AMERICAN PSYCHIATRIC ASSOCIATION

800 Maine Avenue, S.W.
Suite 900
Washington, D.C. 20024

June 5, 2023

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1783–P
Baltimore, MD 21244–8010

Re: CMS–1783–P; Medicare Program; FY 2024 Inpatient Psychiatric Facilities Prospective Payment System—Rate Update

Dear Administrator Brooks-LaSure:

The American Psychiatric Association (APA), the national medical specialty society representing over 38,000 psychiatric physicians and their patients, would like to take the opportunity to comment on the FY 2024 Inpatient Psychiatric Facilities (IPF) Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2023 (FY 2024). Our comments focus on key payment provisions and issues related to measurement through the Inpatient Psychiatric Facility Quality Reporting Program (IPFQR).

Mental health systems optimally include a care continuum to meet people's needs in the most accessible, least restrictive environment. In broad perspectives, this continuum includes a range of services such as crisis services, accessible outpatient services, rehabilitation and recovery support services and inpatient psychiatric care. Access to inpatient psychiatric beds undergirds local mental health systems, providing essential services to help treat adults or young people who are experiencing mental illness, just like inpatient medical hospitalization serves the most acutely ill. Unfortunately, the number of psychiatric beds across private and public sectors has dropped significantly in the past 60 years. Today, amidst a mental health crisis, psychiatric inpatient beds are too often not available when needed. As a result, people with mental illnesses end up boarding in emergency departments or being discharged prematurely. In worst-case scenarios, inaccessible treatment results in homelessness or involvement with the criminal justice system. We appreciate the Administrations ongoing support for patients with mental illness and substance use disorders.

We urge CMS to adopt the following recommendations:

- **Increase the proposed market basket update to account for the discrepancy in payment relative to inflation.**
- **Eliminate the long-standing Conditions of Participation (COP) required by CMS for an organization to bill Medicare and Medicaid.**

- **Develop a modified per diem rate based on actual audited costs by type of facility and geography with compensation for complexity, severity, and additional tests/treatment clinically indicated to achieve a realistic operating margin of at least 10%.**
- **Rebase the payment system to allow the marginal value of approximate equivalence to a market basket of all medical-surgical services over 3-5 years.**
- **Assess the current methodology to ensure it captures all current costs accurately, including costs for staffing, capital expenses, pharmaceuticals, and additional costs attributed to new and emerging evidence-based interventions.**
- **Reclassify Delirium (F05) as a major complication or comorbidity (MCC) in the DRG classification system, just as Metabolic encephalopathy (G93.41) is currently classified.**
- **Delay implementation and mandatory reporting of the three measures related to social drivers of health until the measure concepts can be fully tested and validated within the IPF setting.**
- **Remove the Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS-5) measure from the IPFQR program as it is no longer supported by current guidance.**

Proposed Payment Policies

Market Basket Update

APA supports CMS' proposal to rebase and revise the market basket using the most recent data available. It has been widely reported that facilities are facing significant workforce shortages across the full spectrum of clinical care. As a result, costs associated with salaries, benefits and contract labor have increased, much more so than on medical-surgical units. This is further compounded by the well-documented workforce shortage. In many instances, hospital beds go unused despite increasing demand, due to the lack of sufficient staffing. The ongoing focus by CMS on addressing ligature-risks in the facility setting has further compromised the viability of psychiatric units. According to a 2019 report from the National Association for Behavioral Healthcare the average cost at that time to address ligature-risk was approximately $15,600 per psychiatric bed;[1] costs that would not have been fully captured in the 2016 data. Since the 2019 report, facilities have faced a substantial increase in staffing and capital costs, including those associated with ligature-risk related citations and rising costs of materials during and following the public health emergency. One member reported that the budget to refurbish a child unit skyrocketed from $900,000 in 2018 to $2.8 million in 2023. It is imperative that payments keep pace with the cost to provide care.

While capturing current costs has the potential to increase reimbursement for this important site of service, market basket updates overall have failed to keep pace with inflation and do little to resolve the perpetual underfunding of this site of care. Reimbursement for inpatient psychiatric units typically covers only half of the total costs of care. As a result, we have seen a well-documented decline in the number of acute psychiatric inpatient beds over the past decade delaying access to care for patients, including

[1] NABH Report on "The High Cost of Compliance: Assessing the Regulatory Burden on Inpatient Psychiatric Facilities", May 2023. DOI: https://www.nabh.org/the-high-cost-of-compliance/

Medicare beneficiaries.[2] If reimbursement rates for psychiatric hospitalizations do not cover the cost to deliver care, this treatment option may cease to be available. **We urge CMS to increase the proposed market basket update to account for the discrepancy in payment relative to inflation.** Specifically, we recommend:

- Reducing regulatory burden that drives up costs without commensurate benefit: Eliminate 42 CFR part 482 Subpart E COPs (e.g., Subpart E, 482.60; 482.61 (medical record requirements: treatment plans); 482.62 (staff requirements)). Despite repeated calls from the field to remove the Conditions of Participation, CMS has failed to take action. **APA urges CMS to eliminate the long-standing Conditions of Participation (COP) required by CMS for an organization to bill Medicare and Medicaid.** The COPs include substantial administrative burdens that are no longer relevant, are not required of any other discipline, and incur unnecessary costs. In 2019 the estimated nationwide cost of compliance was $622 million dollars annually.[3]
- **Developing a modified per diem rate based on actual audited costs by type of facility and geography with compensation for complexity, severity, and additional tests/treatment clinically indicated to achieve a realistic operating margin of at least 10%.**
- **Rebasing the payment system to allow the marginal value of approximate equivalence to a market basket of all medical-surgical services over 3-5 years.** This would require rebasing procedural margins for inpatient and outpatient care at the hospital level.
- **Assess the methodology to ensure it captures the current costs accurately.** The well-documented staffing/personnel shortages have led to an increase in costs to recruit and retain qualified personnel. The increases in cost are even more significant for facilities providing care for patients with mental health and substance use disorders due to the ongoing workforce shortage. Does the current methodology related to staffing costs focus enough on psychiatry-only costs or does it include medical-surgical staff costs which would dilute the increase in staffing costs for psychiatric care? Does the existing methodology include a mechanism to capture costs of new (and emerging) evidence-based psychiatric medications (i.e., injectables, ketamine) and interventions (i.e., TMS) that incur additional costs including costs for new technology? For instance, is the cost of long acting injectables, one of the most effective treatments for patients with schizophrenia, captured in the cost calculation?[4] When the IPF PPS methodology was first introduced it included a separate payment adjustment for electro-convulsive therapy (ECT), in recognition of the additional costs associated with this procedure. There are new and emerging evidence-based interventions that, like ECT, require additional resources, yet it appears there is no mechanism within the current IPF methodology to capture these costs. The Inpatient Prospective Payment System (IPPS) uses the New Technology Add-on Payment (NTAP) to capture these costs. We urge CMS to implement a similar mechanism to capture these costs within the IPF payment system to ensure that these evidence-based treatments are available to Medicare beneficiaries. **All costs associated with providing evidence-based care should be accounted for in the calculation of payment rates.**

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[2] APA Report on "The Psychiatric Bed Crisis in the US: Understanding the Problem and Moving Toward Solutions", May 2023. https://www.psychiatry.org/psychiatrists/research/psychiatric-bed-crisis-report

[3] NABH Report on "The High Cost of Compliance: Assessing the Regulatory Burden on Inpatient Psychiatric Facilities", May 2023. DOI: https://www.nabh.org/the-high-cost-of-compliance/

[4] Correll CU, Citrome L, Haddad PM, Lauriello J, Olfson M, Calloway SM, Kane JM. The Use of Long-Acting Injectable Antipsychotics in Schizophrenia: Evaluating the Evidence. J Clin Psychiatry. 2016;77(suppl 3):1-24. doi: 10.4088/JCP.15032su1. PMID: 27732772.

Proposed Updates to the IPF PPS Patient-Level Adjustment Factors

DRG Classification System/Complications

APA urges CMS to recognize that "Delirium due to a known physiological condition (F05)" describes CMS set of symptoms that are equivalent to those described by "Metabolic encephalopathy (G93.41)," requiring additional resources during inpatient stays. We request CMS reclassify Delirium (F05) as a major complication or comorbidity (MCC) in the DRG classification system, just as Metabolic encephalopathy (G93.41) is currently classified. Delirium and encephalopathy are often used interchangeably and refer to a shared set of acute neurocognitive conditions and require additional resources to treat. They both describe core symptoms of impairment of level of consciousness and cognitive change caused by a medical condition or substance. However, unlike encephalopathy, delirium has well-validated diagnostic criteria that have allowed for the characterization of its complexity and numerous adverse outcomes, which are severe. Indeed, the robust literature detailing the impact of delirium on patient and caregiver distress, care complexity and costs, readmissions, rates of functional decline, institutionalization, cognitive decline, subsequent dementia diagnosis, and mortality simply has no parallel in the encephalopathy literature.

Delirium is linked to increased mortality across multiple patient populations. In the critically ill patient, delirium is associated with more medical complications, longer duration of mechanical ventilation, higher rates of discharge to skilled nursing facilities, longer lengths of stay in ICU and hospital, and increased costs of care when compared to critically ill patients who were not delirious.[5,6,7] Patients who develop delirium in the ICU have a two-to-four-times increased risk of death when compared to a matched patient population who do not develop delirium.[8] Patients who experience delirium on a general medicine unit have one-and-a-half times the increased risk for death in the year following hospitalization.[9] Delirious patients in the emergency department have an approximately 70% increased risk of death during the first six months following the visit.[10]

An increase in mortality is not the only adverse outcome suffered by patients experiencing delirium. Delirium has been associated with an impairment in physical function for 30 days or more after

[5] Zhang Z, Pan L, Ni H. Impact of delirium on clinical outcome in critically ill patients: a meta-analysis. Gen Hosp Psychiatry. 2013;35(2):105-11.

[6] Dziegielewski C, Skead C, Canturk T, Webber C, Fernando SM, Thompson LH, Foster M, Ristovic V, Lawlor PG, Chaudhuri D, Dave C, Herritt B, Bush SH, Kanji S, Tanuseputro P, Thavorn K, Rosenberg E, Kyeremanteng K. Delirium and Associated Length of Stay and Costs in Critically Ill Patients. Crit Care Res Pract. 2021 Apr 24;2021:6612187. doi: 10.1155/2021/6612187. PMID: 33981458; PMCID: PMC8088381.

[7] Kinchin I, Mitchell E, Agar M, Trépel D. The economic cost of delirium: A systematic review and quality assessment. Alzheimers Dement. 2021 Jun;17(6):1026-1041. doi: 10.1002/alz.12262. Epub 2021 Jan 21. PMID: 33480183.

[8] Ely EW, Shintani A, Truman B, et al. Delirium as a predictor of mortality in mechanically ventilated patients in the intensive care unit. JAMA. 2004;291:1753–1762.

[9] Leslie DL, Zhang Y, Holford TR, et al. Premature death associated with delirium at 1-year follow-up. Arch Intern Med. 2005;165:1657–1662.

[10] Han JH, Shintani A, Eden S, et al. Delirium in the emergency department: an independent predictor of death within 6 months. Ann Emerg Med. 2010;56:244–252.

discharge.[11,12] Delirium has also been linked to new cognitive impairment in previously healthy individuals a year after their ICU admission and the occurrence of delirium (Pandharipande PP, et al. 2013).[13] In patients with prior cognitive impairment, such as Alzheimer's disease, the pre-existing dementia is worsened by an episode of delirium.[14]

Proposed Addition of Quality Measures in IPFQR

APA applauds CMS's commitment to addressing health equity in its quality and measurement programs. Identifying health disparities and addressing gaps in care are vitally important goals, and we support efforts to find the most useful and appropriate methods for collecting data on disparities and social determinants of health. **We urge CMS to prioritize measures with identified disparities in treatment or outcomes; this will allow CMS to bring attention to inequities in these areas and incentivize institutions to improve.**

CMS has proposed three health equity measures:

- *Facility Health Equity and Social Drivers of Health Measures*
- *Screening for Social Drivers of Health Measure, and*
- *Screen Positive Rate for Social Drivers of Health Measure*

APA is concerned that **none of these measures have been fully tested or validated specifically for the IPF setting.** Testing is critical to understanding if the proposed measure leads to improved patient outcomes; if the level of resources available or the patient population within the IPF impacts performance; and the feasibility of implanting the measure in this setting. In addition, there is variability among IPFs and between IPFs and acute care facilities in terms of the number of resources available to both implement the measure and begin to positively address the identified social drivers. **APA urges CMS to delay implementation and mandatory reporting until the measure concepts can be fully tested within the IPF setting.**

Facility Health Equity and Social Drivers of Health Measures

APA supports previous comments made by the American Hospital Association requesting that CMS modify the scoring to award one point for each individual attestation rather than an all or nothing approach to the scoring. This increases transparency and makes the measure more meaningful.

Screening for Social Drivers of Health Measure

While APA agrees that screening is important, a measure reflecting the frequency of the screening itself provides no information as to whether patients' needs were addressed, disparities eliminated or information as to whether patient outcomes improved. Operationalizing this screening and connecting patients to community resources is a tremendous task requiring resources and technological capabilities

[11] Rudolph JL, Inouye SK, Jones RN, et al. Delirium: an independent predictor of functional decline after cardiac surgery. J Am Geriatr Soc. 2010;58:643–649.

[12] Oldenbeuving, AW, PL de Kort, BP Jansen, et al. Delirium in the acute phase after stroke: incidence, risk factors, and outcome. Neurology. 2011;76:993–999.

[13] Pandharipande PP, Girard TD, Jackson JC, et al. Long-term cognitive impairment after critical illness. N Engl J Med. 2013;369(14):1306-1316.

[14] Fong TG, Jones RN, Shi P, et al. Delirium accelerates cognitive decline in Alzheimer disease. Neurology. 2009;72(18):1570-1575.

IPFs lack, especially in rural and underserved areas. Finally, this measure allows for flexibility in the selection of the screening tool, and while that affords facilities the opportunity to select tools that best suit their environment, it risks the ability to compile and compare data in a meaningful way.

Screen Positive Rate for Social Drivers of Health Measure
In its current form, a facility's performance on the measure will likely be dependent on characteristics of the patient population being treated in ways that do not necessarily relate to the quality of their care.

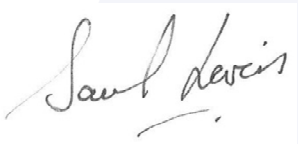
Proposed Removal Quality Measures in IPFQR

Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS-5)

APA supports the removal of the measure and agrees with CMS that it no longer is supported by current guidance.

Thank you for your review and consideration of these comments. If you have questions or want to discuss these comments in more detail, please contact Becky Yowell (byowell@psych.org) Director, Reimbursement Policy and Quality.

Sincerely,



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