentage increase of 6.3%.

CHA notes that nothing in section 1886(s) of the Social Security Act prohibits CMS from making a one-time forecast error adjustment to the IPF IPPS market basket update to correct for the significant underpayment in FFY 2022. **Therefore, CHA asks that CMS apply a one-time 2.6 percentage point "forecast error adjustment" to the proposed FFY 2024 IPF market basket update of 3.2% for a 5.6% update, net of the .2% ACA productivity adjustment to account for the significant underpayment that occurred in FFY 2022 as a result of the impact of the COVID-19 PHE on input prices.**

Finally, as in prior years, CHA believes the assumptions underpinning the ACA-mandated productivity adjustment are fundamentally flawed. As such, we strongly disagree with the continuation of this policy — particularly during any fiscal year impacted by 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 operating labor-related portion of the federal rate — 75.4% — implies in the FFY 2024 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 productivity fell[8] 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 reduction to hospital payments. Further, we ask CMS to use its authority under Section 1886(s) to remove the productivity adjustment for any fiscal year that was covered under PHE determination (i.e., 2020 (.4%), 2021 (.0%), 2022 (.7%), and 2023 (.3%) from the calculation of market basket for FFY 2024 and any year thereafter.

IPF PPS Outliers

For FFY 2024, CMS proposes continuing to set the fixed loss threshold amount so that outlier payments account for 2% of total payments made under the IPF PPS. CMS proposes to use the same methodology to determine the fixed-loss threshold for FFY 2024 that it has used dating back to FY 2008. Based on an analysis of the December 2022 update of FFY 2022 IPF claims and the FFY 2023 rate increases, CMS estimates that outlier payments for FY 2023 will be 3.0% of total payments (1.0 percentage point higher than its target). Therefore, CMS proposes to increase the fixed-loss threshold to $34,750 in FFY 2024 (up from $24,630 as finalized in FFY 2023) to better target 2.0% IPF payments as outliers. **CHA is deeply**

[8] https://www0.gsb.columbia.edu/faculty/abartel/papers/human_capital.pdf

concerned by the 41.1% increase in the IPF PPS fixed-loss outlier threshold amount. We believe this will result in inadequate payment for Medicare beneficiaries who have high-cost stays, which will put further financial pressure on already challenged inpatient psychiatric facilities and potentially increase access issues.

The proposed rule describes an alternative that calculates the FY 2024 outlier loss threshold after removing those IPFs with extremely high or low costs per day (3+ standard deviations from the mean). Using this narrower set of more homogeneous IPFs yields an outlier threshold of $30,000 (a 22% increase relative to FY 2023). **CHA strongly encourages CMS to use the alternative that removes outliers over the traditional calculation.**

Area Wage Index – Labor-Related Share Rebasing

CMS' proposed total operating labor-related share of 75.4% for FFY 2024 is 1.0 percentage point higher than the FFY 2023 labor share of 74.2%. The higher labor-related share is primarily due to the incorporation of the 2021 Medicare cost report data which increased the compensation cost weight by 0.9 percentage point compared to the 2016-based IPF market basket. **CHA appreciates CMS' proposal to increase the labor-related share based on data that better reflect increased labor costs as a percentage of an IPF's overall cost structure.**

CMS proposes to continue classifying a cost category as labor-related if the costs are labor-intensive and vary with the local labor market. Similar to the 2016-based IPF market basket (and in other PPS payment systems that incorporate a labor-related share), the proposed 2021-based IPF market basket includes two cost categories for nonmedical Professional Fees (including, but not limited to, expenses for legal, accounting, and engineering services). These cost categories are Professional Fees: Labor-related and Professional Fees: Nonlabor-related. **As it has in responses to CMS' prior labor-related share rebasing proposals in other payment systems, CHA continues to strongly disagree with CMS' assertion that some portion of professional contract labor costs and home office costs are not subject to geographic variation in labor costs. We ask that in the final rule, CMS allocate all 8.0 percentage points[9] for professional services and home office costs to the Professional Services: Labor-Related Category.**

For the proposed 2021-based IPF market basket, CMS proposes to estimate the labor-related percentage of non-medical professional fees (and assign these expenses to the Professional Fees: Labor-related services cost category) based on the same method used to determine the labor-related percentage of professional fees in the 2016-based IPF market basket.

As it has during prior rebasings of the labor-related share, CMS proposes to determine the proportion of legal, accounting and auditing, engineering, and management consulting services that meet its definition of labor-related services based on a survey of hospitals conducted in 2008. Based on these results, CMS proposes to apportion approximately 2.1 percentage points of the 3.3 percentage point figure into the Professional Fees: Labor-related share cost category and designate *the remaining 1.2 percentage point into the Professional Fees: Nonlabor-related cost category*[10].

CHA questions the validity of CMS' assumption that fees for services provided by firms located outside of a hospital's core-based statistical area (CBSA) do not vary based on geography. The implied

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[9] 4 percentage points related to Accounting & Auditing, Legal, Engineering, and Management Consulting Services plus 5.4 percentage points related to Home Office labor costs

[10] Emphasis added.

underpinning of this assumption is that national and regional professional services firms do not compete with local professional services firms based in a hospital's CBSA. However, this is patently false. When hospitals seek professional services, the services they are seeking are not so unique (e.g., accounting, engineering, management consulting) that they could only be provided by regional or national firms. CMS' own survey data support this conclusion, as approximately 64% of these services are sourced from firms in the local market. Therefore, hospitals solicit proposals for "professional services" from local, regional, and national firms.

When competing with local firms for a given contract or project, regional and national firms have every incentive to adjust their pricing in response to local labor market conditions. If the local labor market has lower wages than the national average — which will influence the pricing of a local firm's response to a request for proposal from a hospital — regional and national firms must reduce the offered price of their services to be competitive with local firms that offer the same services. Conversely, if the local labor market has higher wages than the national average, regional and national firms have every incentive to price accordingly to increase their profit margins on a given contract. Therefore, pricing for services offered by regional and national firms to hospitals in differing CBSAs will vary significantly based on local rates due to these firms competing with local firms that provide the same service.

CHA respectfully asks CMS to offer evidence pricing for professional services, provided by regional and national firms, to hospitals that are offered in a national market not subject to geographic cost variation. Unless the agency can produce strong evidence that prices for professional services provided by firms outside of a hospital's local labor market are homogenous — that an IPF in Sault Ste Marie, Michigan, is charged the same hourly rates for audit services by a national accounting firm as an IPF in Sacramento, California — CHA respectfully asks CMS to restore the 1.2 percentage points it proposes to reclassify to Professional Services: Nonlabor-related to the Professional Services: Labor-related category. In the absence of data that prove standardized pricing by regional and national professional services firms, CHA believes the Professional Services: Labor-related category cost weight should be 3.3 percentage points.

CMS also asserts, without providing additional evidence, that because a hospital's home office costs are outside of its local market, these labor costs do not vary due to differences in cost-of-living. Based on this assertion, the agency proposes to classify a portion of these expenses as labor-related and nonlabor-related. Based on analysis of cost report data, CMS proposes allocating 2.1 percentage points of the Home Office/Related Organization Contract Labor cost weight (4.7% times 46%) to the Professional Fees: Labor-related cost weight and *2.5 percentage points of the Home Office/Related Organization Contract Labor cost weight to the Professional Fees: Nonlabor-related cost weight*[11] (4.7% times 54%). **CHA strongly disagrees with the assertion Home Office/Related Organization compensation costs that occur outside of a hospital's labor market are not subject to geographic wage variation. As such, we do not believe the proposed reclassification to the Professional Fees: Nonlabor-related cost category is justified.**

CHA replicated CMS' Home Office/Related Organization analysis. We identified approximately 809 hospitals (37% of hospitals with home office data) that were not in the same labor market as their home office. Of these hospitals, 202 were in labor markets with a wage index greater than 1. While these hospitals account for only 25% of hospitals with home offices outside of their labor markets, their salary,

[11] Emphasis added.

wage, and benefit costs are approximately 34% of the salary, wage, and benefit costs for hospitals with home offices outside their labor market.

Further, the analysis indicates that the home office/related party average hourly salary, wage, and benefit costs for hospitals with home offices outside of their labor market is $54.82. However, for the 202 hospitals in a labor market with a wage index greater than 1, the average hourly home office wage is $57.74 (5% higher than average). By contrast, the average hourly home office wage for the 607 hospitals in a labor market with a wage index of 1 or less is $53.43 (3% lower than average).

Analysis of Home Office Costs for Hospitals with Home Offices Outside Their Labor Market

	Hospital Count	% of Total Hospital Count	Home Office/Related Party Salary, Wage, and Benefit Cost	% Total Wage Related Costs	Home Office/Related Party Hours	Home Office Average Hourly Wage	% Difference from Total Average Hourly Wage
Hospitals with Wage Index Values <=1	607	75%	$ 7,886,217,045	66%	147,609,035	$ 53.43	-3%
Hospitals with Wage Index Values >1	202	25%	$ 4,068,762,125	34%	70,462,064	$ 57.74	5%
Total	809	100%	$ 11,954,979,170	100%	218,071,100	$ 54.82	0%

These data indicate that, contrary to CMS' unsupported assertion, home office salary, wage, and benefit costs for hospitals with home offices outside of their labor market are subject to geographic wage variation. Hospitals in labor markets with wage indexes greater than 1 on average have higher home office wage-related costs than hospitals with wage indexes of 1 or less. **Given this evidence of geographic wage variation in home office costs for hospitals that are not located in the same labor market as their home office, CHA respectfully asks CMS to withdraw its proposal to reclassify 2.5 percentage points of the Home Office/Related Organization cost weight to the Professional Fees: Non-Labor-Related cost category. Instead, we ask the agency to allocate the full 4.7 percentage points of the Home Office/Related Organization cost weight to the Professional Fees: Labor-Related cost category.**

Request for Information to Inform Revisions to the IPF PPS

Section 4125 of the Consolidated Appropriations Act of 2023 requires revisions to the IPF PPS for FFY 2025 and future years as the secretary determines appropriate. As such, in the proposed rule, CMS includes a request for information on ancillary charge data, the use of social determinants of health (SDOH), and other factors that should be considered to accurately adjust Medicare payments to IPFs. Below, please find CHA's comments on these areas.

Ancillary Charge Data

In the proposed rule, CMS expresses concern that some psychiatric hospitals' IPF PPS claims do not include any ancillary charges. The request for information (RFI) asks a range of questions trying to understand why this occurs and if CMS should reject IPF PPS claims that do not include ancillary charges.

Based on conversations with members, CHA understands that freestanding psychiatric facility claims typically do not include ancillary charges. Under Medi-Cal, California's Medicaid program, the mental health psychiatric hospitalization benefit is separately administered by the various counties. The inpatient mental health benefit is designed such that physical health is carved out of the claim for a freestanding psychiatric hospital. Therefore, if a freestanding psychiatric hospital included ancillary

charges — for example for an MRI — the entire claim would be denied for providing services outside the "scope" of said hospital. Given that many patients in freestanding psychiatric facilities are Medi-Cal or dually eligible, these hospitals' billing systems are not configured to include the ancillary charges on the claim. Therefore, it would be inappropriate for CMS to reject claims that lack ancillary charges from psychiatric hospitals in states where the mental health hospitalization benefit is carved out from physical health and separately administered, such as in California.

SDOH and Other Payment Adjustment Factors

In general, CHA strongly supports the use of a robust system of adjustments to account for the increased costs associated with patients who present with comorbidities and complications. Frequently, additional ancillary services (e.g., medical or neurological exams, labs, and imaging services, etc.) are needed to identify physical conditions that exacerbate or first present as psychiatric symptoms. In many instances, these associated costs are not captured in the existing adjustments. We strongly 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. Below, we provide recommendations related to CMS' analysis of potential adjustments related to SDOH and offer suggestions for other mechanisms to explore that could capture the additional resource use required by patients who present with comorbidities and complications.

Homelessness and Other Z Codes: A CMS technical report[12] 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 stable housing.

CHA notes that under state regulation,[13] California's hospitals are required 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. Therefore, we question whether Z590 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 provided additional comments in response to CMS' request for information related to reporting SDOH in the FFY 2023 proposed IPPS rule. We encourage CMS staff to review those comments for additional feedback on reporting related to Z590.

The proposed rule provides a list of Z codes that CMS states have an adjustment factor greater than 1, suggesting that these codes increase the costliness of IPF stays. CHA encourages CMS to explore the use of Z codes as adjusters in the revised IPF PPS. Specific to the list of codes provided in the proposed rule, CHA notes that many of them[14] imply that the patient may not have stable housing in which to be discharged back to once the need for inpatient psychiatric hospitalization. In these situations, it is likely

[12] https://www.cms.gov/files/document/technical-report-medicare-program-inpatient-psychiatric-facilities-prospective-payment-system.pdf
[13] https://hcai.ca.gov/wp-content/uploads/2022/03/HCAI-Patient-Data-Reporting-Requirements-regulation-proposal.pdf
[14] Z599 Problems related to housing and economic circumstances, unspecified; Z600 Problems of adjustment to life-cycle transitions; Z634 Disappearance and death of family member; Z653 Problems related to other legal circumstances.

that the patient will remain in the IPF longer while the facility attempts to arrange a safe discharge into an appropriate, community setting.

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.

Eligibility for Both Medicare and Medicaid: CHA's members report that dually eligible psychiatric patients are more expensive to care for. Medicare patients who are dually eligible are typically admitted with co-morbidities that are currently not incorporated into the existing IPF PPS. When they no longer require inpatient psychiatric hospitalization, it can take longer to discharge them to the next appropriate setting of care. These patients are frequently unable, due to a lack of resources, to be discharged safely back to their homes so hospitals must try to find a safe living situation into which they can be discharged, or the patient remains in the hospital. This observation is supported by CMS' February 2022 technical report on the IPF PPS payment adjusters.[15] While the link between poverty and the increased burden of illness is well established,[16] there is currently no adjuster in the IPF PPS payment system. CHA respectfully asks that when CMS explores additional variables to add to the IPF PPS that it models the impact of dual eligible status on cost per inpatient stay. If CMS' analysis proves that it costs more to care for dually eligible patients, we ask that the agency include a separate adjuster for Medicare beneficiaries who are also eligible for Medicaid. Another alternative to explore to illuminate the impact of economic factors on IPF PPS cost per case is eligibility for the Medicare Part D low-income subsidy.

Refined Psych DRG Adjustment: The current IPF PPS provides a patient-specific adjustment for 17 MS-DRGs based on a regression analysis of costs associated with diagnosis codes that map to a given MS-DRG. However, CHA's members note there can be considerable cost variability between two patients whose diagnoses group to the same MS-DRG. As an example, "Patient A" whose ICD-10 codes map to MS-DRG 885 — psychoses — may be relatively low cost if they have a history of employment and stable housing, and no history of violence. For Patient A, the payment associated with IPF PPS payment associated with MS-DRG 885 may cover the costs associated with the inpatient stay. "Patient B" also has diagnoses that also map to MS-DRG 885. However, "Patient B" has multiple comorbidities, a history of homelessness, violence, and law enforcement involvement. His/her stay will cost substantially more than the payment associated with MS-DRG 885 due to the additional resources required to care for this patient and ensure that he/she does not harm themselves, other patients, and/or staff during their stay. CHA strongly encourages CMS to explore creating base and "complication and comorbidity" MS-DRGs for related clinical conditions to account for the additional resources required by more complex patients. If CMS does not have sufficient data to create base MS-DRGs and MS-DRG within the same family that provides an additional adjustment for cases that involve "complications or comorbidities," it needs to consider implementing an adjustment to account for the risk of violent behavior within an IPF's population as discussed below.

Risk of Violent Behavior: Psychiatric units with a greater 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

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[15] www.cms.gov/files/document/technical-report-medicare-program-inpatient-psychiatric-facilities-prospective-payment-system.pdf
[16] https://www.healthaffairs.org/do/10.1377/hpb20180817.901935/

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 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[17] 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[18] 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.

Current Data and Information Collection Requirements

Section 4125 of the CAA of 2023 requires that beginning with rate year 2028 and each subsequent year, psychiatric hospitals and psychiatric units must submit standardized patient assessment data at time of admission and discharge. The standardized data will collect information on functional status, cognitive function, special services required for treatment of psychiatric conditions, co-morbidities, impairments, and other conditions as determined by the secretary. **CHA notes that much of the data necessary to implement the payment adjustments described above will be collected via the patient assessment instrument (PAI).** CHA supports the thoughtful development and deployment of a PAI. We believe such a development entails CMS working collaboratively with IPFs and other stakeholders to develop a PAI that collects data that can be used to refine the IPF payment methodology in a manner that fits into existing IPF clinical and administrative workflows. Further, a thoughtful deployment requires allowing providers to pilot the PAI and incorporating lessons learned from pilots before the PAI is used to adjust IPF PPS payments in 2031.

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

Flexibility for Opening IPF Units

CHA supports CMS' proposal to ease the certification of new IPF units. Specifically, we are in favor of allowing host hospitals to open a new unit at any time during the cost reporting period, with a 30-day advance. We agree that this change would help offset the shortage of mental health services.

Inpatient Psychiatric Facility Quality Reporting Program (IPF QRP)

CMS proposes several changes to the IPF QRP, including the addition of four new measures, the removal of two existing measures, a modification to one existing measure, and changes to administrative requirements and policies.

Proposed Adoption of Facility Commitment to Health Equity Measure

CMS proposes the addition of a structural measure — Facility Commitment to Health Equity — beginning with the CY 2025 reporting period reflecting performance in 2024/FFY 2026 payment determination and for subsequent years. The measure is intended to assess an IPF's commitment to health equity across five domains (e.g., Data Collection), each of which includes multiple elements (e.g., the collection of demographic information and/or SDOH information, training of staff in culturally sensitive collection of demographic and/or SDOH information, and input of demographic and/or SDOH data into structured, interoperable data elements using certified electronic health record (EHR) technology). IPFs must attest affirmatively to each of the elements within a domain to receive a point for the domain — no partial credit is awarded for attesting to specific elements within a domain. As proposed — and in alignment with the acute inpatient hospital version of the measure — CMS would publicly report the IPFs' score up to a maximum of five points, one for each domain.

California IPFs are deeply committed to improving health equity and share CMS' goals of reducing health care disparities for historically discriminated and underserved communities. As our members are working to achieve their hospital-specific equity goals, we believe the attestations and domains included in the proposed measure align with many of these ongoing efforts and we generally support this attestation-based measure. However, we are concerned that the proposed scoring methodology and public reporting proposals may result in misleading views of IPFs' health equity strategies, particularly due to the all-or-nothing nature of how points are awarded in each domain.
For example, Domain 1 — Equity is a Strategic Priority — includes four elements that require IPFs' strategic plans have identified priority populations who currently experience health disparities, identify specific goals and discrete actions to achieving those goals, outline the specific resources dedicated to achieving those goals, and describe the hospital's approach to engaging key stakeholders, such as community-based organizations. Under the proposed scoring methodology, an IPF early in its efforts to address health equity would receive no credit if it has worked to identify equity goals and determined how it will use facility resources to achieve those goals but has not yet engaged community-based organizations, which could take more time and may be somewhat out of the facility's control. Under the current scoring and public reporting proposal, the public may be misled to believe the facility has not made a commitment to reducing health care disparities in its strategic plans, though it has achieved three out of four elements in the domain.

Further, IPFs may be disadvantaged in achieving a full score on the measure, because Domain 2 — Data Collection — includes the attestation statement, "Our facility inputs demographic and/or SDOH information collected from patients into structured, interoperable data elements using a certified electronic health record (EHR) technology." Psychiatric hospitals and most behavioral health provider types were excluded from the $35 billion in subsidies for EHR implementation provided by the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act) (Pub. L. 111-5). As

noted during a recent Medicaid and CHIP Payment and Commission (MACPAC) meeting,[19] adoption of certified EHRs among psychiatric hospitals lags significantly behind all other hospital settings, with only 49% of psychiatric hospitals in possession of certified EHR technology. The IPFs most likely to utilize certified EHRs are within acute inpatient hospitals or larger, freestanding facilities in integrated health systems. As such, performance on this measure would be much more challenging for smaller and less resourced IPFs. **We urge CMS to revise the measure specifications to reflect the limited ability of IPFs to utilize certified EHR technology to achieve points in the Data Collection domain.**

Finally, we urge CMS to reconsider its proposal and score IPFs based on how many elements within each domain can be attested to for a total possible score of 11. We believe this would be more transparent and representative of ongoing facility efforts to achieve health equity goals. Further, as currently proposed, each domain is weighted equally, with each domain representing 20% of the total score. Because certain domains have fewer elements than others, CMS seems to be weighing certain actions that make up the entirety of a domain — like facility participation in local, regional, or national quality improvement activities focused on reducing health disparities — higher than other actions, such as the three elements within the Data Collection domain. However, it is not clear in the proposed rule that this is the intent of the agency. As IPFs begin to establish and work toward achieving their health equity goals, we believe awarding credit for each potential element provides CMS and the public a more holistic and transparent view of this ongoing work.

Proposed Adoption of Two Social Drivers of Health Screening Measures
CMS proposes to adopt two measures to the IPF QRP related to screening for health-related social needs (HRSNs). CMS proposes to begin reporting for both measures on a voluntary basis beginning with the CY 2025 reporting period (data collected in 2024), with mandatory reporting required beginning in CY 2026 (data collected in 2025) for the FFY 2027 payment determination, and subsequent years. The first proposed measure is a structural process measure, Screening for Social Drivers of Health. The measure would assess the percentage of patients admitted to the IPF who are 18 years or older at the time of admission and are screened for each of five categories of HRSNs: food insecurity, housing instability, transportation problems, utility difficulties, and interpersonal safety.

CHA supports the addition of this measure to the IPF QRP program, and we appreciate that CMS will allow for one year of voluntary reporting prior to requiring the measure by CY 2026. The collection of comprehensive and accurate data on HRSNs is essential to understanding how the social needs of patients contribute to disparities in our health care system. Screening patients for this information is an important step that will allow IPFs to shape their strategic health equity goals. In addition, we appreciate that CMS will allow IPFs the flexibility to choose the screening tool and modes of data collection most appropriate to their facility, which will reduce the burden for those who are already conducting these screenings. Finally, we urge CMS to submit this measure for consensus-based entity endorsement prior to mandatory reporting.

However, CHA has concerns with the second proposed measure — Screen Positive Rate for Social Drivers of Health — and we urge CMS not to adopt it as publicly reported at this time. This measure would assess the proportion of patients who screened positive for one or more of the five HRSNs listed previously and require IPFs to report five separate rates for each of the HRSN domains. As an IPF QRP measure, the positive screening rates for each of the HRSN domains would be publicly reported. CHA questions the value of publicly reporting these rates and cautions the agency against unintended

[19] https://www.macpac.gov/wp-content/uploads/2021/09/Behavioral-health-IT-adoption-and-care-integration.pdf

consequences that could occur from this reporting. For example, we are concerned that the public will view IPF quality negatively based on factors outside the control of the facility — such as high levels of housing instability more reflective of housing shortages and economic circumstances within a community — incentivizing those with the most resources to seek care from other facilities with lower rates of positive HRSN screening rates, and further exacerbating disparities. These effects could be most challenging for IPFs in the most underserved communities, where high rates of HRSNs among the patient population are reflective of numerous societal and economic factors, rather than the quality of care provided by the facility.

It is also important to recognize that IPFs are likely to have relatively high rates of patients who screen positive for HRSNs, compared to acute inpatient hospitals where the same measure is in use. Patients with mental illnesses and/or substance use disorders ill enough to need inpatient psychiatric treatment often experience high rates of HRSNs, such as homelessness, lack of transportation, food insecurity, and limited access to meaningful employment or education. We urge CMS to carefully consider the value in publicly reporting these rates and not to unintentionally penalize IPFs that serve this high-need population.

CHA agrees that information gleaned from HRSN screening could be useful to IPFs in understanding the unmet needs of their patient population and could help to inform community benefit programs and strategic health equity goals. However, this information will already be provided to hospitals by conducting the HRSN screening — as proposed in the first measure — and as such, we do not believe it is necessary to publicly report the screen positive rates.

Finally, we urge CMS to revisit its measure exclusions for both screening measures, should they be finalized as mandatory measures. Specifically, CMS proposes to exclude patients who opt out of screening and patients who are unable to complete the screening themselves *and* lack a guardian or caregiver available to do so on the patient's behalf. Due to the sensitive nature of the screening domains — including interpersonal safety — we urge CMS to remove "and lack a guardian or caregiver available to do so on the patient's behalf," and limit the exclusion to patients who opt out of screening or are unable to complete the screening. There may be patients who have a caregiver or guardian available but are not able to answer screening questions honestly in their presence due to abuse or other circumstances.

Proposed Adoption of the Psychiatric Inpatient Experience (PIX) Survey
CMS proposes to adopt a patient experience of care measure, beginning with voluntary reporting in CY 2026 and mandatory reporting in CY 2027. The measure would require the use of a specific patient experience of care instrument, the PIX survey, and is based on patient responses on a 5-point Likert scale to survey items. The survey comprises 23 items across four domains, including relationship with the treatment team, nursing presence, treatment effectiveness, and healing environment. The survey would be distributed to patients, on paper or on a table computer, by administrative staff at a time beginning 24 hours prior to planned discharge.

CHA supports the inclusion of patient experience measures in quality reporting programs, and we appreciate that CMS has identified a survey that was developed specifically for the inpatient psychiatric population**.** However, we are concerned that testing of the survey was limited to the Yale New Haven Psychiatric Hospital system — where the survey was also developed — and may not be reflective of IPFs across the nation. **While we appreciate that CMS has initially proposed two years of voluntary reporting, we urge CMS to conduct additional testing through a voluntary pilot program, prior to expanding the survey to all IPFs under the QRP.**

A pilot program could help to address many of the questions CHA members and other stakeholders have raised about the survey, including the impact of the survey on varying settings (such as urban and rural, or freestanding IPFs and units), responses depending on patient status (voluntary versus involuntary admissions), and how survey administration impacts performance. Because administration is not proposed using a third-party vendor, we urge CMS to ensure that there are safeguards against patient coaching of survey responses.

Finally, we urge CMS to provide more information on how feedback data will be provided back to IPFs to ensure that survey responses provide actionable information that IPFs can use to improve the patient experience. CHA members who already use other survey tools have remarked on the importance of receiving useful feedback on improving satisfaction rates for patients.

Proposed Modification of the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure

CMS proposes to modify the current HCP COVID-19 vaccination measure beginning with the FFY 2025 IPF QRP, consistent with proposals across all Medicare quality reporting programs. Specifically, CMS would replace the definition of "complete vaccination course" with a definition of "up to date" with CDC-recommended COVID-19 vaccines. The agency proposes this modification to incorporate evolving CDC guidance related to booster doses and their associated time frames.

While the denominator of the current measure would not change — and is reflective of all HCP eligible to work in the facility for at least one day during the reporting period — the numerator of the measure would be changed to be the cumulative number of HCP in the denominator population who are considered up to date with the recommended COVID-19 vaccines as defined by the CDC[20] on the first day of the quarter. Compliance with the FFY 2025 IPF QRP requirements would be based on reporting of eligible HCP who are up to date beginning with quarter four of calendar year 2023. Beginning with the FFY 2026 IPF QRP, IPFs would be required to submit data for the entire calendar year.

CMS does not propose any changes to the data submission or reporting processes for the measure, and IPFs would continue to be required to collect data for at least one self-selected week during each month of the reporting quarter and submit that data to the CDC National Healthcare Safety Network (NHSN) prior to the quarterly deadline.

CHA strongly supports ongoing efforts to maintain high levels of up-to-date vaccination for COVID-19 among both HCPs and the communities they serve. However, as we exit the PHE and enter an endemic phase of the disease, we are concerned that the data reporting requirements associated with the measure will divert already stretched resources from patient care to administrative processes. The CDC definition of "up to date," can change every quarter, and it is challenging for IPFs to collect and continuously assess the vaccination status of every single employee that works in the facility for a given reporting period. Further, the requirement that IPFs collect and report on this data for at least one week each month has strained the already stressed workforce.

In developing the measure, CMS relied heavily on the specifications and experience with the Influenza Vaccination among the HCP measure. The flu vaccine measure assesses vaccinations during "flu season," as defined as October through March, and is reported annually. While there are still questions about the seasonality of COVID-19, future vaccination schedules, and how often new versions of a COVID-19

[20] https://www.cdc.gov/nhsn/pdfs/hps/covidvax/uptodateguidance-508.pdf

vaccine will be available, an annual data collection and reporting process is significantly less burdensome than reporting data for one week out of each month of the year. **We urge CMS to consider limiting the reporting requirements to at least one week for each quarter, and work with the CDC to move towards a version of the measure that could be reported annually.**

In addition, we continue to have concerns that the lag in the timeline between reporting the data to NHSN and public reporting of the measure results in publicly reported data that is outdated and inconsistent with the public's understanding vaccination rates in a given facility. As proposed, data for quarter 4 of 2023 would not be publicly reported until October 2024, at which point it is likely that the definition of "up to date" could be significantly different than when the data was collected, due to changes in recommended vaccination schedules or updated boosters. Finally, we remain concerned that the measure has not gone through rigorous testing for reliability and validity and has not been endorsed by the consensus-based entity (CBE).

Proposed Measure Removals

CMS proposes to remove the following IPF QRP measures, beginning with the FFY 2025 payment determination:

- Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS-5): CHA supports the removal of this measure because it no longer aligns with current clinical guidelines and practice.
- Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention Provided (TOB-2/2a): CHA supports the removal of this measure, and we agree that the IPF QRPs related measure, Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge (TOB-3/3a), has potential to better drive improvement in patient outcomes.

CHA appreciates the opportunity to comment on the FFY 2024 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