May 28, 2024

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

SUBJECT: CMS-1806-P, Medicare Program; FFY 2025 Inpatient Psychiatric Facilities Prospective Payment System – Rate Update, Proposed Rule, Federal Register (Vol. 89, No. 65), April 3, 2024

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) 2025 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. From 2019 to 2023, costs per adjusted discharge rose 25%[1] (driven by increases in salary costs +33%, supply expenses +18%, and pharmaceuticals costs +19%). However, base payment rates for Medicare have failed to keep pace with input price inflation. The total operating margin for California's psychiatric freestanding facilities is -6.1% (average Medicare operating margin is -6.8%)[2]. This financial fragility, which is exacerbated by Medicare payment policy, poses a risk to access to these much-needed services not only to Medicare beneficiaries but all members of the community. Chronic underfunding by Medicare contributed to the closure of one hospital in California (Madera Community Hospital[3,4]) and drove another into bankruptcy (Beverly Hospital[5]). Unfortunately, more hospital closures are expected to

[1] Current State of California Hospital Finances, Kaufman Hall, May 2024
[2] CHA analysis of 2022 Office of Healthcare Access and Information (HCAI) data.
[3] https://calmatters.org/health/2023/01/hospital-closure/
[4] 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.
[5] 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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follow. Kaufman Hall, a nationally renowned consulting firm, estimates that 70% of California's hospitals have unsustainably low margins[6].

Short of full closure, many hospitals are forced to eliminate financially unsustainable services that are needed by the community to ensure the remainder of the facility can remain open. The most frequently eliminated service lines are those that have a higher mix of Medicare and Medicaid patients (like inpatient psychiatric care[7]) due to governmental payment rates that fail to cover the cost of providing care.

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, which results 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[8] to Madera's closing.

If finalized as proposed, the FFY 2025 IPF rule will only exacerbate the access issues facing Medicare beneficiaries and other community members. The rule compounds the already dire financial circumstances for psychiatric hospitals. The proposed net market basket update (MBU) of +2.7% is inadequate relative to the input price inflation faced by IPFs and continues CMS' historic trend of proposing woefully insufficient payment updates.

For example, in 2022, CMS finalized an unadjusted MBU of 2.7%. However, CMS' actual market basket data for IPFs shows that costs actually increased by 5.3% (a difference of 2.6% from the final rule MBU), resulting in a significant underpayment for psychiatric hospitals in FFY 2022. Further, in 2023, CMS finalized a MBU of 4.1%. Again, the actual data used by CMS to set the MBU for IPFs show that costs actually increased by 4.8% (a difference of 0.7% from the final MBU), resulting in continued, significant underpayment to IPFs in 2023 as well. A similar underpayment is anticipated for FFY 2024 based on current forecast data. To ensure broad access to inpatient psychiatric services for Medicare patients, the following comments on the proposed 2025 IPF PPS proposed rule are offered:

- *Provide an Adequate Market Basket Update*: It is respectfully asked that CMS use data that better reflects the input price inflation that IPFs have experienced and are projected to experience in 2025. Further, CMS must make a one-time "forecast error adjustment" to account for CMS' inability to accurately project the IPF MBU in recent years. Both measures are necessary to ensure access for Medicare beneficiaries and other patients to inpatient psychiatric services.

- *Phase in Increases to Payment for Electroconvulsive Therapy (ECT):* CMS is respectfully asked to phase the increase in payment for ECT in over a period of three years. The budget neutral nature of the IPF system raises concerns that a sudden reduction in payments for all other services because of the ECT increase will exacerbate access issues for patients who need inpatient psychiatric care.

[6] Current State of California Hospital Finances, Kaufman Hall, May 2024
[7] https://www.beckershospitalreview.com/finance/10-hospitals-closing-departments-or-ending-services.html
[8] https://www.fresnobee.com/news/local/article272712840.html

- *Work with Congress to Support Access for Safety-Net Populations:* All hospitals subject to the IPF PPS care for populations at greater risk for inequitable outcomes. Instead of implementing the Medicare Safety Net Index (MSNI) and redistributing already inadequate payments amongst psychiatric hospitals, CMS must work with Congress to increase payments to all facilities – especially those that serve disproportionately large numbers of individuals who are uninsured, underinsured, or covered by governmental payers. Until such a time as when Congress provides additional IPF funds for safety-net populations, CMS can ensure access to care for those most at risk of inequitable access and outcomes by providing an adequate payment update as discussed below.

- *30-Day Risk-Standardized All-Cause Emergency Department (ED) Visit Following an IPF Discharge (IPF ED Visit) Measure:* CMS should not finalize this measure as proposed for the IPF QRP due to concerns it would penalize IPFs for factors beyond their control.

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

Market Basket Update

CMS proposes a market basket increase for FFY 2025 of 3.1%. This is then reduced by the negative 0.4 percentage-point "productivity adjustment" required under the Affordable Care Act (ACA). The resulting proposed IPF MBU equals 2.7% (3.1% minus 0.4 percentage points for productivity reduction).

CHA is deeply disappointed by the proposed 2.7% net MBU, as it is wholly inadequate relative to the input cost inflation experienced by IPFs described above. The continued underfunding of inpatient mental health services could lead one to call into question this administration's professed commitment to addressing the mental health crisis. It is obvious that inadequate Medicare payment is a direct contributor to reductions in inpatient psychiatric bed capacity. Considering this, we ask CMS to:

1. Recalculate the MBU using data that more accurately reflects the growth in input prices experienced by IPF PPS facilities
2. Provide a one-time "forecast error adjustment" that accounts for CMS' gross underpayment of IPFs from 2021 to 2023

While CMS will refresh the MBU in the final rule with more recent data, there is concern the revised update will still be insufficient relative to input cost inflation (as it has in prior years). As discussed above, costs per adjusted discharge increased 25% from 2019 through 2023. However, over the same period, the MBU has only increased per unit payments by 12.43%[9].

Even before the application of the productivity adjustment, 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 the current inflationary environment. **Therefore, CMS is asked to consider other methods and data sources to calculate the final rule "base" (before additional adjustments) MBU that better reflects the rapidly increasing input prices facing IPFs.**

[9] CHA analysis of CMS market basket data.

CMS is asked to consider using the weighted average growth rate in allowable Medicare costs per risk-adjusted discharge[10] for IPFs between FFY 2020 and FFY 2022 to calculate the FFY 2025 final rule MBU. Based on CHA analysis, this would yield an unadjusted MBU of 7.90%. If CMS fails to provide an adequate MBU, payments below the cost of providing inpatient psychiatric care will result in reduced access to services for Medicare beneficiaries.

In letters[11,12] responding to the proposed 2022, 2023, and 2024 IPF proposed rules, hospitals, CHA, and other stakeholders expressed concern that recent MBUs proposed (and subsequently finalized) were inadequate relative to input price inflation. Unfortunately, these concerns continue to be realized. Since 2021, the MBU finalized by CMS based on projected data has underpaid IPFs by a cumulative 3.9% relative to what the actual market basket data showed hospitals should have been paid for services to Medicare beneficiaries. The table below provides details.

Medicare Underpayment of IPFs Due to Inadequate Market Basket Update
Related to FFYs 2021 - 2023

FFY	Final Rule Projected MBU	MBU Based on Actual Data	IPF Under Reimbursement
2021	2.2	2.8	-0.6
2022	2.7	5.3	-2.6
2023	4.1	4.8	-0.7
Total	N/A	N/A	-3.9

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 MBU. As an example, the table below illustrates the forecast error adjustments finalized in the 2023 (2021 MBU) and 2023 (2022 MBU) and proposed for 2025 (2023 MBU).

Skilled-Nursing Facility Forecast Error Adjustments Finalized/Proposed
Related to FFYs 2021 - 2023

FFY	Final Rule Projected MBU	MBU Based on Actual Data	SNF Forecast Error Adjustment
2021	2.2	3.7	-1.5
2022	2.7	6.3	-3.6
2023	3.9	5.6	-1.7
Total	N/A	N/A	-6.8

Nothing in section 1886(s) of the Social Security Act prohibits CMS from making a one-time forecast error adjustment to the IPF IPPS MBU to correct for the significant underpayment in FFY 2022. **Therefore, CMS is asked to apply a one-time 3.9 percentage point "forecast error adjustment" to the proposed FFY 2025 IPF MBU of 7.9%[13] for an 11.8% update, prior to application of the 0.4% ACA productivity adjustment.** This is necessary to account for the significant underpayment that occurred in FFYs 2021 through 2023 due to the challenges CMS experienced forecasting input price growth. This adjustment is merited and will help preserve badly needed access to services that are frequently used by patients at risk of inequitable health outcomes. It would also protect patients from access issues

[10] CHA analysis of CMS IPF cost report data.
[11] https://calhospital.org/wp-content/uploads/2023/05/CHA-Comments-FFY2022-FFY-2023-IPF-PPS-Proposed-Rules-Combined.pdf
[12] https://calhospital.org/wp-content/uploads/2023/06/CHA-FFY-2024-IPPS-Proposed-Rule-Comment-Letter-060923-Final.pdf
[13] Assumes CMS finalizes the proposal to use the weighted average risk adjusted growth in IPF costs from FFY 2018 – 2022.

potentially created by CMS' proposal to increase ECT payments in a budget neutral manner which will reduce payments for all other IPF services.

Increase in the ECT Payment per Treatment

CMS has been making a per treatment payment for ECT in addition to per diem and outliers since the inception of the IPF PPS in 2005. Since that time the ECT payment rate has been updated for inflation and budget neutrality but not recalculated based on more recent cost data.

CMS proposes revising the ECT treatment add-on based on more recent outpatient prospective payment system (OPPS) costs. The original methodology for determining the ECT payment per treatment was based on the median cost for procedure code 90870 developed for the OPPS. Since that time, CMS used geometric mean costs instead of median costs to develop the OPPS relative weights. For this reason, CMS proposes to develop the ECT payment per treatment add-on under the IPF PPS using the pre-scaled and pre-adjusted 2024 OPPS geometric mean cost (based on 2022 hospital claims) for procedure code 90870 of $675.93. This compares to a rate of $385.58 per ECT treatment that is being used in FY 2024 under the IPF PPS.

After applying the inadequate MBU (1.027), wage index budget neutrality (0.9998), and budget neutrality for refinement standardization (0.9514 inclusive of the increase in the ECT per treatment rate), the proposed payment for ECT in FY 2025 will be $660.31. CMS notes that the budget neutrality adjustment for refinement standardization — accounting for changes to the patient-level adjustment factors and the ED adjustment factor — changes from 0.9536 to 0.9514 because of the increase in payment per ECT treatment. That is, there is a slightly larger decrease to IPF PPS payment rates for budget neutrality from this proposal as illustrated in the table below.

	Final FFY 2024	Proposed FFY 2025	Percent Change
IPF Per Diem Base Rate	$895.63	$874.93	-2.31%
ECT Base Rate	$385.58	$660.30	+71.25%

As discussed above, there are concerns that inadequate payments by Medicare and other governmental payers are creating access issues to inpatient psychiatric services – particularly for individuals who are already at risk for inequitable outcomes. Increasing ECT payments in a budget neutral manner (as required by statute) reduces Medicare payment for all other inpatient psychiatric services. To prevent access issues, CMS is again respectfully asked to provide an adequate, accurate MBU. This will help offset the budget neutrality adjustment required when recalculating ECT payments based on more recent data. **If CMS declines to provide an adequate payment update that results in a positive payment update for all services, the agency is respectfully asked to phase this increase in over three years. Phasing the adjustment in will allow time for inpatient psychiatric hospitals to adjust to the reduction in payment for all other services provided to Medicare beneficiaries.**

Request For Information (RFI) Revisions to the IPF PPS Required by the Consolidate Appropriations Act, 2023: Adjustment for Safety-Net Populations

The IPF PPS does not have an adjustment that recognizes higher intensity of inpatient services when hospitals serve a disproportionate share (DSH) of low-income patients. Section 1886(s) of the Act does not require any specific adjustment of this type, nor does it require the use of any particular

methodology. CMS has explored a DSH adjustment for the IPF PPS, but prior regression analyses have not supported adopting one, or if CMS did adopt one, it would be negative.

In the proposed rule, CMS requests feedback on adopting the Medicare Payment Advisory Commission's MSNI. CMS modeled the potential distributional impacts of modeling revised adjustments for rural location, teaching status and the adoption of an MSNI adjustment. The distributional impacts could be significant as indicated in the proposed rule. The effect of implementing the MSNI on the IPF PPS federal per diem base rate would be a reduction of nearly 28% ($244.81), if adopted in concert with an updated rural payment and teaching adjustment, but only 0.74% from updating only the rural and teaching adjustment ($6.48).

Given the financial challenges facing all psychiatric hospitals, the agency's concerns about the ability of certain hospitals to provide inpatient mental health services for populations at greater risk of inequitable outcomes is shared. However, given the budget neutral constraints of the statute, redistributing existing funds is deeply concerning as the agency is merely robbing Peter to pay Paul. This would result in questionable policy outcomes (e.g. significantly reducing payment to all urban freestanding psychiatric hospitals) as illustrated in Table 21 of the proposed rule. Further, unlike Medicare disproportionate share payments incorporated into the IPPS, the MSNI does not recognize the costs associated with providing services to all safety-net populations and will therefore disadvantage some safety-net IPF PPS hospitals.

First, CMS is strongly encouraged to work with Congress to increase the funding specifically for hospitals that serve safety-net populations. These funds are necessary to ensure access to care for all patients — especially Medicare beneficiaries who are at risk of inequitable outcomes. Second, instead of adopting the MSNI at this time, CMS is encouraged to — as discussed above — provide an adequate payment update. This is the best action that CMS can take to support psychiatric hospitals to ensure they can provide care to all populations at greater risk of inequitable outcomes, not just those populations covered by Medicare.

Requirements for Reporting Ancillary Charges and All-Inclusive Status Eligibility Under the IPF PPS

In the proposed rule, CMS clarifies the eligibility criteria to be approved to file all-inclusive cost reports. Only government-owned or tribally owned facilities satisfy these criteria. Therefore, CMS proposes only these facilities are permitted to file an all-inclusive cost report for cost-reporting periods beginning on or after Oct. 1. In order to be approved to file an all-inclusive cost report, hospitals must either have an all-inclusive rate (one charge covering all services) or a no-charge structure.

This "clarification" is strongly opposed. For all-inclusive reporters, their clear objective in selecting the all-inclusive option is to reduce administrative costs that do not contribute to improved patient outcomes. This objective is a prominent concern across the entire health care delivery system and is especially acute for behavioral health providers that often do not realize the efficiencies gained through sophisticated health information technology systems, which unfortunately applies to many IPFs.

Many IPFs made the operational decision not to generate a charge for these types of ancillary services given they are not sufficiently significant to warrant the administrative burden associated with ancillary charging activity. Furthermore, in general, the industry standard is for IPFs to negotiate per diem rates with commercial payers where certain ancillary charges (such as laboratory and drugs) are not a material determinate in the acceptance of certain per diem rates from a payer. As a result, and in the interest of being operationally efficient, these facilities do not generate ancillary charges on their claims since payment is not impacted.

The absence of separate ancillary charges does not correlate to the assumption that ancillary services were not provided to the patient. In most cases, if not in all cases, the hospital will use its patient order entry system to order a laboratory test or drugs ordered by a physician, and those services are documented in the patient medical record. However, some hospitals and health systems have made the operational decision not to generate a charge for these types of ancillary services given they are not sufficiently significant to warrant the costs associated with this ancillary charging activity. It is critical that CMS know the omission of certain ancillary charges on the claim does not by default mean the ancillary service (e.g. laboratory testing and drugs) was not provided to the patient. All patient care decisions are dictated by the treating physician and fully documented in the medical record. The fact that an ancillary charge was not generated in the billing system does not impact the clinical decisions regarding the treatment of patients.

Implementing a transition away from all-inclusive reporting would require retooling internal systems such as interfacing clinical ancillary systems (where physician patient orders originate) with the charge description master so that an ancillary charge can be generated on the patient billing claim. In fact, some members have estimated that the approximate initial cost of modifying internal systems to transition from all-inclusive reporting would be $250,000 to $300,000 per hospital along with ongoing annual maintenance fees of up to $40,000 per hospital. CMS should not penalize hospitals and increase the cost of care by finalizing this "clarification."

IPF Quality Reporting Program (QRP) Proposal to Adopt the 30-Day Risk-Standardized All-Cause Emergency Department (ED) Visit Following an IPF Discharge (IPF ED Visit) Measure

CMS proposes to add one measure — the 30-Day Risk-Standardized All-Cause ED Visit Following an IPF Discharge (IPF ED Visit) measure — to the IPF QRP beginning with the calendar year 2025 reporting year/FFY 2027 payment determination. This claims-based measure is intended to assess the number of ED visits and observation stays for any reason (related to psychiatric hospitalization or not) within 30 days of IPF discharge. It is also intended to compliment three existing measures in the IPF QRP that assess post-discharge outcomes: Follow-up After Psychiatric Hospitalization, Medication Continuation Following Inpatient Psychiatric Discharge, and Thirty Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization. Notably, the measure was reviewed by the consensus-based entity and did not achieve endorsement.

IPFs understand their important role in discharge planning that ensures appropriate follow-up care and maximizes the chance for patients' successful community reintegration following a psychiatric hospitalization. However, by including ED or observation visits for all-causes, whether related to a psychiatric diagnosis or not, the proposed measure would assess IPFs based on factors outside of their control. For example, a patient discharged within 30 days of an IPF may visit an ED with an acute respiratory infection — such as COVID-19, influenza, or respiratory syncytial virus — which would be more indicative of levels of community illness than the quality of care provided while that patient was being treated for a psychiatric illness in the IPF, or the discharge planning processes provided by the IPF. Including conditions unrelated to mental illnesses within the numerator could lead to confusion about the quality of care provided by the IPF and could potentially mask data that is more directly related to the care provided inside IPFs.

Similarly, the measure could penalize IPFs in underserved communities that may have higher levels of chronic illnesses and limited access to outpatient specialty and primary care. Patients in these communities may turn to the ED as the only option to receive the care they need with no bearing on the

ability of the IPF to direct patients to other options for chronic condition management. **CMS should not finalize this measure as proposed for the IPF QRP.**

The opportunity to comment on the FFY 2025 IPF PPS proposed rule is appreciated. If you have any questions, please contact me at cmulvany@calhospital.org or (202) 270-2143, or Megan Howard, vice president, federal policy, at mhoward@calhospital.org or (202) 488-3742.

Sincerely,

/s/
Chad Mulvany
Vice President, Federal Policy