National Association for Behavioral Healthcare

Access. Care. Recovery.

28 May 2024

Chiquita Brooks-LaSure, Administrator
The Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244

***Submitted Electronically***

**Re: CMS–1806–P. Medicare Program; FY 2025 Inpatient Psychiatric Facilities Prospective Payment System—Rate Update.**

Dear Administrator Brooks LaSure:

The National Association for Behavioral Healthcare (NABH) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) FY 2025 inpatient psychiatric facility (IPF) prospective payment system proposed rule. Our primary concerns pertain to the inadequate market basket update as well as the untenable implementation schedule for the proposed change to the all-inclusive reporting policy.

NABH members provide the full continuum of behavioral healthcare services to children, adolescents, adults, and older adults with mental health and substance use disorders (SUD) in inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient programs (IOP), medication-assisted treatment centers, specialty outpatient behavioral healthcare programs, and recovery support services in 49 states and Washington, D.C.

**IPFs Need Modern Information Technology**
Given the significant health information technology (HIT) limitations across the behavioral healthcare (BH) sector, most IPFs and other BH providers lack the capacity to exchange patient health information with clinical partners interoperably. This obstacle restricts the timeliness and effectiveness of care delivery, joint case management across settings, cross-setting patient transfers, and efforts to achieve parity in integrating physical and mental health.[1] [2] In addition, the obsolete HIT in our field prevents participation with various recent proposals from CMS and other policymakers, including integration with key clinical partners, full functionality with federal and state health exchanges, and electronic prior authorization processes. Also, while some psychiatric hospitals and units have HIT systems that comply with current HHS standards for data exchange and other required functionality, most are using outmoded systems that are used primarily to bill payers electronically, with some capability of basic prescription management;

[1] "Electronic Health Information Exchange At Discharge From Inpatient Psychiatric Care In Acute Care Hospitals," Morgan C. Shields, Grant Ritter, and Alisa B. Busch. *Health Affairs.* June 2020.
[2] Use of Electronic Health Information Technology in a National Sample of Hospitals That Provide Specialty Substance Use Care, Morgan C. Shields, Ph.D., Constance M. Horgan, Sc.D., Grant A. Ritter, Ph.D., Alisa B. Busch, M.D. M.S., *Psychiatry Services in Advance*. 2021.

however, most lack the capability to send or receive interoperable data. In fact, many in our field still rely, at least in part, on faxes, emails, and phone calls.

**The generational gap between BH IT and medical-surgical HIT levels exists primarily because the *HITECH Act of 2009* funds were not extended to IPFs and other BH providers.** Today, BH patients and other stakeholders are still paying the price for this omission. As a partial offset to our members' exclusion from HITECH resources, NABH has engaged with several initiatives that the U.S. Health and Human Services Department (HHS) launched this year to begin rectifying that significant gap between the HIT capacity that separates BH providers from other providers in the healthcare continuum **Through these projects, HHS recognizes that IPFs and the overall BH field remain a generation behind when it comes to the fundamental building blocks needed for BH interoperability and other modern IT functions.**

## Proposed Payment Provisions

**Proposed Market Basket Update Falls Short and Requires an Offset**
Consistent with recent annual payment updates for this and other prospective payment systems, the proposed net update for FY 2025 – an increase of 2.6% percent relative to FY 2024 rates – does not adequately account for the nationwide cost pressures that IPFs continue to face. The update does not reflect the remaining healthcare cost inflation that was sparked by the COVID-19 pandemic and still persists in the form of workforce pressures and shortages and other elevated costs. These include continued head-to-head wage competitions with other employers within and outside of local healthcare marketplaces, which are exacerbated by burnout among clinical and non-clinical personnel, and other factors that continually pressure IPFs to raise compensation levels.

Our concerns about inadequate market basket updates not fully accounting for costs, as we emphasized in our FY 2024 comments, persist with this rule, as well. The table below shows the ongoing and unsustainable gaps between actual and forecasted market basket increases from FY 2021 through FY 2024 IPF PPS. **This persistent gap is indefensible on policy grounds and is especially egregious when considering the overwhelming urgency of the BH service shortages facing the United States.** In short, the scale of this cumulative under-adjustment, 4.1 percentage points, is alarming and warrants a one-time offset.

| IPF Market Basket[3] | FY 2021 | FY 2022 | FY 2023 | FY 2024 |
|---|---|---|---|---|
| Forecast Used in the Update | 2.2 | 2.7 | 4.1 | 3.5 |
| Actual Based on Later Utilization | 2.8 | 5.3 | 4.8 | 3.7 |
| Difference | -0.6 | -2.6 | -0.7 | -0.2 |

[3]OACT, 4th quarter 2023 release of the market basket information with historical data through the 3rd quarter of 2023 (Market Basket Data | CMS) for the actual update based on later utilization.

**To help rectify this worrisome and chronic underpayment, in the pending final rule we urge CMS to apply a forecast error adjustment to the per-diem base rate for FY 2025. Specifically, a 0.7 percentage point increase would account for the payment gap from FY 2023, which is the most recent year with a full year of available data.** Such an adjustment would result in an FY 2025 net payment update of 3.3 percentage points for this rule (2.6 plus 0.7 percentage points).

**Delay Implementation of the Proposed Restriction on All-inclusive Reporting**
NABH urges CMS to delay implementing its proposed policy restriction on all-inclusive reporting. **Given the complexity of transitioning from all-inclusive to traditional reporting of ancillary charges, the proposed effective date of Oct. 1, 2024 is impossible and should be changed to Oct. 1, 2026.** In fact, some IPFs will need to implement a *manual system* initially to begin reporting ancillary charges prior to achieving the level of system readiness needed for compliance with this change (as we discuss below).

This significant proposal to limit all-inclusive reporting to government and tribally owned IPFs will require major changes to the internal systems of IPFs that, under this shift in policy, would begin reporting ancillary charges on their Medicare claims. We note that under guidance from CMS' Medicare Administrative Contractors, the option of all-inclusive reporting has been allowed for many years.

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 factors charge can be generated on the patient billing claim. In fact, in alignment with the details below, some members have estimated that the initial cost of modifying internal systems to transition from all-inclusive reporting would range from $250,000 to $300,000 per hospital along, with additional costs for on-going annual maintenance fees of up to $40,000 per hospital.

**IT Preparedness**
Many NABH members will need to assess current billing processes to identify the new resources needed and challenges associated with beginning to report ancillary charges. For many IPFs facing this new reporting requirement, a particular challenge will be a lack of applicable IT interfaces needed to report charges electronically. NABH members are reporting the following key challenges:

- Local Area Network (LAN) Remediation Needs: For many IPFs, the current IT infrastructure platform technology is outdated and will require technical upgrades to integrate with electronic medical record systems, office management systems, and/or ancillary clinical systems.
- IPFs may face the cost of purchasing additional computer hardware and software to link to the noted systems. These types of purchases tend to encounter supply chain issues that delay providers' implementation plans.

- Additional contract and/or in-house personnel support will be needed to implement these changes, which, relative to the well-documented workforce challenges for the healthcare and most other industries, also bring affordability and implementation challenges.
    - In particular, we expect that timely and affordable support from external IT vendors will be very difficult to secure and, as such, implementing this policy change will require additional time.

**Interim Manual Reporting Process**
Of special note, some all-inclusive providers will first need to implement an interim, manual approach before they achieve full compliance because an automated solution is not available. Before systematizing an automated process, the interim manual protocol would include:

- A qualified clinical professional, such as a nurse or coder, would pull the patient chart to identify the ancillary services provided to the patients.
- The billing department would manually create a charge ticket to submit to the payer.
- The ancillary billing charge ticket information would then manually be entered into the electronic patient system for billing purposes and claim generation.

This manual process would generate material burden until the automated protocol is implemented. **Our members estimate that, on average, two hours will be needed for each manual chart review – an investment that would require additional personnel and oversight time and costs, with annual facility costs ranging from $300,000 and $700,000, depending on an IPF's case volume.**

**Commercial Insurers and Medicare Advantage**
Under this policy change, all-inclusive IPFs likely eventually will also shift their billing practices for commercial insurers to report ancillary services. Today, these IPFs do not report ancillaries such as laboratory and drug charges because they are not material costs. We note that many Medicare Advantage plans also use all-inclusive billing and payment arrangements.

**The complexity and cost of this transition validate that IPFs' clear objective for selecting the all-inclusive reporting option is to reduce administrative burden.** In fact, as noted in its June 2023 report to Congress, the Medicare Payment and Advisory Commission found that even most *non*-all-inclusive IPFs (53%) often are *not* reporting ancillary charges. Further, because the BH field's overall IT capacity is a generation behind, as we discussed above, IPFs have been motivated disproportionately to capitalize on every potential operational efficiency, such as selecting the all-inclusive billing option.

**Given these considerations, NABH urges CMS to delay the requirement for ancillary-services reporting by two years, to at least Oct. 1, 2026.**

**Mitigate the Outlier Loss Threshold Increase**
Consistent with the feedback in our FY 2024 proposed rule comments, NABH supports implementing an alternative calculation for updating the outlier loss threshold. The alternative methodology would result in additional cases becoming eligible for an outlier payment in FY

2025. Specifically, we support the CMS-developed approach to remove from the calculation IPFs with extremely high or low costs per day (3+ standard deviations from the mean) to base the update on a narrower set of more homogeneous IPFs. Further, for context on the disproportionate scale of the proposed outlier loss threshold increase, a 6.3% increase to $35,590, the rule's proposed net update is only 2.6 percentage points.

## Proposed Quality Reporting Changes

NABH supports the continued evaluation and improvement of the IPF quality reporting program (QRP) to ensure that the program and affected providers focus on the most meaningful and reliable measures that have been validated for the IPF setting. That said, given our members' limited bandwidth as they help lead their local responses to the mental health crisis, we call on CMS to expand the QRP only when critically needed and the remove measures that are no longer useful or proven ineffective.

**30-Day All-Cause Emergency Department (ED) Visit Following an IPF Discharge**
While we understand CMS' goal in proposing this measure, which is to learn more about IPF patients' continuity of care and outcomes over a broader episode, we do not support the addition of this measure to the IPF QRP. First, we note that in general, IPF patients are admitted because they are at risk of harm to themselves or others; in other words, IPFs treat patients with highly intense and even life-and-death needs.

In addition, this population struggles with a wide array of social determinants of health that contribute to these difficulties, such as the lack of a home, cell phone, support system, and more. Collectively, these characteristics result in a dynamic and multi-factor clinical profile, including readmissions drivers that are complex. Yet, this proposed readmissions measure is based on a one-dimensional view that does not acknowledge that this population should retain full access to Emergency Departments (ED), including for readmission, which can be the sole, life-saving resource.

Following a discharge, typically an IPF does not oversee or control patient behavior and compliance with the post-discharge care plan. Meanwhile, as referenced above, IPFs and other BH providers generally lack electronic connectivity with local partners, which prohibits meaningful cross-setting discharge and follow-up care coordination. As such, IPFs generally do not know if their patients return to an ED, even if the patient returns to an in-system ED. Finally, the patient population in IPFs includes many individuals who are in an emergency situation, making post-discharge communications, much less clinical intervention, very difficult and often impossible. **Given these extensive challenges, it would be inappropriate to incorporate this metric in the IPF QRP, as doing so would tacitly and falsely indicate that IPFs actually have some control over the readmission practices of their patients.**

**Increasing QRP Data Submission Frequency**
**NABH opposes increasing the IPF QRP data submission frequency requirement.** In short, our members are struggling with the post-pandemic, steady increase of suicides and deaths due

to opioid/fentanyl overdoses. In addition, as noted, IPFs and the broader BH field suffer from the operational limitations causes by outmoded HIT. As such, data reporting duties place a heavier burden on our field. Based on these two reasons, increasing from annual to quarterly data reporting frequency is simply untenable for our members.

## Requests for Information

**IPF PPS Patient Assessment Instrument**
**Now is not the time for the IPF field to allocate resources to develop a patient assessment instrument** (PAI). Rather, policymakers and providers should focus resources on combatting the immediate challenges of the nation's mental health crisis. Further, we urge CMS to recognize that the need for PAI development at this particular time is lessened through this very rule's proposed IPF PPS refinements to selected DRGs and comorbidities, in addition to the roll-out of additional quality measures that took effect in FYs 2023 and 2024. Collectively, these PPS maintenance and improvement measures make meaningful strides toward ensuring payment accuracy and quality outcomes under this payment system. **After this final rule is implemented, CMS should first assess the impact of these payment system refinements on payment accuracy and identify any remaining cost drivers that, if addressed, could potentially increase accuracy of the PPS, and then consider the relative benefit that a PAI could offer.**

That said, we recognize that Congress has asked CMS to explore the design of a potential PAI for IPFs. With that in mind, we share essential process-development concerns and protocols that should be factored into any future PAI development work. These concerns, in part, reflect lessons learned when CMS and its contractors worked for a decade to develop a post-acute care PAI that ultimately was not implemented because of design, implementation and other shortcomings.

- Exclusively consider potential PAI elements that were tested in IPFs, rather than repurposing measures tested in other healthcare settings, to validate their ability to actually capture the intended information when applied to a cross-section of IPF patients.
- Identify the full range of potential IPF cost drivers including examining procedure costs, revenue codes, and other available data points that indicate the need for additional resources use as the patient level, such as 1:1 care for certain conditions, the need for a private room for violent patients or those with an infectious disease, activities of daily living, cognitive factors, etc.
- Limit PAI items to only those with meaningful levels of r-square statistical significance.
- Limit the PAI to the only the most useful elements to mitigate provider burden.
    - Estimate and compensate providers for this new data-collection burden.
- Mitigate PAI length in accordance with unique characteristics of IPF patient population. IPFs commonly treat patients in a highly-intensive clinical state, such as those experiencing psychoses, suicidal behaviors, and other crisis-level conditions. Therefore, conducting PAI assessment with such patients would be impossible at times.

- Confirm adequate levels of inter-rater reliability for each item, to mitigate the subjectivity of clinicians collecting PAI data.
- Include in any PAI proposal provider education on how to improve common coding, data submission, and other documentation inadequacies.
- Develop PAI training language and supports that yield consistent implementation of PAI patient assessments, which is essential for ultimately achieving reliable and useful data via an IPF PAI. Prior PAI efforts have struggled to prevent training ambiguities that lower inter-rater reliability.

**Maintain Current Facility-level Adjustments**
NABH supports CMS' plan to maintain as-is the two facility-level adjustments that apply to the IPF PPS. While the teaching and rural adjustments, as currently formulated, have general support across the field, we agree with CMS that it is premature to advance toward an additional adjustment for "safety net" facilities. Our position aligns with CMS' concerns that the budget-neutral adjustment for a potential future adjustment of this type would significantly redistribute IPF payments. The rule hypothetically estimates that a budget neutrality adjustment for this third facility add-on payment that would be an offset of $245 to the per diem base rate, a reduction of nearly 28 percent. **A budget neutrality offset of this scale would result in untenable volatility for the overall field when, in stark contrast, what our members desperately need is stability and the addition of new resources to expand access to care.** As such, any future considerations of this type of adjustment should be limited to a non-budget neutral approach, in alignment with the inpatient PPS framework.

## Other Policy Considerations

**Request for Provider-level Impact Estimates**
**Consistent with other Medicare prospective payment systems for hospitals, we ask CMS to include in its IPF PPS rulemaking a provider-level impact file. Currently, IPF PPS proposed and final rules only include impact estimates by type of facility.** The absence of provider-level impact data limits stakeholder interpretation of the rule, both at the individual provider level as well as from NABH's national perspective. In the specific case of this rule, NABH and our partners struggled to replicate this element of the rule. This proposal includes DRG and comorbidity shifts that resulted in material budget-neutrality adjustments – yet the impact of these shifts on individual IPFs was withheld. Moving forward, beginning with this pending final rule, we ask CMS to publish a facility-specific impact file with IPF-specific impact details including the unique payment factors used to calculate payments for each IPF, as it does with rulemaking on the inpatient and inpatient rehabilitation facility prospective payment systems.

**Reimburse Cost-sharing for Involuntarily Committee Patients**
Often, Medicare patients who are involuntarily committed to an IPF do not cover their cost-sharing reimbursements. First, as this in-crisis population did not choose to seek care, they may not feel responsible for resulting costs. Second, for patients in this category that face socio-economic and other sources of instability, even when they want to cover their cost-sharing, they

may lack the financial wherewithal. **As such, we call on CMS to reimburse IPFs for the cost-sharing that would otherwise be sought from involuntarily committee patients.**

Thank you for considering NABH's recommendations on this important rule. We look forward to supporting and working with you and your staff to address these issues. Please contact me at shawn@nabh.org or 202-393-6700, ext. 100 if you have questions.

Sincerely,

Shawn Coughlin
President and CEO