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SUBMITTED VIA: www.regulations.gov

Ms. Seema Verma
Administrator, Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

26 June 2018

Re: CMS-1690-P: Proposed Rule: Medicare Program; FY 2019 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2018 (FY 2019); RIN 0938-AT23

Dear Ms. Verma:

As an association representing behavioral healthcare provider organizations and professionals, the National Association for Behavioral Healthcare (NABH) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) "Medicare Program; FY 2019 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates For Fiscal Year Beginning October 1, 2018" (CMS–1690–P) published in the *Federal Register* on May 8, 2018.

Founded in 1933, NABH represents and advocates for behavioral health provider systems that are committed to delivering responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Our members are behavioral health provider organizations that own or manage more than 1000 specialty psychiatric hospitals, general hospital psychiatric and addiction treatment units and behavioral health divisions, residential treatment facilities, youth services organizations, and extensive outpatient networks. These providers deliver all levels of care, including partial hospitalization services, outpatient services, residential treatment, and inpatient care.

For years, NABH has worked with CMS, accrediting agencies, consumers, and other stakeholders to develop and support using inpatient psychiatric performance measures. Our association was one of the original organizations that spent more than 10 years developing the Hospital Based Inpatient Psychiatric Services (HBIPS) measures that were among the Inpatient Psychiatric Facilities Quality Reporting (IPFQR) program's first performance measures.

Although the IPFQR measure set has been used for several years, CMS has not evaluated if it has met its objectives. Our industry is concerned that the complex data collection and reporting requirements have not improved patient care or outcomes. Furthermore, the amount of resources required to collect, and report information outweighs the data's value and purpose.

The proposed rule includes important changes intended to recalibrate the program, and the rule represents one of the agency's most progressive efforts in this area since the Inpatient Psychiatric Facilities Prospective Payment System was established.

The NABH Quality Committee has identified a set of principles that are consistent with the CMS' goals. We believe that all performance measurement and outcomes data-collection efforts must:

1. Improve the effectiveness and efficiency of patient care;

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2. Focus on indicators that provide the most useful clinical and operational data possible;

3. Focus on indicators that are reasonable for organizations to collect and later act on;

4. Provide a balance between the level of intensity to collect data and the value and purpose of that data.

5. Offer potential to be used for measurably improving healthcare processes, outcomes, efficiency, and patient experiences.

We base our comments below on these criteria.

Regulatory and Reporting Burden

Forty-four is a very conservative estimate of the number of data points that the IPFQR program measure sets requires to be documented, abstracted, and reported for each patient. This estimate does not include the number of data points required for demographic data, diagnosis codes (which could number as many as 25 elements per patient), and procedure codes. Most of the data are extracted manually and must be reported manually (see section *Request for Information on Interoperability and Electronic Healthcare Information* for more information). The numerator for each of the transition measures (NQF 647 and 648) contains 11 discrete items. If any of the combined 22 items is not reported, then the measure set is considered incomplete, which jeopardizes an organization's reimbursement.

Several different denominators are used throughout the measure set and require different samples. Examples of these include: the denominator for the TOB-1 (proposed for removed under the rule) measure reflects the number of hospitalized patients 18 years of age or older, yet the denominator for TOB-2 and TOB-3 (proposed for removal under the rule) reflects the number of hospitalized patients aged 18 and older who are identified as current tobacco users; the SUB measures require similar distinctions between patients who screen positive for an alcohol or drug use disorder. Some measures include patients under 18, while others exclude them. The influenza immunization measure includes inpatients aged 6 months and older who have been discharged from October-March each year. The screening for metabolic disorders measure includes patients on certain medications. Building each of the sample denominators and applying the appropriate numerators is a very labor-intensive effort.

The psychiatric care industry is currently facing a workforce shortage. Consequently, organizations are carefully evaluating how their professionals spend their time. We have heard consistently that providers feel the IPFQR dataset drains staff time from clinical care without a concomitant benefit. Providers spend an incessant amount of time asking patients questions (many of which could be asked in an outpatient setting) and documenting their answers when they could be spending that time caring for their patients.

Our members are equally concerned about the burden the measures impose on patients. Our members care for patients who have acute psychiatric illnesses and need to be stabilized in a crisis. Lengths of stay are very short. Demands on patients must be prioritized. Their needs for safety and support are paramount, and their ability to give and receive information is usually challenged. Given the complexities and the complication with this measure set, we applaud CMS for focusing on removing burdens and allowing providers to focus on what is most important: improving care for patient with serious mental illness.

Proposed New Removal Factor 8: Costs Outweigh Benefit of Measure

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The measure removal and retention factors established in the FY 2018 rule provide a solid foundation and the addition of factor 8 would enhance that set significantly. As outlined above, the resources needed to adhere to the IPFQR come at a great cost while our members are not seeing the intended benefit of improved inpatient psychiatric treatment. Therefore, we strongly urge CMS to adopt factor 8 in the final rule.

If CMS includes this factor, we suggest the agency develop a more precise definition of "cost." NABH members quantify costs of a measure in many ways, and it would be helpful if CMS elaborated on how it will define cost in the IPFQR context.

We suggest factor 8 be specific and should prioritize removing measures and burdens that do not drive improvements to the quality of psychiatric care. For example, if a measure has high cost and a low connection to psychiatric care, it should be removed in favor of a measure that has high cost and high impact on psychiatric care. In this example, the cost of both measures is high—but the benefits in the latter measure is greater. Additionally, CMS should account for the combined costs of measures in this factor. It's important to remember that facilities are responsible for the entire data set. So, while an individual requirement may not appear burdensome, it is critical to think of that piece as part of a greater whole—which can become burdensome very quickly.

We look forward to working with CMS and providing additional technical assistance on how to define and measure cost to help determine if it has a place in the IPFQR program.

Proposed Measures for Removal Due to Cost (Factor 8)

Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431)

NABH members understand influenza vaccinations are important for both patients and staff. An influenza vaccine should not, however, be a priority measurement area for the IPFQR program. This measure poses a significant burden, and we think it should be removed from the set.

The administrative burdens of using the National Healthcare Safety Network (NHSN) for reporting the measure are is cumbersome for inpatient psychiatric facilities (IPF) because IPFS only use NHSN to report a single measure. Whereas, other acute care hospitals use NHSN to report multiple measures. The NHSN requires that participants complete the five-step NHSN system user authentication annually; re-consent electronically; keep the contact information up-to-date; ensure they have an active administrator account; keep Secure Access Management Service credentials active by logging in approximately every 2 months; and create a monthly reporting plan.

There is no empirical evidence that shows either a direct or indirect relationship between this measure and quality behavioral healthcare in an IPF setting. In this way, the measure does not add value to the set because it directs attention away from measures that are specific to behavioral health. We recommend that CMS remove this measure in the final rule.

Alcohol Use Screening (NQF #1661)

NABH supports CMS' decision to remove this measure from the IPFQR measure set. We recognize it is important to screen for alcohol use and we acknowledge that many of the patients our members treat misuse alcohol and other substances.

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It's important to note, however, that patients in IPFs are screened routinely for all substance abuse issues, and, this measure arbitrarily separates alcohol use from other substances. Our members perform in-depth assessments of patients' alcohol and substance abuse history and current use and those patients are treated appropriately, so there is no need for a screening question about alcohol only.

This measure and all the SUB measures included in the set were developed for broad population screening and do not adequately produce the kind of alcohol and substance use data that are required to treatment persons with serious mental illnesses.

The National Quality Forum (NQF) Measures Application Partnership (MAP) recommends deleting both the SUB measures from the IPFQR set. In its recommendations (Maximizing the Value of Measurement: MAP 2017 Guidance, Final Report March 15, 2017), the NQF noted the "importance of addressing both substance abuse and tobacco cessation but recommended that CMS prioritize measures that will better address the quality of mental health care." We think the final rule should delete this measure, which is better suited for a general population, rather than a psychiatric population.

Assessment of Patient Experience of Care

We support the proposed rule's recommendation to remove this measure because it is an attestation measure, not a quality-of-care measure. As an attestation measure, it should not be part of a requirement that is publicly reported and affects payment. Through discussions with our member organizations, we understand IPFs are widely using some type of patient experience measure. Some are using highly structured evaluations (i.e., with help from groups such as Press Ganey). Others have adopted a variety of existing tools or developed their own tools to meet the needs of their patient populations. We support removing this measure in the final rule.

Use of an Electronic Health Record (EHR)

NABH agrees with CMS that this measure should be removed from the IPFQR set. While the industry is making progress to adopt EHR technology in IPF facilities, there is not sufficient l evidence to conclude that using currently available EHR technology platforms results in better care.

In addition, the lack of interoperability and communication among behavioral health and physical health EHR products has slowed progress in this area (see section titled *Request for Information on Interoperability and Electronic Healthcare Information* for more information). Privacy laws and regulations that limit sharing psychiatric and substance use patients' personal health information make it difficult to design effective EHRs. Based on these limitations, we believe publicly reporting EHR adoption in behavioral healthcare at this time does not provide meaningful and useful information for consumers and others. Therefore, we think the final rule should remove this measure.

Tobacco Use Treatment Provided or Offered at Discharge (TOB-3 and TOB-3a, NQF #1656)

NABH supports the proposed rule's recommendation to eliminate the Tobacco Use Treatment Provided or Offered at Discharge (TOB-3 and TOB-3a, NQF #1656) measure. We acknowledge that tobacco use is a significant public health issue and patients with mental illness make up a great number of the tobacco use population. However, the TOB measures were developed for population screening, and they have not been tested systematically in inpatient psychiatric settings. These are population measures intended for patients in general acute care hospitals. We do not think the

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measures are actionable in ways that lead to better psychiatric care in an IPF. Furthermore, the TOB measures do not provide information that distinguishes quality psychiatric care from other care and should not be required for public reporting and payment. We lack data on the best strategies to help acutely ill psychiatric patients address their smoking behaviors.

Behavioral healthcare treatment providers routinely screen for tobacco use when they evaluate patients as part of substance use screening, and patients generally live tobacco-free during their hospitalization due to regulatory requirements. Hospitalization presents an important opportunity to assess and address tobacco use treatment needs on an individualized basis as part of an overall substance use treatment plan. Working with patients to develop the tools to manage their various addictions is a critical, individualized, and routine part of care. But we believe requiring detailed, chart-abstracted data collection on all patients is not an effective way to assess the quality of IPFs. Therefore, we support removing this measure from the final rule.

Additional note: Some of our NABH members have expressed concern that removing this measure could result in an added burden in another area. As CMS states in the rule, "…we believe the benefit of keeping the Tobacco Use Treatment Provided or Offered at Discharge (TOB-3 and TOB-3a, NQF #1656) measure in the IPFQR Program has now become limited because the same measure data is captured in the data elements required by the Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (NQF #0647) measure." CMS should not seek to expand the requirements of the Transition Record measure to compensate for the removal of TOB-3 and TOB3a because, as CMS noted in the proposed rule, the existing Transition Record measure is sufficient to gather the necessary information from IPFs.

Proposed Measures for Removal Due to Topping-Out (Factor 1)

Proposed Removal: Tobacco Use Screening (TOB-1, NQF #1651) Measure

We agree with CMS' analysis of the TOB-1 measure being topped out and its decision to remove it from the IPFQR measure set.

We are aware of the high levels of comorbid tobacco use among patients in inpatient facilities. Our field takes this seriously and has created individualized approaches to helping patients who use nicotine. We know that some percentage of patients are ready to quit at the time of inpatient treatment (patients generally live tobacco-free during their hospitalization due to regulatory requirements). However, we continue to look for substantive data to support the usefulness of the interventions required of the Tobacco Use Treatment (TOB) measures for all patients who are seriously psychiatrically impaired during a brief, stabilizing hospitalization. We are required to use very limited resources in ways that are not demonstrated to be effective. There is significant burden to both patients and staff in applying these measures and recording and retrieving data. We question whether this information distinguishes high and low performers among providers of psychiatric inpatient services or that the information is helpful in informing the public about the quality of the psychiatric care. We support removing the measure in the final rule.

Hours of Physical Restraint Use (HBIPS-2, NQF #0640) and Seclusion Use (HBIPS-3, NQF #0641)

NABH appreciates CMS' detailed analysis in its recommendation to remove both the Hours of Physical Restraint Use and Seclusion Use Measures from the IPFQR set. That said, we do not think these measures should be removed.

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When used properly, restraint and seclusion can be a safe and effective way to reduce injury. These emergency measures aim to: 1) protect patients in danger of harming themselves or others, and 2) enable patients to continue treatment successfully. Treatment settings that serve individuals with severe mental illnesses and substance abuse problems who are at times dangerous to themselves or others must develop and follow strategies and policies that determine why, when, and how to use these measures. Also, if used improperly, these measures could potentially cause injury or lead to abuse. The challenge is to find a balance that ensures patient safety and maintains patient dignity.

Providers nationwide have been working on strategies that minimize restraint and seclusion, and ensure that when these techniques are used, they are used safely. In addition, improved clinical options—such as medications and de-escalation techniques—have lessened the need for restraint and seclusion.

We agree with CMS' data and analysis on this issue; however, we don't think these measures should be removed from the set. These two measures are intended to ensure that restraint and seclusion are used appropriately, as infrequently as possible, and only when less restrictive methods are considered and found not feasible. These measures help IPFs focus on quality patient care and can provide early warnings of systemwide problems that need attention. Furthermore, discussions of restraint and seclusion can lead to discussions about other systemwide issues, which can ultimately lead result in better care.

These measures remain important and functional quality measures for IPFs. Therefore, we suggest CMS analyze subpopulations by stratifying the data collected to examine if certain subpopulations receive higher rates of seclusion and restraint. Two straightforward stratifications are age and gender. NABH and our members welcome the opportunity to work with CMS to examine these two measures in new ways.

Additional Measure to be Considered for Removal or Modification

Transition Record with Specified Elements Received by Discharged Patients

NABH strongly supports effective transitions from one treatment setting to another to ensure continuity of care. A key component of this transition is communicating relevant information clearly. The American Medical Association-convened Physician Consortium for Performance Improvement (PCPI) developed the "Transition Record with Specified Elements Received by Discharged Patients" (NQF 647) measure to use with a broad range of patients, with a focus on patients cared for in medical settings (as noted in language such as major procedures, surrogate decision making, studies pending at discharge). The measures contain specific elements that, at a minimum, need to be included in a transition record that a patient receives at the time of discharge. The hospitals in the IPFQR program are required to submit data on all age groups of patients. Although the measures note they were developed for all ages, references and supporting statistics are weighted toward the adult population.

NABH maintains that measure 647 was not designed for — nor does it meet the specialty-focused needs of — the psychiatric patients addressed under the IPFQR program. It creates a duplicative burden for providers because comprehensive information at the point of discharge because the Medicare Condition of Participation (CoP) already requires this information. Under a CoP in the Medicare program, hospitals are required to provide patients with detailed discharge information as part of their comprehensive discharge planning process. CMS has provided recent and extensive guidance through its Interpretive Guidelines for 42 CFR 482.43, Discharge Planning (that applies to all facilities that bill under IPF PPS). The CoP requires that written discharge instructions (in non-technical language) be developed for, discussed with, and given to patients. Elements to be included in the discharge summary include: a list of medications, evidence of patient (and when appropriate, family) education, referrals for follow-up care, and notices of

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necessary medical information to providers to whom the patient was referred before the first post-discharge appointment (or within seven days of discharge, whichever comes first). The CoP also requires hospitals to have a process in place to track readmissions and also evaluate whether the readmissions were potentially due to problems in discharge planning or the implementation of discharge plans. See:

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-32.pdf.

CMS surveys the CoP routinely if the hospital is not accredited. In addition, The Joint Commission (TJC) also performs this process. If a facility fails to meet the requirements, then CMS cites it for non-compliance under the Medicare program and the facility risks losing Medicare reimbursement. CMS publicly reports the survey results, which consumers can use to make decisions about their healthcare providers. Requiring a quality measure that is well-addressed in (and, in certain aspects, misaligned with) the CoPs is burdensome and duplicative and is not consistent with the IPFQR program's goals. We think the CoP for discharge planning meets the goal of "promoting appropriate care coordination by specifying that patients discharged from an inpatient facility receive relevant and meaningful transition information."

We recommend CMS reevaluate this measure, and NABH staff and our members welcome the opportunity to assist CMS in this process.

Timely Transmission of Transition Record

While NABH strongly supports effective care transitions in providing high-quality behavioral healthcare, we have concerns about the Timely Transmission of Transition Record.

The behavioral health field identified the critical importance of communication between the hospital and next level of care several years ago. The field (including public and private psychiatric hospitals and units in general hospitals) worked hard to identify the essential elements required in that communication and the relevant timeframe to share it. We worked together to specify, test, re-evaluate, and imbed the measures (HBIPS-6 and HBIPS-7) into relevant accreditation activities.

The measure has a prescribed list of elements, and several of the elements (reason for hospitalization, diagnosis, medication list, and plan for follow-up care) overlap with those in the HBIPS list. Most other elements in the measure have very little relevance to psychiatric patients (e.g., major procedures, studies pending at discharge, medical advance directive).

We recommend CMS review evaluate this measure. NABH and our members would welcome the opportunity to assist CMS in this process.

Future on Measure on Depression Screening

Process measure that measures the number of facilities that administer a standardized assessment instrument & Outcome measure related to treatment and management of depression

CMS notes in the proposed rule that "to ensure that facilities are consistently using a standardized assessment instrument, we believe that it may be necessary to first adopt a process measure that assesses facility administration of a standardized depression assessment, such as the PHQ-9, at both admission and discharge for adult inpatient

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admissions, thereby, encouraging facilities that do not currently consistently use such an instrument to use one." NABH has strong concerns about this approach for a number of reasons.

The Patient Health Questionnaire (PHQ) was developed in 1999 as a self-report version of the Primary Care Evaluation of Mental Disorders (PRIME-MD), which was designed to diagnose several mental disorders that are commonly seen in primary care. It has proven to be an effective, reliable and valid screening tool for primary care. However, it has not been examined for its effectiveness in IPFs. There are several factors related to or unique to IPFs that give members of NABH pause about using PHQ-9.

The length of stay for patients in psychiatric hospitals can very short, and the average length of stay according to NABH data are getting short overtime. Given the limited amount of time patients maybe in an IPF there may not be measurable reductions in PHQ-9 scores. Furthermore, times of transition can be very stressful for patients and measuring PHQ-9 upon discharge might artificially inflate their scores.

Patients admitted to an IPF might be unable to complete the PHQ-9 at admission. A considerable number of patients admitted to IPFs are sent to this level of care because they are violent or are an imminent danger to themselves or others. This makes certain tasks, such as the PHQ-9 at admission, an extremely difficult task.

Also, many IPFs use assessment instruments and measures already. Different facilities use different measures based on what works best for them. In general, providers care less about which screening and tracking model is used as long as they find a tool that works well for them.

NABH suggests CMS start with a question to facilities about what tools they are using and how they are using those tools. Then from that information develop a menu of options from which IPFs can select. It will be very burdensome to get all IPF to use the same tool. Therefore, CMS' goal should be to ensure that IPFs are using a tool and it has been tested.

Any other possible new measures or new measure topics

Responding to the proposed rule's request to include topics for future consideration, we suggest CMS develop a safety planning measure for patients who have suicidal ideation. A very high percentage of patients are admitted to psychiatric hospitals because they cannot keep themselves safe in the community or in other settings. Reasons for hospitalization can include suicidal ideation and/or impulsive self-destructive actions. Suicidal ideas and behaviors are significant clinical issues that require clinical interventions.

Suicide is a national public health crisis. Research shows that the first two weeks after hospitalization are a high-risk period for patients who have suicidal ideation. A critical process of care is assisting patients manage current and future suicidal ideation. A measure could be developed to look at how hospitals help patients develop a plan for dealing with suicidal ideation—both during hospitalization and after discharge. There is a significant body of literature that could guide this development. This type of measure could also address family and caregiver engagement, which is an area CMS has identified as an area not currently sufficiently covered by IPFQR program measures. Safety planning is a good proxy for patient-centered involvement and could be linked to discharge planning and readiness. We would prioritize this as an area for measure development.

Accounting for Social Risk Factors in the IPFQR Program

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We agree with CMS t that "social risk factors such as income, education, race and ethnicity, employment, disability, community resources, and social support …play a major role in health." We acknowledge the important work being done at the national level to identify potential methods for measuring and accounting for social risk factors, including stratified public reporting. We know NQF requires developers to consider social risk factors in their data analysis. Although we are not prepared to comment on specific risk factors at this time, we are committed to partnering with CMS in this area as the science evolves. We know our members' patients face many challenges related to social risk factors, and we want to account for these risk factors through public data reporting.

Drugs and Laboratory Costs

The proposed rule states that in recent years "over 20 percent of IPF stays reported no ancillary costs, such as laboratory and drug costs, in their cost reports, or laboratory or drug charges on their claims." CMS raises concerns about this trend, because "we [CMS] pay only the IPF for services furnished to a Medicare beneficiary who is an inpatient of that IPF (except for certain professional services), and payments are considered to be payments in full for all inpatient hospital services provided directly or under arrangement (see 42 CFR 412.404(d)), as specified in 42 CFR 409.10." The preamble goes on to note that CMS may share its findings with the CMS Office of the Center for Program Integrity and CMS Office of Financial Management for further investigation. This discussion echoes concerns that CMS raised in 2015 concerning IPFs' failure to report ancillary costs, such as laboratory and drug costs, in cost reports or charges on claims. That section preamble goes on to state "Until further analysis is completed, we can only surmise that the stays did not require ancillaries and therefore, were not provided, or that the ancillary services were separately billed . . . [¶] Ancillary costs such as laboratory costs and drugs are already included in the Medicare IPF PPS per diem payment and should not be unbundled and billed separately to Medicare. We expect that the IPF would be recording the cost of all drugs provided to its Medicare patients on its Medicare cost reports and reporting charges for those drugs on its Medicare claims."

As a general matter, IPFs are aware that the IPF PPS payment is "payment in full for all inpatient hospital services" and covers ancillary costs. CMS's assumption that any costs that are not reflected in a cost report are likely billed separately is incorrect. Some of our members do not bill separately for ancillary costs, including laboratory or drug costs. Because these costs often represent a relatively low portion of our member hospitals' costs, they typically do not make a separate charge for ancillary services. The costs associated with ancillary services are typically reported in the Routine cost center in the Medicare cost report. CMS has long understood that a Medicare provider need not report the cost of ancillary services separately where those costs are insignificant, as reflected in the following discussion of all-inclusive rates in the Provider Reimbursement Manual: "Certain ancillary services may not be considered sufficiently significant to justify a separate calculation of costs for Medicare and non-Medicare patients." Provider Reimbursement Manual - I, § 2208.1A. In the case of laboratory and drug costs, such costs on average represent approximately 1% and 4% respectively, of the costs of IPF services. Thus, they are not considered sufficiently significant to justify a separate calculation of costs in our view.

Updates to Wage Index for FY 2019

CMS uses a wage index to adjust the labor-related portions of IPF payments under the IPF PPS. The proposed rule provides the following context for the source of its wage data for IPF hospitals: "Since the inception of the IPF PPS, we have used the pre-floor, pre-reclassified acute care hospital wage index in developing a wage index to be applied to IPFs, because there is not an IPF specific wage index available. 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." 83 F.R. 21104, 21110. This observation is true, our members experience demonstrates that IPFs do compete directly with acute care hospitals for talent.

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However, as the proposed rule acknowledges, "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 taking into account geographic reclassifications, floors, and other adjustments made to the wage index under the IPPS." 83 F.R. at 21110. 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," so named by the Affordable Care Act provision that established a floor on the area wage indexes in particularly rural states. 42 US.C. 1395ww(d)(3)(E). Under that provision, states with a high share of low population-density counties have a "floor" on their area wage index of 1.00. Furthermore, in accordance section 10324(a) of the Affordable Care Act, the frontier State adjustment is not subject to budget neutrality. Because CMS does not take this floor into account 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 a frontier state 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. To address this inequity, we urge CMS not to disregard the frontier state "floor" when it applies the acute care hospital wage index to IPFs including the non-application of budget neutrality which is consistent with the IPPS payment methodology.

The Secretary has broad authority to implement a prospective payment system for IPFs. Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, P.L. 106–113, Sec. 124 (1999). 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," 42 C.F.R. § 412.424(d)(1), 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," 42 C.F.R. § 412.428(c) (emphasis added). The regulatory guidance of using an appropriate wage index based on the best available hospital wage index and information is fulfilled with the use of the frontier state wage index floor of 1.0 to adjust IPF payments in a frontier state.

Request for Information on Interoperability and Electronic Healthcare Information

In February 2009, President Obama signed the *American Recovery and Reinvestment Act*, which included about $20 billion in health information technology (HIT) funding. As part of this legislation, hospitals received incentive payments to encourage adopting EHRs. This bill specifically excluded psychiatric hospitals even though psychiatric hospitals have the same needs as other hospitals for federal support to help implement health HIT and EHRs. In addition, psychiatric hospitals have substantially fewer beds (a psychiatric hospital on average has about 90 beds) than a typical general hospital, and they also have less revenue, making it even more difficult to fully fund IT development.

The ultimate goal of widespread adoption of health information technology — to save American lives through improved coordination of care —is particularly relevant to persons with mental and addictive disorders. Individuals with serious mental illnesses die, on average, 25 years sooner than other Americans due to a high incidence of untreated co-occurring chronic medical conditions in this patient population that include cancer, hypertension, diabetes, asthma, heart disease, and cardio-pulmonary conditions.

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HIT is the essential cornerstone of efforts to address this public health issue. But due to a lack of HIT incentives for behavioral health providers, there has been little or no incentive for EHR vendors to develop behavioral health specific platforms. Consequently, this has led to the lack of EHR adoption among behavioral health providers.

Given the existing status of EHR in behavioral health, this passage from the proposed rule is incredibly concerning to our members: "In light of the widespread adoption of EHRs along with the increasing availability of health information exchange infrastructure predominantly among hospitals, we are interested in hearing from stakeholders on how we could use the CMS health and safety standards that are required for providers and suppliers participating in the Medicare and Medicaid programs (that is, the Conditions of Participation (CoPs), Conditions for Coverage (CfCs), and Requirements for Participation (RfPs) for Long-Term Care Facilities to further advance electronic exchange of information that supports safe, effective transitions of care between hospitals and community providers. Specifically, CMS might consider revisions to the current CMS CoPs for hospitals such as: Requiring that hospitals transferring medically necessary information to another facility upon a patient transfer or discharge do so electronically; requiring that hospitals electronically send required discharge information to a community provider via electronic means if possible and if a community provider can be identified; and requiring that hospitals make certain information available to patients or a specified third-party application (for example, required discharge instructions) via electronic means if requested."

EHRs are not widely adopted in IPFs. If CMS requires hospitals transferring medically necessary information to another facility during a patient transfer or discharge to do so electronically, then IPFs would be unable to participate because most do not contain patient information electronically. Therefore, it would be damaging to the behavioral health community if CMS decided to use the CoPs to implement changes that require EHRs.

If CMS is committed to removing fundamental barriers to interoperability and health information exchange, it should extend health information technology incentives to behavioral health providers. There is bipartisan, bicameral legislation from Sens. Rob Portman (R-Ohio) and Sheldon Whitehouse (D-R.I.) and Reps. Lynn Jenkins (R-Kansas) and Doris Matsui (D-Calif.) that would authorize a behavioral health IT demonstration program at CMS. While we applaud their efforts, we understand legislation is not necessary to do this. CMS' Innovation Center could devise a program similar to the one outlined in the legislation that would extend EHR incentives to psychiatric hospitals, community mental health centers, accredited residential or outpatient mental health treatment facilities, clinical psychologists, and clinical social workers. Each of these groups was left out of the HITECH Act.

We look forward to continuing our work with you to help identify other opportunities for CMS to maintain flexibility and efficiency in the Medicare program through regulatory, sub-regulatory, policy, practice, and procedural changes.

If you have questions, please contact me directly at 202-393-6700, ext. 100, or contact NABH Director of Policy and Regulatory Affairs Scott Dziengelski at 202-393-6700, ext. 115.

Thank you for the opportunity to provide our suggestions and concerns.

Sincerely,

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