National Association for Behavioral Healthcare

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31 May 2022

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Fiscal Year 2023 Inpatient Psychiatric Facilities Prospective Payment System - Rate Update and Quality Reporting - Request for Information Proposed Rule (CMS-1769-P)

Dear Administrator Brooks-LaSure:

On behalf of the National Association for Behavioral Healthcare (NABH), thank you for the opportunity to comment on the Medicare Program Fiscal Year 2023 Inpatient Psychiatric Facilities (IPF) Prospective Payment System (PPS) Rate Update and Quality Reporting Program Request for Information and Proposed Rule.

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 (MAT) centers. Our membership includes behavioral healthcare providers in 49 states and Washington, D.C.

The Covid-19 pandemic has highlighted and amplified the need for mental health and addiction treatment. Studies have consistently found significantly higher levels of anxiety and depression and suicidal ideation since 2020.[i, ii] In addition, alcohol consumption has increased significantly, [iii] and drug overdose deaths continue to accelerate, reaching about 100,000 deaths during the 12-month period ending in June 2021.[iv] Suicide rates have remained high, with troubling increases among certain groups, including Black Americans and adolescent girls. [v] Moreover, experience with past epidemics indicates that the impact on behavioral health may continue for years to come.[vi] The number of people needing behavioral healthcare following the pandemic is predicted to increase by 50% compared with pre-pandemic levels.[vii]

Serious behavioral health conditions are highly prevalent among Medicare beneficiaries. Serious mental illness affects 23% of beneficiaries in traditional Medicare, and 12% of those in Medicare Advantage plans.[viii] Beneficiaries under 65 years old have high rates of serious mental illness (34%) in addition to the 26% who experience mild-to-moderate mental illness.[ix] More than 50% of inpatient stays by Medicare beneficiaries under 65 were related to mental health or addiction in 2016 (not including stays psychiatric hospitals).[x] Furthermore, more than 3.4 million individuals 65 and older reported having an alcohol or illicit drug disorder in 2020.[xi]

Proposed Updates to the IPF PPS Rates

Although the Covid-19 pandemic has magnified the need for improved access to behavioral healthcare, we know there are severe shortages of behavioral healthcare providers in many parts of the United States. According to the Health Resources and Services Administration (HRSA), as of Sept. 2, 2021, more than one-third of Americans (125 million people) lived in one of the 5,788 mental health professional shortage areas.[xii] In these areas, the number of mental health providers available were adequate to meet about 27% of the estimated need.[xiii] About half of U.S. counties and 80% of rural counties have no practicing psychiatrists, and more than 60% of psychiatrists are nearing retirement.[xiv] By 2030, the number of psychiatrists is expected to decrease by 20%, and addiction counselors will also be in short supply.[xv]

A significant issue driving behavioral health workforce shortages is that reimbursement rates have not kept pace with the increased need for mental health and substance use disorder (SUD) services and increased costs during the pandemic. As a result of this financial shortfall, IPFs are struggling to invest in the wage and benefit increases necessary to retain their existing workforce or hire additional staff to meet expanded demand for treatment. This is particularly problematic for inpatient psychiatric facilities that must compete for clinicians and other healthcare personnel with inpatient hospitals and other providers in their communities that have higher profit margins and are therefore able to offer higher salaries. Reimbursement amounts for psychiatric care often do not cover a provider's costs, and research studies show that lack of reimbursement creates significant barriers to mental health and SUD treatment.[xvi]

Lower reimbursement for mental health and SUD services results in non-competitive salaries for the nation's behavioral health workforce in general. Salaries in behavioral health professions are well below those for comparable positions in other health care sectors, according to a Substance Abuse and Mental Health Services (SAMHSA) report to Congress.[xvii] One of the primary reasons for the shortage of psychiatrists and psychologists is financial; for example, the median compensation for psychiatrists is the third lowest among the 30 medical specialties.[xviii] As a result, medical school and Ph.D. students avoid behavioral health professions.[xix]

Moreover, many IPFs have been forced to reduce their capacity to provide treatment during the Covid-19 pandemic to implement infection-prevention policies. IPFs have reduced capacity while general hospitals have converted psychiatric treatment beds to other purposes as the demand for hospital beds for Covid-19 treatment increased. As a result, it has been even harder to find a psychiatric treatment bed for individuals with serious conditions or for those experiencing a crisis during these challenging times.[xx] In addition, we expect that many acute inpatient hospitals may not return those beds to psychiatric care because providing that type of care is not as lucrative as providing care for other conditions,[xxi] - magnifying the already widespread lack of adequate availability of inpatient care for people with serious mental health and/or SUD conditions.

Furthermore, since the onset of the pandemic, IPFs have had to absorb unanticipated additional costs related to Covid-19. They have developed new telehealth services and programs with significant new costs for technology and training. In addition, they have incurred added costs related to personal protective equipment and screening as well as costs related to additional cleaning and infection control measures. In addition, they have had to reduce admissions to ensure appropriate social distancing. Funding provided by Congress through the Provider Relief Fund did not cover a large share of the additional costs and lost revenue resulting from this pandemic. Moreover, unlike many of the other hospitals and providers, IPFs did not receive any targeted funding allocation from the Provider Relief Fund to address their increased costs as well as the increased need for mental healthcare and addiction treatment during this pandemic.

Conclusion

Consequently, NABH urges CMS to include a one-time adjustment to the IPF PPS rate to take into account these unexpected and significant costs. In addition, we would like to express strong support for the proposed permanent 5% cap on wage index decreases.

Rate Refinement and Corresponding Technical Report

Thank you for the opportunity to comment on the results of the data analysis of the IPF PPS adjustments summarized in the CMS technical report. NABH appreciates that CMS has performed an updated analysis to assess whether the IPF PPS payment methodology should incorporate any refinements to respond to changes in provider costs. After reviewing the technical report and conducting workgroup discussions within NABH's membership, we are providing comments for CMS' use as the agency considers prospective changes to the underlying payment system in future years.

General Observations

CMS notes the existing IPF PPS model continues to be generally appropriate in terms of effectively aligning IPF PPS payments with the cost of providing IPF services, and NABH agrees. Additionally, CMS observes the updated regression analysis from CMS' contractor identifies a few technical adjustments that could refine the IPF PPS model in future years. While NABH agrees there are some adjustments supported by the data analysis in the technical report, NABH does not believe incorporating all identified technical adjustments would be appropriate.

First, when considering whether to incorporate new or modified adjustments, NABH believes it is important that any changes in the IPF PPS payment model first be supported by data and also be consistent with Medicare's policy goals. NABH does not believe each identified adjustment is supported by strong data or public policy. For those reasons, NABH does not support all of the potential adjustments the technical report identifies, as described in this letter.

Second, Covid-19 has had a significant impact on hospitals' overall costs, and IPFs are no exception. It is likely IPFs will continue to experience higher costs due to increasing labor costs, additional disease control processes, and other changes for the foreseeable future. These costs would not be reflected in 2018 data. For this reason, relying on the technical report for any future adjustments may not be advisable given the significant changes hospitals have experienced since 2018.

Conclusion

NABH urges CMS to incorporate only refinements to the IPF PPS model that the data and well-founded payment policy support. CMS should adopt only payment- methodology refinements that will continue to support high-quality care and improved access for Medicare beneficiaries, particularly considering the expanding need for mental healthcare and the continued cost burdens IPFs face related to the pandemic.

Consolidating Age Groups

Based on reviewing 2018 data, the technical report suggests reducing the patient age groups from 9 to 7 by consolidating the age 45 – 49 and age 50 – 54 into a single group and also consolidating the age 70 –74 and age 75 –79 into a single group. When reviewing the data, the analysts observed these groups had identical factors; therefore, it would be administratively easier and data-supported to combine the age groups. While NABH has not performed any corresponding analysis, NABH is not surprised by the contractor's findings. In general, NABH's membership observes the biggest cost difference when comparing younger patients and the more elderly patients.

Conclusion

NABH supports decreasing the patient age groups from 9 to 7 by consolidated categories that effectively have identical factors in the contractor's analysis.

Comorbidity Adjustments

The technical report generally did not find that the data support adding new comorbidities to the adjustment factor. After analyzing whether the IPF PPS model should include homelessness and pregnancy as identified comorbidities, the data did not support that either condition significantly increases costs. Additionally, analysis of the 2018 data shows that five of the comorbidity groupings are not statistically significant. When considering which factors should be incorporated in calculating a payment adjustment, NABH believes CMS should only include adjustments that both the data and public policy support strongly.

Conclusion

NABH agrees with the technical report that homelessness and pregnancy should not be included as a comorbidity grouping because the data does not support that these comorbidities have a significant impact on costs. NABH urges CMS to only include comorbidity groupings if they are strongly indicated in the data.

Teaching Status Adjustment

Teaching hospitals receive an adjustment to their per-diem rate to reimburse them for the additional costs incurred of training psychiatric residents in their facilities. These teaching hospitals are vital to supporting the mental healthcare safety net because most of the country is currently located in a mental health professional shortage area, affecting 149 million people. HRSA estimates the country would need an additional 7,482 mental health practitioners to cover these gaps.[xxii] Based on analysis of the 2018 data, the technical report supports increasing the teaching status adjustment variable from 0.5150 to 0.9486. This increase should significantly improve reimbursement for teaching hospitals, and it is much needed.

Conclusion
NABH supports increasing the teaching status adjustment to further support training efforts in order to increase the number of practicing mental health practitioners.

Social Determinants of Health
CMS requests comments on which additional patient characteristics, typically referred to as social determinants of health (SDOH), affect the cost of providing IPF services. CMS also requests public comments on suggestions for how to better identify these patient characteristics and their effects on cost. NABH agrees that social determinants of heath are important considerations for assessing health disparities and encourages CMS to continue exploring the best means for identifying this information in claims data. One of the reasons the existing IPF PPS methodology has been (and continues to be) so effective is CMS' reliance on claims data. Using claims-based data allows IPFs to maintain lower administrative costs and work more efficiently while still providing sufficient data for CMS to assess any necessary adjustments to account for differences between patients and facilities. Overall it decreases the administrative burden for all parties, including CMS.

NABH supports additional research into the most effective and least disruptive means to assess these effects and incorporate any additional information collection into hospital reporting. This research would be beneficial for assessing the appropriate payment methodology and also for considering other beneficial programs CMS and the hospitals can pursue to improve care for vulnerable populations. Because SDOH affect all patient populations and not only Medicare beneficiaries, it will likely be important to ensure any analysis is not overly stratified for specific payor groups to avoid unintentional negative outcomes from any related changes.

Conclusion
NABH encourages CMS to continue pursuing additional data collection through the robust use of claims data regarding social determinants of health and how these patient characteristics affect the cost of providing IPF services.

Length-of-Stay Adjustment
The report that CMS' contractor prepared concludes that shorter lengths of stay are more common and generally have higher relative costs than longer lengths of stay. Additionally, when updating the regression analysis using 2018 data, the technical report suggests increasing the adjustment for shorter lengths of stay accordingly, with rather large increases for stays less than seven days. While NABH agrees the majority of IPF stays are generally shorter stays, NABH is concerned that significantly increasing the per-diem adjustment for shorter stays, particularly the first day, would create improper financial incentives. With higher reimbursement for the earlier days, this change could have the unintended consequence of incentivizing providers to discharge a patient earlier than is clinically indicated because a new patient in that bed would effectively generate a higher reimbursement yield for each inpatient encounter. This potential consequential behavior would be inconsistent with care mandates IPFs should follow for patient well-being.

Conclusion
If CMS were to consider incorporating a per-diem adjustment related to length of stay, NABH urges CMS to balance the results of the technical report with clinical care policy considerations to ensure the payment methodology is consistent with Medicare payment goals of aligning payment with resources expended to treat beneficiaries. It is

important that the IPF PPS model does not incentivize discharging patients early in order to take advantage of the higher reimbursement for short stays.

Outlier Policy
The technical report's analysis of the outlier data identifies that fewer IPF cases qualify as outliers under the current 2% outlier target than CMS originally estimated for the IPF PPS model. Therefore, the report analyzes the impact of increasing the outlier target to 3% or 4%. While increasing the outlier target would reasonably increase the number of claims qualifying for outlier payments and facilities receiving outlier payments, it would necessarily decrease other payment rates in order to attain budget neutrality.

Unlike medical/surgical outliers, psychiatric outliers generally are not costlier because of increased acuity. Based on discussions with its membership, NABH believes psychiatric outliers are typically the result of patient placement challenges. Often, for IPFs, the length of these outlier stays is a result of too few discharge options. Many facilities are unable to discharge patients because there are no appropriate step-down levels of care available in many communities, which results in longer stays. Thus, the outlier adjustment does not directly address the root cause of this issue. NABH does not support decreasing IPF PPS payments generally in order to increase the outlier target because this would inappropriately decrease base rates for all facilities while failing to address the cause of extended stays.

Conclusion
NABH does not support increasing the outlier target rate beyond 2%.

DSH Adjustment
When preparing the original IPF PPS model, CMS chose not to incorporate a disproportionate share hospital (DSH) adjustment because the result would be a decrease for most facility payments, which is inconsistent with the goals of a DSH adjustment.[xxiii] The technical report, using 2018 data, shows a similar negative relationship between the per diem cost and DSH status. The majority of hospitals would experience decreased payments if CMS incorporates a DSH adjustment. As hospitals continue to face financial difficulties in the wake of Covid-19, particularly with increasing wage costs, it would not be well-founded payment policy to incorporate a DSH adjustment if it results in decreased reimbursement for the majority of providers when both empirical and anecdotal evidence does not fully support this payment change.

Conclusion
For the same reasons CMS declined to adopt a DSH adjustment when designing the IPF PPS model, NABH urges CMS not to adopt a DSH adjustment. CMS should only incorporate a DSH adjustment if the data fully supports and illustrates a positive relationship between the facilities' increased costs and DSH status.

Rural Location Adjustment
The technical report suggests decreasing the rural location adjustment from 1.17 to 1.11; however, the impact of using 2018 data is practically negligible when the analysts remove the occupancy control variables. Reducing payments to rural hospitals would be destabilizing and would not represent well-founded payment policy.

Rural hospitals are the primary points of care and access for many Medicare beneficiaries who cannot travel to urban areas for mental healthcare. They are a fundamental component of the behavioral health safety net, and Medicare reimbursement should support these facilities to ensure beneficiaries have continued access. Millions of Americans live in communities that do not have essential healthcare services, particularly mental healthcare. Many

of these patients already have significant barriers to receiving the care they need. Rural hospitals provide critical access points for patients in their own and neighboring communities.

Despite the important role they serve, year over year, we see more rural hospitals closing.[xxiv] In fact, around 181

rural hospitals have closed since 2005, with 138 closures occurring since 2010.[xxv] Rural hospital closures are not only detrimental for a community's physical and mental healthcare but also result in increased unemployment because hospitals are often large employers for rural areas. Particularly with the rural hospitals' increasing labor costs and low wage index, it is important to continue to support strong rates for these facilities.

In reviewing the technical report, it was notable that once the analysts removed the occupancy controls, the rural adjustment was comparable with the current adjustment. NABH believes that due to the unique circumstances of rural facilities, it may not be appropriate to apply the occupancy control factors when assessing appropriate rates for these facilities. Most rural IPFs have far fewer beds than the average urban IPF, which means smaller census changes have a much larger proportional impact on the facility's occupancy rate. But the rural facility will not experience significantly lower costs due to this same occupancy rate change. Rural facilities are more sensitive to occupancy rate changes than the larger urban facilities. The technical report does not discuss much on the intent of using occupancy rates as a control factor. However, to the extent one intent of the occupancy control factor is to assess the efficient use of resources, a lower occupancy rate in a rural facility is not necessarily indicative of an inefficient use of resources. Rural IPFs frequently provide the *only* source of mental healthcare in their communities. It is vital to ensure these access points remain open for those populations. As such, it may be best to assess the potential changes to the rural location adjustment without applying the occupancy control variables.

Additionally, Covid-19 has both increased the need for mental healthcare while also significantly affecting hospitals' costs and processes going forward. NABH cautions CMS on relying too heavily on refinements that may be indicated in the 2018 data that CMS would then apply to a post-Covid environment. The Covid-19 pandemic hit rural hospitals especially hard and have experienced an even greater drain on their limited resources. It is possible an analysis based on 2018 data has generally limited applicability post-Covid, but this impact could be even more pronounced for rural facilities.

Conclusion
In sum, NABH does not support decreasing the rural location adjustment.

Use of Data Set
The data used for the technical report and all resulting conclusions were prepared for a very specific purpose: assessing potential refinements for the IPF PPS model. This analysis also included a trimming process that resulted in trimming a significant proportion of facilities and then weighted the remaining facilities to balance the analysis. As such, NABH would caution CMS or other agencies from relying too heavily on this data set for uses other than analyzing potential refinements to the IPF PPS model. During the trimming process, the contractor removed a large proportion of IPF facilities due to their lack of specifically identified ancillary charge data. NABH does not believe this exclusion had a significant impact on the results and conclusions for this analysis, but that may not be the case if this data set is used for other purposes.

Conclusion
NABH urges CMS and any other federal or state agency to recognize the limitations in using this data for purposes other than its intended use.

Measuring Equity and Healthcare Quality Disparities - Request for Information

In the request for information (RFI) included in the Medicare Program FY 2023 IPF proposed rule, CMS outlines a general framework for assessing disparities in healthcare quality across different treatment settings as well as approaches to assessing drivers of disparities in the IPFQR Program specifically. The first section regarding a general framework discusses methodological issues that CMS would like to address consistently across the Medicare quality programs. This section focuses on stratification (measuring performance differences among subgroups of beneficiaries) of clinical quality measure data as a favored approach to measuring disparities and outlines issues regarding reporting of stratified results and selecting and prioritizing measures for stratified \

reporting.

Another strategy CMS discuses is using social risk factors and demographic data for disparity reporting, along with various ways of collecting or imputing that data. This section also discusses identifying meaningful results and the benefits of reporting results privately to providers and/or reporting results publicly.

In the section of the RFI that specifically references the IPF Quality Reporting (IPFQR) Program and assessing drivers of disparities and measures of equity, CMS states that it is considering using enrollment, claims, and assessment data to examine the extent to which various SDOH and other factors drive disparities in IPF data. CMS proposes this approach in response to prior comments noting that IPFs have limited information or resources for determining the extent to which a patient's SDOH explain a given disparity. CMS also indicates that provider-specific results could be confidentially shared with IPFs to allow them to set priorities regarding performance areas to focus on.

Conclusion
Using administrative and claims data to identify IPF patients with SDOH or other factors and assess the extent to which these issues drive disparities in healthcare would be less burdensome for providers and patients and would also likely be more effective than requiring the IPFs to collect and report this data. Furthermore, we support CMS's proposal to share any information collected on these issues with the IPFs privately.

However, it is important to recognize that IPFs are likely to have relatively high rates of SDOH or other factors that tend to drive disparities because people with mental illnesses and/or substance use disorders that are so seriously ill they need inpatient psychiatric treatment generally have high rates of SDOH, e.g., homelessness, lack of transportation, food insecurity, limited access to meaningful employment or education. It would be unfair and counter-productive to penalize IPFs for serving this high need population. Moreover, IPFs should not be held accountable for issues over which they have no control. Payors and managed care plans are better situated to ensure individuals with serious mental illness or substance use disorders have access to social services and supports to help them remain healthy in their communities.

Two Specific Health Equity Measures Proposed
As part of this RFI, CMS also proposes for consideration two specific measures that could be adapted for use in the IPFQR Program: 1) the Health Equity Summary Score (HESS) and 2) Degree of Hospital Leadership Engagement in Health Equity Performance Data.

The HESS combines data from several performance measures and was developed to compare performance of Medicare Advantage plans. CMS is proposing to adapt this measure for use in provider quality reporting programs including the Inpatient Quality Reporting Program and the IPFQR Program. The HESS draws from two types of data: 1) patient experience of care data for seven measures included in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and 2) clinical care data for five HEDIS measures. The CAHPS data included in this composite measure focuses on doctor communication, ease of getting needed care, getting care quickly, ease of getting needed prescription drugs, customer service, care coordination, and flu immunization. The HEDIS measures that are included assess breast cancer screening, colorectal cancer screening, diabetes care, and adult body mass index. Both types of data are linkable to social risk factors among individual Medicare beneficiaries.

Conclusion
As detailed below, NABH members have serious concerns about using the CAHPS data to measure experience of care in psychiatric settings. The questions included in this survey instrument were not developed to assess and do not account for the specific circumstances of inpatient psychiatric treatment. Furthermore, we fear that the response rate will be particularly low among inpatient psychiatric treatment patients. Moreover, none of the HEDIS measures included in the HESS relate to mental health or substance use disorder treatment. Therefore,

it is not clear how this composite measure would meaningfully assess health disparities among individuals receiving treatment in IPFs.

The other measure of the Degree of Hospital Leadership Engagement in Health Equity Performance Data is a structural measure for which hospitals attest to meeting five types of activities aimed at achieving health equity for racial and ethnic minorities, people with disabilities, sexual and gender minorities, individuals with limited English proficiency, and rural populations. Hospitals are assessed on meeting the following objectives: 1) having in place a strategic plan for advancing equity; 2) collecting demographic and social determinants of health data for patients and including this information in certified electronic health records; 3) using this data to identify equity gaps and including this information on performance dashboards; 4) participating in local, regional, or national quality improvement activities focused on reducing disparities; and 5) having senior leadership annually review performance under the strategic plan for achieving health equity and review performance indicators stratified by demographic and social factors.

This measure fails to take into account the widespread lack of electronic health records (EHRs) in psychiatric hospitals. As discussed at recent meetings of the Medicaid and CHIP Payment and Commission (MACPAC), 49 percent of psychiatric hospitals have implemented certified EHR technology compared with 96 percent of general hospitals as of August of 2019.[xxvi] In addition, office-based behavioral healthcare providers are also far less likely to use EHRs than other providers (including psychiatrists at 61 percent compared to other specialists in high 90 and 80 percent). According to the consulting firm McKinsey & Company that presented this data to MACPAC in September of 2021, this discrepancy is due to the exclusion of psychiatric hospitals and most behavioral health provider types 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).

While larger IPFs and those within general inpatient hospitals may have access to certified EHR technology, the smaller facilities would be disproportionately affected by any requirements regarding data collection that assumes access to EHR systems. This measure that incorporates the extent to which IPFs are recording demographic and SDOH data in certified EHRs is likely to unfairly penalize IPFs for their lack of EHRs even though they did not receive federal subsidies to implement this technology like inpatient hospitals did.

Furthermore, NABH urges CMS to focus any efforts to stratify data 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.

Moreover, 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.

In addition, 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.

Conclusion
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 proposed measures and existing program data described above.

Experience-of-Care Measure
We would also like to take this opportunity to comment regarding ongoing work led by CMS and the Agency for Healthcare Resources and Quality (AHRQ) to develop a patient experience-of-care measure for inpatient psychiatric care using the framework of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. We reiterate our concerns about using the HCAHPS survey for 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 have thus far been explicitly excluded from the administration of this survey.

The HCAHPS survey does not consider 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 must 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.

Due to 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 several 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.

Conclusion
NABH has concerns about 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 in their care.

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Patient Reported Outcome Measure for Depression

We would also like to comment on ongoing work by CMS to develop a measure of Improvement in Depression Symptoms during an IPF Stay. This measure calculates the percentage of adult patients discharged from an IPF with a documented improvement in PROMIS Depression Short Form (8b) scores between admission and discharge. The PROMIS Short Form is an eight-item inventory of depression symptoms with a one-week, look-back period.

We are concerned that this measure incorporates a depression screening tool, the PROMIS measure, the electronic version of which is not in the public domain, which means that providers would have to purchase access. Providers are not permitted to implement their own version of the PROMIS depression scale. Moreover, the vendor with the licensing rights for the electronic form requires providers to purchase the entire PROMIS suite even if providers need only the part regarding depression. Any measure used for the IPFQR Program should be in the public domain in both electronic and paper formats to ensure access.

In addition, it is not clear that the PROMIS depression measure is appropriate because it has not been validated in samples of patients with any psychiatric illness, much less in samples of patients with depression specifically. If the PROMIS measure is used, it should first be validated in samples of psychiatric patients and particularly for patients with depression.

Furthermore, it is unclear whether IPFs would be expected to screen all patients for improvements in depressive symptoms, or only those with a diagnosis of depression. This would determine which patients IPFs would include in the denominator for this measure.

Patients with depressive symptoms who enter an IPF will have varied levels of severity of these symptoms. Therefore, any measure of improvement of depressive symptoms should be risk-adjusted for diagnosis and other demographic characteristics.

Moreover, depressive symptoms vary significantly across different age groups and other patient populations. Therefore, requiring a specific scale for all patients could undermine the accuracy of the results and utility for quality assurance.

Conclusion

We recommend that if CMS pursues including a patient-reported outcome measure on depression in the IPFQR Program, IPFs be permitted to choose from among a set of validated depression scales that are within the public domain and that are appropriate for the population they serve.

Thank you for considering our concerns and recommendations. If you have any questions, please contact me directly at shawn@nabh.org or 202-393-6700, ext. 100.

Sincerely,

Shawn Coughlin
President and CEO

National Association for Behavioral Healthcare

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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 49 states and Washington, D.C.. The association was founded in 1933.

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