National Association for Behavioral Healthcare

Access. Care. Recovery.

5 June 2023

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

Submitted Electronically

Dear Administrator Brooks LaSure:

The National Association for Behavioral Healthcare (NABH) appreciates the opportunity to comment on the FY 2024 inpatient psychiatric facility prospective payment system (IPF PPS) proposed rule. NABH members provide the full continuum of behavioral healthcare services, including treating 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.

While NABH supports many elements of the proposed rule, our comments also address foundational concerns including the inadequate proposed update, structural limitations that prevent the IPF field from engaging in some of the rule's proposals, as well as concerns related to some of the proposed IPF quality reporting program (QRP) expansion items.

Proposed FY 2024 Payment Update Does Not Reflect Actual Cost Pressures

The proposed net payment increase of 1.9 percentage point, relative to FY 2023 payment levels, is woefully inadequate and does not reflect recent and current cost pressures that IPFs face. We appreciate that CMS' own revised cost estimates for the FY 2022 market basket, discussed below, reflect these recent and ongoing IPF cost pressures. Simply put, the currently proposed net update is unsustainable.

NABH supports two policy steps to achieve a more sustainable FY 2024 update:

- We urge CMS to use its authority to make a retrospective forecast error adjustment to account for the too-low market basket update in FY 2022, which was caused by the agency's underestimation of costs; and
- We support CMS' alternative outlier threshold update methodology, which would raise the net payment update for FY 2024.

Collectively, these two steps would increase the FY 2024 net market basket update to greater than 5.6 percentage points, relative to FY 2023 payments.

Retrospective Adjustment to Account for the FY 2022 Market Basket Forecast Error: The proposed rule itself recognizes the major gap between the FY 2022 market basket update finalized in rulemaking (2.7%) versus the actual market basket update for FY 2022 (5.3%).

Given the magnitude of these errors and the ongoing cost pressures on the behavioral healthcare delivery system, we cannot overlook the resulting underpayment. In fact, based on CMS' rationale for the FY 2022 forecast error of 2.6 percentage points – under accounting for record high inflation and significant increases in the costs of labor, drugs, and equipment – as well as the underestimated market basket in FY 2021 (by 0.7 percentage point) and 2023 (by 0.5 percentage point), we harbor doubts about the accuracy of this rule's estimated FY 2024 market basket. We are especially concerned for the almost 70% of IPFs that operate with a negative margin under this payment system, as the Medicare Payment Advisory Commission (MedPAC) reported for 2021. **With these material concerns in mind, we urge CMS to use its special exceptions and adjustments authority to offset the FY 2022 error and resulting IPF underpayment with a corresponding increase to the FY 2024 payment update.** In addition, we ask CMS in the final rule to discuss the impact of its FY 2022 under payment on access to care, especially for otherwise IPF-eligible patients in behavioral health shortage areas.

Use Alternative Outlier Loss Threshold Calculation Methodology**:** In addition to this retrospective adjustment, NABH supports further increasing the FY 2024 net payment update by using the alternative outlier calculation method put forward by CMS in the rule. Specifically, the rule describes an alternative that calculates the FY 2024 outlier loss threshold after removing those IPFs with extremely high or low costs per day (3+ standard deviations from the mean). Using this narrower set of more homogeneous IPFs yields an outlier threshold of $30,000 (a 22% increase relative to FY 2023). NABH supports this alternative over the traditional calculation, which would yield a FY 2024 outlier threshold of $34,750 (a 41% increase) and serve as another source of operational volatility.

On policy and access grounds, implementing the lower threshold aligns with the IPF PPS outlier concern that MedPAC raised last year: "…a threshold that is too high might risk underpaying some high-cost patients who fall under the threshold."[1] In this letter, MedPAC also asked CMS to consider the specific types of relatively high-cost patients who could face access limitations because their case would become ineligible with a too-high threshold, which decreases the IPF cases that quality for an outlier payment.

Modern Information Technology Infrastructure Needed

Given current health information technology (HIT) limitations across the behavioral healthcare sector, many IPFs lack the capacity for interoperable exchange of patient health information. This limitation affects 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 IPFs have HIT systems that comply with current HHS standards for data exchange and other functional specifications, this is not true for many IPFs. Most IPFs are able to bill payers electronically, and some have a form of electronic prescription management; however, most

[1] May 2022 MedPAC letter to CMS on the FY 2023 IPF PPS proposed rule. https://www.medpac.gov/wp-content/uploads/2022/05/05272022_FY2023_IPF_PPS_MedPAC_COMMENT_v2_SEC.pdf

lack the ability to send or receive interoperable data. Rather, the majority of IPFs still rely on outdated communication methods including faxes, emails, and phone calls.

Proposed IPF Market Basket Rebasing and Revising

Considering recent erroneous market basket estimates, NABH supports the rule's proposed rebasing and revising of the IPF-specific market basket, which seeks to align Medicare payments more closely under this payment system with the actual cost of providing care. The proposed rebasing process of the FY 2024 market basket would replace the currently used 2016 data with 2021 data, including Medicare cost reports for both freestanding and hospital-based IPFs, to better account for current IPF costs. Regarding revising the relative weights of the seven major cost categories of the IPF market basket for FY 2024, consistent with feedback from our members, the agency's calculations demonstrate increases in workforce cost pressures for contract labor (115% increase) and office-based contract labor (74% increase), and the largest decrease for pharmaceuticals (23% decrease).

Wage Index

To mitigate year-to-year volatility, in last year's rulemaking CMS finalized a permanent cap of 5% on reductions to the wage index for any reason – a change NABH supports. **For FY 2024 and beyond, NABH urges CMS to adopt the 5-percent cap in a non-budget neutral manner.** Further, because actual wage index values that Medicare Administrative Contractors apply to IPFs subject to the cap continue to differ significantly from published values, we encourage CMS to modify the wage index tables in the final rule to include the actual value for those providers subject to the cap.

In addition, we highlight our concern related to basing any IPF's wage index value on wage data from a general acute-care hospital that has closed. In this scenario, because the wage-index values for area IPFs are based on the concurrent pre-floor, pre-reclassified inpatient PPS hospital wage index, the data from the closed hospital have a higher likelihood of being unreliable and may result in related IPFs receiving an inappropriately deflated wage index value. In particular, in a core-based statistical area (CBSA) where the *only* inpatient PPS hospital has closed, applying its wage levels to IPFs in the area raises concerns, as the wage levels reported prior to the closure may reflect anomalous wage-setting practices affected by concurrent instability and staff-hiring stressors, including downsizing and/or key departures prior to closure. Such aberrant wage index data should not be allowed to skew the wage-index update of affected IPFs in the CBSA. **Rather, to mitigate wage index inaccuracies for IPFs in this relatively rare circumstance, we call on CMS to use existing authority to utilize the pre-floor, pre-reclassified wage index for the nearest CBSA with an *active* inpatient PPS hospital.**

Additional Flexibility for Opening IPF Units

NABH supports CMS' proposal to ease the certification of new IPF units. Specifically, we support allowing host hospitals to open a new unit at any time during the cost reporting period,

with 30-day advance notice. We agree that this change would help offset the shortage of mental health services.

Proposed Changes to IPF QRP

As noted above, while we support the overriding goals driving CMS' proposed improvements to the IPF QRP, we have foundational concerns regarding the ability of our members to fully comply with this section of the proposed rule.

Outdated IT Infrastructure: First, as discussed, the proposed QRP changes overlook the uneven HIT capacity found across IPFs. **Considering those IPFs with HIT systems that fall below current CMS standards, we urge CMS to pause and consider whether elements of its QRP expansion actually can be implemented by the field as a whole.** In particular, the agency should evaluate the relative burden and, in some cases, insurmountable barriers that under-resourced IPFs would face when attempting to implement the proposed expansions.

Proposed QRP Expansion Overlooks IPF Patient Characteristics. In addition, most of the proposed new measures have not been tested in an IPF setting and appear to overlook key considerations involved with treating the IPF patient mix. A material portion of IPF patients face intensive and urgent needs, including the risk of harm to self or others, substance-use complexities, homelessness, and/or low income status. **We ask CMS to account for such patients in its measure design and testing processes, as some cases likely would prevent an IPF's full compliance with the IPF QRP, as the measures are currently designed.**

Proposed equity-focused measures**:** The rule proposes a new measure requiring each IPF to attest to its own equity-related competencies related to these domains:

- Equity as a strategic priority,
- Data collection,
- Data analysis,
- Quality improvement, and
- Leadership engagement.

In addition, CMS is proposing a measure to capture the rate of screened IPF patients with one or more of these social drivers of health (SDOH);

- Food insecurity,
- Housing instability,
- Transportation needs,
- Utility difficulties, and
- Interpersonal safety.

While we support the objective of using these measures to advance equity and inclusion across IPFs, we ask the agency to first test them with volunteering IPFs to identify

modifications needed to align with the unique characteristics of the IPF patient population. To add to the discussion above about unique clinical attributes of the IPF patient mix, we provide the additional example of patients facing suicidal ideation or other immediate safety threats, for whom IPFs would be unable to assess issues such as utility difficulties and transportation needs, and the other SDOH.

Also, given the persistent, elevated demand for behavioral healthcare services, the commonly urgent needs of our patients and smaller average bed size, IPFs generally have less bandwidth available for data collection relative to general acute-care hospitals. Finally, because general acute-care hospitals are currently implementing this measure, CMS and IPFs should pause to first benefit from studying implementation in that setting to identify improvements applicable to future use within the IPF QRP.

In addition, we caution against over-interpreting the results of the proposed equity measure on frequency of screenings, as screening frequency on its own does not address whether any of a patient's social drivers actually have been addressed or the impact on health that is attributable to a particular social driver or set of social drivers.

Proposed patient experience of care survey. CMS is proposing that IPFs implement the PIX survey, which includes 23 items across the following four domains, during the final 24 hours of an admission. IPF performance would be reported online as five separate rates: one for each of these four domains plus one overall rate. The survey is distributed to patients, on paper or on a tablet computer, by administrative staff at a time beginning 24 hours prior to planned discharge.

1. Relationship with treatment team,
2. Nursing presence,
3. Treatment effectiveness, and
4. Healing environment.

Because the agency acknowledges that the field already uses different survey instruments, we propose a transition period with voluntary reporting beginning in CY 2026, mandatory reporting in CY 2027, and payment impact starting in FY 2028.

Prior to implementing a mandatory survey with payment ramifications, our members ask CMS to extend the voluntary stage of survey implementation. During this time, NABH members request the opportunity to engage with CMS to discuss the survey-implementation experience of volunteering IPFs with respect to their less-stable patient population, along with prior continuous quality improvement recommendations received along with patient satisfaction results that current survey tools generate. Such exchange would also provide an opportunity to discuss how to address the overall IPF field's structural IT limitations that could prevent electronic execution of a new survey, and other proposed QRP additions by some providers.

With regard to survey design, we appreciate that the PIX survey specifically was developed for IPFs; however, because it was tested only with Yale, we encourage testing with a wider array of IPFs to ensure its ability to collect valid and reliable data across a broader cross-section of

the field, as well as comparing inter-rater reliability levels across the full spectrum of IPF settings and relative to data validity levels achieved in the inpatient PPS setting. We also ask for more details and the related policy rationale in the final rule about how and by whom (CMS or an external party) survey data will be aggregated.

We also note that for IPFs with paper-based systems, substantial additional staff resources would be needed for sharing data with CMS, including to query, process, analyze, aggregate, and manually enter the additional data on the CMS portal, increasing staff workload.

Regarding timing, while we support prompt forward movement toward full implementation, and note that Congress has mandated a future quality measure of patients' perspective on care by 2031, we encourage CMS to invest the time needed during survey development to ensure the tool's accuracy and reliability over the longer term.

Proposed data validation pilot project: The goal of ensuring the accuracy of IPF patient-level clinical data is worthwhile, and the timing and protocols for such an endeavor are critical. **Because the IPF field is currently in its first year of submitting patient-level quality data, it is premature to add a data validation element to the IPF QRP.** Rather, we ask CMS to postpone any such pilot until core elements of the QRP can be implemented and stabilized fully. As it stands, FY 2024 will be the first year that IPF pay-for-reporting will be effective. Adding a pilot with payment ramifications in FY 2025, as proposed, would introduce a complex element to the IPF payment system, especially given prior difficulties by CMS and CMS-contractor auditors with inadequate clinical background in the relevant clinical discipline. Further, the design of such a pilot would warrant a higher level of detail than provided in this rule, with the opportunity for public comment by stakeholders. We also note that Congress has mandated developing an IPF-standardized patient assessment instrument by 2028, which may be a more efficient and timely way to advance the same goals sought by this proposed pilot project. **We ask CMS to consider the level of data accuracy, including data validity, significance and comparability, that could be achieved without a standardized patient assessment tool.**

Proposed update to COVID-19 Vaccination Measure for Healthcare Personnel (HCP): We support CMS' efforts to update this COVID-19 measure to align with evolving standards that the Centers for Disease Control and Prevention (CDC) and the U.S. Food and Drug Administration (FDA) have set. **That said, because the parameters for this particular vaccination measure are still in process with the CDC and FDA, we ask CMS to collect data on a voluntary basis until final standards are set.**

Request for Information on All-inclusive Reporting of IPF Charges

In response to a congressional directive, CMS seeks feedback related to IPF reporting of charges for ancillary services, such as laboratory and drug ancillaries. This request for information pertains to those IPFs that have chosen the option the agency allows to submit claims without specific details on ancillary services received by the patient – commonly referred to as all-inclusive reporting. CMS will use such feedback as it considers whether to continue allowing the all-inclusive reporting option in the future.

NABH analysis of all-inclusive reporting IPFs found a mix of characteristics, including variation in the presence of SUD services, outlier payment levels, rates of disabled Medicare beneficiaries, readmissions rates, and other metrics. **Given this lack of homogeneity in the all-inclusive category, we ask CMS to recognize that an IPF's status as an all-inclusive reporter is not an appropriate metric on which to base assumptions about an IPF's operations and/or patient care.** As such, the all-inclusive claims that CMS allows cannot be conflated with under-delivery of clinical services.

We emphasize that the scope and quality of care provided to each IPF patient are determined by the treating physician's and the hospital or unit's clinical team and care protocols, not an organization's billing practices. In addition, individualized patient plans of care are documented in the medical chart, which are subject to review by CMS and its contract auditors. Further, the quality of such care is assessed by currently available quality metrics, which are being augmented this year through the implementation of new patient-level quality measures. NABH fully encourages **the ongoing strengthening of the IPF quality reporting program, which we see as an appropriate mechanism for assessing quality of care, rather than making assumptions based on unrelated billing practices.** Also, given its allowed status, no payment penalty should be applied for all-inclusive claims because of lacking ancillary charges data, including claims with minor technical errors that are fixable.

For all-inclusive reporting IPFs, the clear objective in selecting this option is to reduce administrative burden. Streamlining administrative functions and cost is a prominent goal across the entire healthcare delivery system as well as for payers. It is especially acute for providers who lack the efficiencies gained through modern HIT, which unfortunately applies to many providers in the IPF field. **Given the reduced HIT capacity across the field, which affects this and many other initiatives that CMS has proposed, we ask the agency to factor into its ongoing policy development specific steps to increase access and affordability of modern HIT tools and systems by IPFs, including policy adaptations in the meantime to account for this impactful limitation.** We are encouraged that a recent discussion with CMS executives indicated a sensitivity to this issue, including recognition that landmark legislation – the *HITECH Act of 2009* – excluded HIT funding for IPFs, which has resulted in the major gap between the HIT capacity of IPFs and funded provider groups, including general acute-care hospitals and physicians.

When evaluating any adaptations to the all-inclusive reporting policy, we urge CMS to consider the full scope of impact. First, changing this policy would require affected IPFs to modify internal billing systems, including interfacing internal clinical ancillary data (where physicians' patient orders originate) with the charge description master so that ancillary charges could be generated on the claim. In addition, such a change would affect IPF billing systems and contracts beyond those used for Medicare fee-for-service (FFS). Currently, contracts and billing protocols with Medicare Advantage (MA) plans and most commercial payers also allow all-inclusive billing and payment arrangements to reduce their administrative costs. **If the IPF PPS all-inclusive reporting option is removed, we anticipate that other payers also would terminate this billing option, which would reduce efficiency and generate both short-term**

costs to retool contracts with payers as well as material initial and on-going to modify billing systems.

Request for Information Regarding Z-Codes and SDOH

NABH understands CMS' goal of exploring the use of "Z-codes" to collect additional information on the distinct clinical needs of each patient, specifically their possible use for collecting data on patients' unique levels of SDOH. However, today the codes are rarely used for Medicare FFS beneficiaries (1.6% of all beneficiaries), so they do not yet seem positioned to meaningfully contribute to this worthwhile goal. For those providers using Z-codes, we note variation in how these codes are allowed across states, which also limits their use in national policymaking. Further, the lack of clarity on the types of personnel that can document SDOH, as well as unclear coding and related protocols, also warrant a pause for now. **Looking forward, we encourage CMS to partner with IPFs prior to formally proposing the use of Z-codes for IPF patients to ensure that any future implementation is effective and captures patients' clinical status in an accurate manner.**

Modernizing IPF Conditions of Participation

It is time to modernize the Medicare conditions of participation including "B-tag" requirements – a detailed set of standards related to IPF patient evaluations, medical records, and staffing. These highly proscriptive and, in part, outdated guidelines are often the basis for citations for noncompliance with documentation requirements. In particular, we urge CMS to update the use of existing B-tags and related interpretive guidance and surveyor training materials to allow greater flexibility to IPF clinicians, including allowing operating at the top of their licenses and certifications. **As such, NABH again calls upon CMS to convene policymakers and stakeholders to partner on modernizing the IPF CoPs, including eliminating outdated items.**

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