National Association for Behavioral Healthcare

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28 May 2021

Elizabeth Richter
Acting Administrator, Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Proposed Rule on the FY 2022 Medicare Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting [CMS-1750-P]

Dear Acting Administrator Richter:

On behalf of the National Association for Behavioral Healthcare (NABH), thank you for the opportunity to comment on the proposed rule to update the Medicare prospective payment system (PPS) and Quality Reporting Program for inpatient hospital services provided by inpatient psychiatric facilities (IPFs). NABH represents behavioral healthcare systems that provide mental health and addiction treatment across the entire continuum of care, including inpatient, residential treatment, partial hospitalization, and intensive outpatient programs, as well as other facility-based outpatient programs including medication assisted treatment centers. Our membership includes behavioral healthcare providers across the United States in every state but Hawaii.

We expect an increasing need for inpatient psychiatric care in the coming years due to the Covid-19 pandemic. National surveys have repeatedly shown dramatic increases in the incidence of anxiety and depression; most recently, the Centers for Disease Control and Prevention (CDC) found that symptoms of anxiety and depression increased significantly between August 2020 to February 2021 consistent with earlier findings during the pandemic.[i] Suicidal ideation has increased,[ii] and drug overdoses have spiked with more than 85,000 deaths reported during the 12-month period ending in August of 2020.[iii] Moreover, even before the pandemic, serious behavioral health conditions had become so prevalent and elevated, they were driving down overall life expectancy in the United States.[iv] Previous epidemics have shown that the impact on behavioral health will continue for years to come.[v]

This pandemic has further magnified the need for improved access to behavioral healthcare. Unfortunately, recent data from CMS indicate that Medicaid enrollees' access to mental health services has decreased dramatically during the pandemic.[vi] Moreover, we know there are severe shortages of behavioral healthcare providers, including inpatient psychiatric treatment facilities, in many parts of the United States. According to the Health Resources and Services Administration, there are more than 5,700 mental health provider shortage areas across the United States, with more than one-third of Americans (119 million people) living in these shortage areas. In these areas, the number of mental health providers available were adequate to meet about 27% of the estimated need.[vii]

Many psychiatric hospitals have negative net operating margins despite offering services that are in high demand in communities across the country.[viii] The Covid-19 pandemic has added to the strain on these facilities with additional financial losses and unexpected costs, including those related to greatly increased use of personal protective equipment, increased screening of individuals coming into the facilities with additional staffing needs for screening, and other infection-control measures, including isolation rooms and units, software and hardware purchases to facilitate telework for administrative staff and telehealth for patients, and lost revenue due to decreased patient volume because of infection concerns and reduced referrals.

In the context of these ongoing concerns, we respectfully submit the following comments on the proposed rule to update the Medicare IPF PPS and Quality Reporting Program.

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Prospective Payment System

Labor Market Delineations

In the FY 2021 proposed IPF PPS rule, CMS established new labor market delineations to recognize the most recent population shifts and labor market conditions. The rule explained that those changes would lead to decreases in the wage index used in setting the rate for certain facilities, which would reduce payments to these facilities. That rule explained that these changes would have a negative financial impact on many IPFs nationwide.

To address the negative impact of these changes, CMS established a two-year phase-in of this change by capping any reduction in a facility's wage index at no more than a 5% decrease in FY 2021.

As noted above, during the Covid-19 pandemic, all hospitals, including inpatient psychiatric facilities, are experiencing significant financial challenges due to higher costs and lost revenue. We also expect an increased need for behavioral healthcare, including inpatient psychiatric services, because of this pandemic.

Reductions in reimbursement established in the FY 2021 IPF PPS will make it even harder for a significant number of psychiatric hospitals and psychiatric units in general hospitals to absorb the additional costs resulting from the pandemic and also meet an increasing need for care.

Recommendation: We urge CMS to establish a more gradual phase-in for the reductions in payment for certain IPFs resulting from the wage index changes adopted in the FY 2021 IPF PPS. While we appreciate the cap on reductions provided for FY 2021, we urge CMS to impose a similar measure in the FY 2022 IPF PPS to help facilities adjust to the reduced reimbursement that changing labor markets demand. Furthermore, we encourage CMS to establish a process whereby psychiatric facilities may apply for an exception to the Core-Based Statistical Area classification applied to their geographic area to allow their IPF PPS reimbursement rate to account for extenuating circumstances that affect local labor market and IPF operating costs.

Wage Index "Frontier" Floor

As we noted earlier, CMS uses a wage index to adjust the labor-related portions of IPF payments under the IPF PPS. Since the IPF PPS was established, CMS has used the pre-floor, pre-reclassified acute care hospital wage index to develop a wage for IPFs, because an IPF specific wage index is not available. CMS has stated in previous rules: "*We believe that IPFs compete in the same labor markets as acute care hospitals, so the pre-floor, pre-reclassified hospital wage index should reflect IPF labor costs.*"[ix] Our members agree with this observation because their experience has demonstrated that IPFs do compete directly with acute care hospitals for employees.

As CMS has previously acknowledged, however, "under the IPF PPS, the wage index is calculated using the IPPS wage index for the labor market area in which the IPF is located, *without* accounting for geographic reclassifications, floors, and other adjustments made to the wage index under the IPPS."[x] (emphasis added in italics). This means that our members are at a severe disadvantage when competing with general acute care hospitals, because their payments under the IPF PPS simply do not reflect the economic conditions of these labor markets.

This issue is particularly acute in the "frontier states," a term that references an *Affordable Care Act* provision that established a floor on the area wage indexes in particularly rural states.[xi] Under that provision, states with a high share of low population-density counties have a "floor" on their area wage index of 1.0. Because CMS does not account for this floor when applying the IPPS wage index to IPFs, the wage index for an acute hospital can be up to 30% higher than an IPF in the same labor market.

Consequently, IPFs in frontier states are underpaid relative to general acute care hospitals in the same geographic areas, even though they compete directly for the same employees. This underpayment undermines an IPF's ability to recruit and retain clinical and administrative staff and offer competitive salaries and benefit packages.

The U.S. Health and Human Services Department secretary has broad authority to implement a prospective payment system for IPFs.[xii] The regulations governing the IPF PPS indicate that CMS should "adjust the labor portion of the Federal per diem base rate to account for geographic differences in the area wage levels using an *appropriate* wage index,"[xiii] and that CMS will publish on an annual basis the "*best available* hospital wage index and information regarding whether an adjustment to the Federal per diem base rate is needed to maintain budget neutrality,"[xiv] (emphasis added in italics). The regulatory guidance of using an *appropriate* wage index based on the *best available* hospital wage index and information would be fulfilled with the use of the frontier state wage index floor of 1.0 to adjust IPF payments in a frontier state. CMS addressed this issue in its August 6, 2018 final rule,[xv] in which CMS acknowledged the provider comments on this issue and stated the agency would consider the "frontier" floor.

Recommendation: To address this inequity, we urge CMS to incorporate the frontier state "floor" when it applies the acute care hospital wage index to IPFs.

Quality Reporting Program

Covid-19 Vaccination among Healthcare Personnel

CMS is proposing to require IPFs to report the percent of healthcare personnel vaccinated for Covid-19. This information would be reported next summer regarding vaccination rates starting this October. It is not clear how vaccination rates among personnel as of this fall will be relevant by summer 2022. Furthermore, there is a great deal of uncertainty regarding these vaccines including how long they provide protection from the effects of Covid-19 and the degree to which individuals with certain underlying conditions are protected from Covid-19 by the vaccines. Furthermore, the vaccines that are currently available have not been fully vetted by the Food and Drug Administration (FDA). Without full FDA authorization of any of the Covid-19 vaccines, some IPFs have not required their employees to receive them.

Furthermore, this measure would require IPFs to enter this information into the CDC's National Healthcare Safety Network (NHSN) web portal. IPFs do not generally use this portal and requiring them to use it just for this purpose will create confusion and unnecessary burden. This burden will fall disproportionately on smaller IPFs that are less likely to have personnel who are familiar with the CDC's web portal.

Previously, CMS included a similar measure in the IPFQR Program that required IPFs to enter the percent of personnel vaccinated for influenza into the NHSN portal. CMS subsequently dropped this measure out of concern about the burden of reporting this measure that did not produce data that was considered very useful. The same considerations apply to the proposed measure regarding Covid-19 vaccination among healthcare personnel.

Recommendation: NABH urges CMS not to adopt this measure into the IPFQR Program.

Follow-up After Psychiatric Hospitalization

CMS is proposing to include the Follow-up After Psychiatric Hospitalization (FAPH) measure in the IPFQR Program instead of the Follow-up After Hospitalization for Mental Illness (FUH) measure. Unlike the FUH measure, the FAPH measure includes patients with substance use disorders (SUDs) and follow up visits with additional types of providers. We are concerned that the FAPH measure has not been endorsed by the National Quality Forum (NQF), which means the expert entity responsible for establishing the validity and effectiveness of

performance measures has not fully vetted it. Therefore, this measure could change to achieve NQF endorsement, which may have implications for how IPF performance is determined and could result in unnecessary administrative burden. Moreover, this measure has raised other issues that the Measures Application Partnership (MAP) —the expert committee convened to advise on adoption of performance measures into CMS programs—has noted. The MAP also recommended that the NQF endorse the measure before it is adopted into the IPFQR Program.

One example of an issue this measure raises relates to information-sharing restrictions and widespread confusion regarding applicability of 42 CFR Part 2 to SUD treatment information. This ongoing uncertainty, particularly after recent changes to these regulations and additional upcoming changes that the *Coronavirus Aid, Relief, and Economic Security* (CARES) Act (Pub. L. 116-136) requires, may affect the degree to which follow-up visits are identifiable in claims data, which could affect IPFs' performance on this measure.

Furthermore, it is likely that many follow-up visits for SUD treatment will not be included in Medicare claims data, given significant limitations in Medicare coverage for SUD treatment. For example, Medicare does not cover a number of provider types that provide much of the outpatient treatment for SUDs, including licensed or certified professional counselors, licensed or certified clinical alcohol and drug counselors, and marriage and family therapists. Moreover, Medicare does not cover services in intensive outpatient programs and residential treatment settings, which are programs that addiction treatment experts recommend as intermediate levels of care[xvi] appropriate for post-acute follow-up treatment for SUDs.

We greatly appreciate the actions CMS has taken during the Covid-19 pandemic to facilitate access to care for Medicare beneficiaries via telehealth. Coverage of telehealth for mental health and addiction treatment has been critical during these terribly challenging times, and coverage of audio-only technology has been particularly important for Medicare beneficiaries. A recent study found that one in four Medicare beneficiaries had a telehealth visit last summer and fall, and more than half of them accessed care using a telephone only.[xvii] Accordingly, we urge CMS to clarify that telehealth visits, including audio-only visits, count as follow-up visits for the FUH measure as well as the FAPH measure if it is included.

Recommendations: NABH recommends that CMS refrain from adding the FAPH measure to the IPFQR Program unless and until the NQF endorses it. We also urge CMS to clarify that telehealth visits, including audio-only visits, count as follow-up visits for the FUH measure currently include in the IPFQR Program as well as the FAPH measure if it is adopted.

Removal of Alcohol and Tobacco Brief Intervention and Transmission of Transition Record Measures

CMS proposes to remove the Alcohol Use Brief Intervention Provided or Offered (SUB-2/2a) and Tobacco Use Brief Intervention Provided or Offered (TOB-2/2a) measures. NABH does not have any concerns about removal of these measures. The other related measures, Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge (SUB-3/3a) and Tobacco Use Treatment Provided or Offered at Discharge (TOB-3/3a) are more burdensome to report and NABH encourages CMS to remove these measures as well.

CMS also proposes to remove the Timely Transmission of Transition Record measure. NABH supports removal of this record and urges CMS to remove the related Transition Record with Specified Elements Received by Discharged Patients as well. Neither of these measures was developed for IPFs and they are ill-suited for assessing performance in these settings. The information required to be reported by these measures to demonstrate performance is inappropriate and vague. Moreover, the NQF has removed endorsement of this measure and therefore it is not being maintained. CMS should reexamine how best to measure transition record transmission by IPFs because both of the current measures are burdensome and not effective at measuring IPF performance.

Recommendation: NABH supports removing the three measures that CMS has proposed to remove and recommends also removing the three related measures.

Patient-level Reporting

CMS proposes to require patient-level reporting for all chart-based measures. NABH is concerned about the administrative burden this will impose, particularly on free-standing IPFs, because most do not have electronic health record (EHR) systems to support this more detailed data submission.[xviii] Additional time to adjust to this revised reporting format would be helpful. In addition, it would be critical that CMS not make any changes to the IPFQR Program measures that would increase reporting requirements during a transition to patient-level reporting. We also urge CMS to take steps to protect the privacy of this data as it will be more individually identifiable under this approach.

Recommendations: NABH is concerned about the impact of requiring patient-level reporting on freestanding IPFs and urges CMS to provide additional time for IPFs to adjust to this change. In addition, we urge CMS not to add or change chart-abstracted measures during the transition to patient-level reporting. We also urge CMS to take steps to ensure the privacy of these individualized data.

Digital Data Collection

CMS requests comments on a proposal to convert the Transition Record with Specified Elements Received by Discharged Patients to an electronic measure with specification to support digital data collection. It is premature for CMS to develop electronic measures for the IPFQR Program when a large percent of IPFs do not have EHR systems to support this form of reporting.[xix] Until IPFs are provided the subsidies awarded to other inpatient settings for implementation of EHR systems under the *Health Information Technology for Economic and Clinical Health* (HITECH) Act of 2009, the utility of developing measures for electronic reporting for the Medicare IPFQR Program would be limited.

Specification of a measure for electronic reporting often results in substantive changes to how that measure is structured and the specific information being collected for the measure. Therefore, performance on an electronic version of a measure should not be compared with performance on the preexisting version of the measure because the measures are often substantively different. Therefore, adoption of e-measures into the IPFQR Program at this point, given the lack of penetration of EHRs among IPFs, will result in a confusing set of results and disproportionately impact smaller IPFs that are less likely to have EHRs.

In addition, the Transition Record with Specified Elements measure proposed for electronic specification is a particularly inappropriate measure to convert to an electronic measure as the information required to be documented to indicate performance is very vague and does not lend itself easily to structured fields essential to an electronic measure. We recommend that CMS instead devote resources to refining existing measures, including the transition record measures to assess performance by IPFs more effectively and efficiently.

Recommendations: We urge CMS not to develop electronic measures at this time and instead refine existing measures to reflect quality of care in IPFs more appropriately.

Experience-of-Care Measure

CMS requests comments about developing a patient experience-of-care measure and specifically whether the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey would be appropriate for these settings. NABH urges CMS not to adopt the HCAHPS survey into the IPFQR Program. The questions in this survey do not reflect the types of services provided in IPFs. Also, individuals whose principal diagnoses are psychiatric conditions are explicitly excluded from the administration of this survey.

The HCAHPS survey does not take into account that many patients in IPFs are involuntarily admitted and responses to this survey will lead to results that are not indicative of the quality of care in these settings. Furthermore, the requirement that HCAHPS be administered after a patient has left the IPF will result in extremely low response rates. Some of our members have experience with surveys administered after discharge, and they report response rates as low as 2%. Results from including the HCAHPS survey in the IPFQR Program are likely to be so low in number that they will not provide a valid assessment of patients' experience of care in those settings. Finally, HCAHPS must be administered in writing or over the phone, and therefore does not seem consistent with CMS's general support for increased digital data collection.

Some NABH members have developed their own experience-of-care surveys for their IPFs. These instruments are not in the public domain because they are very costly to develop and IPFs are not otherwise reimbursed for this cost. There are consistent themes across these instruments, but the way the questions are phrased often varies. It is also important to consider the different subgroups of patients that may receive treatment in IPFs including children and adolescents, older individuals, people who are involuntarily admitted, and people who cannot answer for themselves. Experience-of-care measures should be structured, administered, and assessed differently depending on the population being surveyed.

In light of this complexity, we recommend that CMS convene a technical expert panel (TEP) that includes NABH members to provide information on how patients' experience of care in IPFs should be assessed if included in the IPFQR Program. One approach might be to identify a very limited number of questions to be reported to CMS that could be included in an IPF's own longer survey. Another approach might be to identify a number of domains or general topic areas that should be included but allow the IPFs to determine how best to structure the individual questions with variations for different patient populations.

While this TEP deliberates on this topic, CMS could consider re-establishing the attestation requirement previously included in the IPFQR Program that asked IPFs to indicate whether they are administering an experience-of-care measure as an interim step.

Recommendations: NABH opposes using the HCAHPS survey for the IPFQR Program and urges CMS to convene a TEP to determine the best approach for incorporating an experience-of-care measure into the Program. In the meantime, we recommend returning to the attestation measure that asked IPFs whether they use an experience-of-care measure while allowing IPFs discretion to determine which measure they use for the different populations they care for.

Patient-Reported Outcomes Measure

CMS requests comments on including a patient-reported outcome measure in the IPFQR Program, particularly a measure that assesses functional outcomes.

We do not believe a measure exists in the public domain that would be sufficiently broad to apply to all the individuals who receive care in IPFs. Measures that do exist are proprietary because these measures are costly to develop and administer. Another challenge with administering these measures in IPFs results from the limited number of inpatient days covered. Average lengths of stay are generally eight to 10 days in private IPFs. This period of time is not sufficient to allow for much progress on patient-reported outcomes.

NABH recommends that CMS engage with measurement and clinical experts, including members of NABH, about how best to include a patient-reported outcome measure in the IPFQR Program. The same TEP recommended for the experience of care measure above could possibly provide input on this patient-reported outcome measure issue as well.

As an interim step, CMS could ask IPFs to attest that they are using a patient-reported outcome measure to assess progress and short-term impact of treatment among their patient populations. CMS could also ask IPFs

to identify which patient-reported outcome measures they are using. The Joint Commission takes a similar approach in its standards for behavioral healthcare organizations. The Care, Treatment, and Services (CST) Standard 03.01.09 requires organizations to use a standardized tool or instrument to monitor an individual's progress, to analyze the data generated and use the results to inform the individual's goals and objectives, and to use the data to evaluate outcomes of the treatment or services provided.[xx]

Recommendations: NABH encourages CMS to convene a TEP to advise on how to incorporate a patient-reported outcome measure into the IPFQR Program. CMS could also consider including on an interim basis an attestation measure asking IPFs to state whether they use a patient-reported outcome measure to assess progress and short-term impact of treatment among their patients and advise on which measures they use for this purpose.

Improving Collection of Information on Health Disparities

CMS requests comments on how to modify data collection and/or analysis of quality measure results to improve information on disparities between certain disadvantaged subgroups and the rest of the patient population in IPFs. The two subgroups highlighted for special attention are racial and ethnic minorities and individuals dually eligible for Medicare and Medicaid.

CMS specifically asks for feedback on which IPFQR Program measures are appropriate for stratified reporting. NABH urges CMS to focus any efforts to stratify results on the claims-based measures included in the IPFQR Program. The data submitted for the chart-based measures is drawn from a subset of the patient populations within IPFs. Many IPFs already are unable to report data for the chart-abstracted measure with sufficient volume to meet the requirement for public reporting of these measures. We believe that further stratifying this data among subgroups will result in findings that are not statistically valid.

Furthermore, as we saw when CMS asked for chart-based measure data to be stratified by age, the burden of this information collection is likely to outweigh the benefit. As many IPFs already demonstrate high levels of performance on these chart-based measures, there are unlikely to be any subgroups with dramatically different results.

At the same time, we would like to emphasize that the utility of stratifying claims-based measures is limited because the claims used for calculating the results exclude private insurance claims. Therefore, a significant portion of the population in IPFs is not included in these data. About a third of patients receiving treatment in private IPFs are commercially insured.

Furthermore, we suggest that a focus on social determinants of health is an important consideration for assessing health disparities, and we encourage CMS to explore further how best this information can be identified in claims data.

CMS also proposes to develop a facility equity score for each IPF based on analysis of stratified quality measure data. NABH opposes any type of score for IPFs based on stratification of quality measure data due to the limitations of these data and reliability of the results as described above. Also, data specific to dual eligible patients would be affected by the varied eligibility for Medicaid among the states which would prevent this data from being reliable for any type of national comparison or nationally benchmarked facility score.

CMS also requests comments on improving demographic data collection and refers to the use of certified health information technology for this purpose. We reiterate that freestanding IPFs continue to lag significantly behind general hospitals in implementation of EHR systems largely because they were excluded from the federal subsidies to establish these systems. While larger IPFs and those within general inpatient hospitals may have access to this technology, the smaller facilities would be disproportionately affected by any requirements regarding data collection that assumes access to EHR systems.

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Recommendations: NABH supports developing data to better understand health disparities among disadvantaged groups and improve equity for racial and ethnic minorities. We encourage CMS to focus on claims-based measures for this analysis and investigate improvements to identification of social determinants of health in claims data. We oppose developing a facility equity score at this time, given the many limitations in existing program data described above.

Thank you for considering our comments. If you have questions, please contact me directly at shawn@nabh.org or 202-393-6700, ext. 100, or contact NABH Director of Policy and Regulatory Affairs Kirsten Beronio at kirsten@nabh.org, or 202-393-6700, ext. 115.

Sincerely,

Shawn Coughlin
President and CEO

About NABH

The National Association for Behavioral Healthcare (NABH) represents provider systems that treat children, adolescents, adults, and older adults with mental health and substance use disorders in inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient programs, medication assisted treatment centers, specialty outpatient behavioral healthcare programs, and recovery support services in every state but Hawaii. The association was founded in 1933.

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