American Hospital Association™
Advancing Health in America

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May 28, 2024

The Honorable Chiquita Brooks-La Sure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1806-P
P.O. Box 8010
Baltimore, MD 21244-8010

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners and, especially, the 106 psychiatric hospitals and 846 hospitals with dedicated behavioral health beds, and our clinician partners — more than 270,000 affiliated physicians, two million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) inpatient psychiatric facility (IPF) prospective payment system (PPS) proposed rule for fiscal year (FY) 2025.

While we are grateful for the chance to provide feedback on the revisions to the IPF PPS as well as the development of an IPF patient assessment instrument (PAI), we urge CMS to proceed on the latter with more caution and less haste. We believe that the agency can both meet its statutory responsibilities and take its time to ensure high-quality and accurate results. In addition, we are concerned that CMS' proposed market basket update is inadequate to ensure continued support of the vital services IPFs provide to their communities. Finally, we do not support the measure proposed for adoption in the IPF quality reporting (IPFQR) program.

PROPOSED IPF PAYMENT UPDATES

CMS proposes to increase payments to IPFs by a net 2.6%, or $70 million, in FY 2025 compared to FY 2024. This payment update includes a 3.1% market basket update minus a 0.4 percentage point productivity cut as required by the Affordable Care Act and a cut of 0.1 percentage point to keep outlier payments at 2%.

Market Basket Update. CMS' proposed market basket update is woefully inadequate in the face of the enormous cost pressures faced by IPFs, which include inflationary pressures as well as longstanding underpayments by public payers. For example, in its June 2023 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) determined that Medicare has failed to cover the cost of caring for patients in hospital-based and freestanding nonprofit IPFs since at least calendar year (CY) 2016.[1] Notably, aggregate Medicare margins across all IPFs were *negative* 9.4% in CY 2021 and an astounding *negative* 28.3% for hospital-based nonprofit IPFs that same year. These data demonstrate the critical financial pressures faced by IPFs, largely related to skyrocketing labor, supply and inflationary costs faced by facilities since then. Indeed, by virtue of the directive to revise the IPF PPS payment methodology to better capture costs faced by these facilities, MedPAC and Congress themselves have also acknowledged that Medicare's current payment system for IPFs is inadequate.

Further, IPFs and all hospitals have seen a dramatic increase in their costs over the last four years. The inflation seen by these facilities, particularly those who care for complexly ill patients like those served by IPFs, has created novel challenges such as employee and labor costs. For example, a recent report from the AHA finds that hospital employee compensation has grown by 45% since 2014.[2] This contrasts with total inflation, which only grew by 28.7% in that time. Labor-related inflation has been driven in large part by a severe workforce shortage, which the Department of Health and Human Services (HHS) says will persist well into the future.[3] Indeed, McKinsey finds that resignations per month among health care workers grew 50% from 2020 through 2023.[4] Because of this, hospitals are turning to pricey contract labor to sustain operations. Indeed, contract labor costs increased by 258% from 2019 through 2023.[5] These increased costs are felt acutely by IPFs as they struggle to maintain highly skilled staff in the form of psychiatrists, psychiatric mental health nurses, mental health technicians, clinical social workers, psychologists and therapists.

Drug and supply costs have also pressured hospital operations due to disruptions in the supply chain and other factors. In fact, HHS found that prices for nearly 2,000 drugs increased an average of 15.2% from 2017 through 2023, notably faster than the rate of general inflation.[6] Further, the American Society of Health System Pharmacists has

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[1] MedPAC, Congressional Request: Behavioral Health Services in the Medicare Program (June 2023). https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch6_MedPAC_Report_To_Congress_SEC.pdf

[2] https://www.aha.org/system/files/media/file/2024/05/Americas-Hospitals-and-Health-Systems-Continue-to-Face-Escalating-Operational-Costs-and-Economic-Pressures.pdf

[3] ASPE Office of Health Policy, *Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce*, HP-2022-13 at 1 (May 3, 2022).

[4] McKinsey & Company. (Sept. 2023). How Health Systems and Educators Can Work to Close the Talent Gap. https://www.mckinsey.com/industries/healthcare/our-insights/how-health-systems-and-educators-can-work-to-close-the-talent-gap

[5] Syntellis and AHA, *Hospital Vitals: Financial and Operational Trends.* (Last visited May 8, 2023), https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf.

[6] ASPE. (Oct. 2023). Changes in the List Prices of Prescription Drugs, 2017-2023. https://aspe.hhs.gov/reports/changes-list-prices-prescription-drugs

found that numerous drug shortages are having a critically negative impact on hospital operations.[7]

Administrative costs have also risen sharply for IPFs in recent years due to burdensome and unnecessary Medicare Advantage (MA) and commercial insurer practices. For example, a study by the U.S. Government Accountability Office found that prior authorization by commercial payers is less likely to be granted for mental health hospital stays compared with medical and surgical hospital stays, and these payers often deny payment for further coverage of inpatient treatment even if a physician determines that additional treatment is needed.[8] Supporting this, McKinsey estimated that hospitals spent $10 billion annually dealing with insurer prior authorizations, and a 2023 study by Premier found that hospitals are spending just under $20 billion annually appealing denials.[9] Despite recent efforts by CMS, IPFs report there has not been any relief from these practices in 2024, and hospitals and systems will need to continue to devote considerable resources toward them for the foreseeable future.

These escalating costs for essential clinicians, personnel, drugs, supplies and other items have put a strain on the entire health care continuum. In all, Kaufman Hall found that overall expenses have risen 18% for hospitals compared to 2021.[10] This is felt keenly by IPFs, who care for high-acuity patients with unique care needs. **For these reasons, we urge CMS to provide a more robust payment update for FY 2025 and in the future until a more accurate PPS methodology can be adopted.**

All-inclusive Cost Reporting. CMS clarifies in this proposed rule that hospitals can only use an all-inclusive rate or no charge structure if they have never had a charge structure in place. The agency states that only government- and tribally-owned facilities meet this criterion, and thus it states that only these facilities will be permitted to file all-inclusive cost reports beginning Oct. 1, 2024. **While we understand and agree with CMS' clarification of this issue, we request that they provide facilities with more time to come into compliance.**

Specifically, IPFs have not been filing all-inclusive cost reports to circumvent appropriate reporting of ancillary charges. Indeed, as demonstrated by L&M Policy Research's report for MedPAC based on interviews with IPFs, facilities track ancillary

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[7] https://news.ashp.org/-/media/assets/drug-shortages/docs/ASHP-2023-Drug-Shortages-Survey-Report.pdf
[8] DHHS GAO. (2022). Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts. https://www.gao.gov/assets/gao-22-104597.pdf
[9] McKinsey & Company. (2021). Administrative Simplification: How to Save a Quarter-Trillion Dollars in US Healthcare. https://www.mckinsey.com/~/media/mckinsey/industries/healthcare%20systems%20and%20services/our%20insights/administrative%20simplification%20how%20to%20save%20a%20quarter%20trillion%20dollars%20in%20us%20healthcare/administrative-simplification-how-to-save-a-quarter-trillion-dollars-in-us-healthcare.pdf
[10] https://www.kaufmanhall.com/sites/default/files/2024-05/KH-NHFR_2024-04.pdf

services internally; however, reporting these services is time-consuming.[11] Further, because IPFs are paid based on per-diem contract arrangements regardless of the scope or intensity of the ancillary services provided, the reporting of the services does not appear to have a direct influence on payment. We agree with CMS that IPF payments need to better represent costs incurred, and that reporting ancillary costs is one step in capturing this information. However, we suggest CMS be lenient with facilities as they transition from what they believed was a proper option for cost reporting.

IPFQR PROPOSALS

Adoption of the All-Cause Risk-Standardized Emergency Department (ED) Visit Following IPF Discharge Measure. CMS proposes to adopt this measure that assesses the number of ED visits and observation stays for any reason within 30 days of IPF discharge beginning with the CY 2025 performance period (which informs FY 2027 payments). **The AHA does not support the adoption of this measure for the IPFQR.**

The AHA understands the concept behind the measure in that the post-discharge period for IPF patients is particularly vulnerable, and that providers have the responsibility to thoughtfully prepare patients for discharge. However, the measure is so broadly defined that it is hard to determine how it would be used to improve inpatient psychiatric care. Indeed, the evidence provided in this measure's specifications does not make a connection between specific evidence-based interventions and measure outcomes.

Even with risk standardization, counting ED visits for any cause — related to their psychiatric hospitalization or not — assigns responsibility to the discharging IPF for incidents the facility could not possibly predict or prevent. In other CMS quality reporting programs (such as those for inpatient rehabilitation facilities, skilled nursing facilities, long-term care facilities and home health agencies), CMS has shifted to using measures of potentially preventable readmissions; additional CMS programs, like those for Outpatient and Ambulatory Surgery Center services, use measures that assess hospitalizations or ED visits in specific contexts such as chemotherapy, particular surgery types or colonoscopy. It is unclear why CMS believes IPFs have a wider range of accountability for return ED visits than do other types of facilities.

Further, this measure failed endorsement by a Consensus-based Entity (CBE) because it was evaluated to have low scientific acceptability. According to the measure's background documentation, facilities included in the measure's testing found the measure difficult to understand and not useful for decision-making. We understand that CMS is not required to only use measures endorsed by a CBE in its programs, but

[11] Interviews with Inpatient Psychiatric Facilities, a Report by L&M Policy Research for the Medicare Payment Advisory Commission (March 2023). https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Interviews_with_IPFs_MedPAC_CONTRACTOR_SEC.pdf

when the measure demonstrates both statistical and conceptual weaknesses as this measure does, CMS should find it unworthy for its programs.

Finally, the AHA again — as we did in our comments on the FY 2024 IPF PPS proposed rule — expresses our continuing disappointment with the lack of proposed new measures for the IPFQR that are specifically designed and tested to measure the provision of inpatient psychiatric care. The IPFQR currently has three other measures that assess post-discharge outcomes: Follow-up after Psychiatric Hospitalization; Medication Continuation Following Inpatient Psychiatric Discharge; and 30-Day All Cause Unplanned Readmission Following Psychiatric Hospitalization. Not only would the proposed all-cause ED visits measure likely overlap these measures, but it also would perpetuate the focus of IPF quality on what happens outside the IPF rather than on the care provided or safety of patients while in the facility.

Quarterly Reporting of Patient-level Data. CMS proposes to require IPFs to submit patient-level data to inform IPFQR measures on a quarterly basis beginning with data collected during the first quarter of 2025, rather than annually as has been required since 2023. The agency reasons that its systems may be unable to handle the volume of data when submitted in a single period, and that more frequent reporting will allow CMS to better analyze measure trends over time. We believe this quadrupling of effort would be a disruption for IPFs without much benefit. CMS reasons that it requires quarterly reporting of chart-abstracted data for certain measures in the Inpatient Quality Reporting System, but IPF discharges are just about 3% the volume of short-stay general acute care hospital discharges; the comparatively lower volumes in IPFs mean that shifts in trends would be difficult to detect in such small intervals, and CMS does not propose to update publicly reported quality measure data more frequently as a result of this proposed update. **For these reasons, we urge CMS to continue with annual reporting to glean insights regarding IPF data reporting on more than just one year of experience and delay quarterly reporting beyond 2025.**

REQUESTS FOR INFORMATION

Revisions to Facility-level Adjustment Factors. The Consolidated Appropriations Act (CAA) of 2023 requires CMS to implement revisions to the IPF PPS payment methodology beginning in FY 2025. In this proposed rule, CMS seeks feedback on whether it would be appropriate to consider proposing revisions to facility-level adjustments in the future based on the results of their recent analysis. Specifically, CMS requests input on adjustments for rural location, teaching status, and an indicator of low-income patient mix called the Medicare Safety Net Index (MSNI).

The AHA discourages CMS from using the MSNI as a facility-level adjustment. MedPAC developed the MSNI as an alternative way to distribute disproportionate share hospital and uncompensated care payments due to what it determined to be inefficiencies with these current adjustments. The index is a composite adjustment comprised partially of a facility's Medicare dependency ratio — the percentage of IPF stays covered by Medicare as opposed to other payers. Thus, it would put facilities that

serve large proportions of low-income patients who are not Medicare beneficiaries (such as the uninsured, older adults on Medicaid or commercial insurance, or children on Medicaid) at an inappropriate disadvantage. CMS' own analysis demonstrated that including MSNI in its regression would lead to a decrease in the adjustment for rural location and teaching status for IPFs, suggesting that the index is not consistent with other indicators of safety-net status. MedPAC did not develop the MSNI with the IPF PPS and specific patient/payer mix of IPFs in mind. The unique aspects of IPF payment — such as the Institutions for Mental Disease Exclusion and the 190-day lifetime limit under Medicare for inpatient psychiatric care coverage — might skew the application of the MSNI.

In addition, CMS does not issue impact files, which estimate payment impacts of various policy changes to the payment system, for IPFs. This makes it challenging at best to determine how the MSNI would affect their payments. Thus, for us to be able to fully and thoughtfully comment on the potential use of this adjustment, AHA requests that the agency provide detailed data for analysis.

IPF Patient Assessment Instrument (IPF-PAI). The CAA of 2023 requires IPFs participating in the IPFQR program to collect and submit certain patient assessment data using a standardized PAI beginning with admissions and discharges in FY 2028. In its request for information on the development of this tool, CMS draws upon the experience from the development of standardized patient assessment data elements (SPADEs) for use across post-acute care settings as required by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014.

We urge CMS to avoid the approach the agency used to implement IMPACT Act requirements in developing the IPF-PAI. The overall process was rushed and has resulted in significant confusion and burden in the post-acute field, and a similar result for the IPF field would be a disservice to patients and providers. In attempting to meet the statutory requirements of the IMPACT Act, CMS first proposed 23 new SPADEs in the FY 2018 post-acute care prospective payment system proposed rules. Most of the elements were existing items used in other settings and proposed to be implemented without setting-specific revision or testing for validity and reliability. In response to concerns raised by stakeholders including the AHA, CMS did not finalize its proposals. Instead, the agency met its statutory duty by requiring post-acute care facilities to collect and submit patient assessment data on categories already required to be reported for the purposes of calculating existing quality measures. In the meantime, the agency conducted a national beta test of the SPADEs to further refine their proposals over the next two years. This disjointed rollout has introduced uncertainty and confusion to the post-acute care field around whether and how CMS might alter or expand its SPADE requirements.

In the case of the IPF-PAI, CMS notes that it anticipates convening a Technical Expert Panel (TEP) to provide input on data elements to include in the PAI and testing the elements for their ability to detect differences among patients and costs of treatment; however, the agency also states that it may not be possible to complete all testing

before launching the IPF-PAI in FY 2028. This extremely quick turnaround is concerning.

We believe that CMS can meet its statutory duty to implement a PAI by FY 2028 as it did for the IMPACT Act by developing a tool limited in scope and then expand upon this tool after further data elements have been appropriately tested for validity and reliability. **In other words, the AHA recommends that CMS use feedback from this RFI as well as TEPs and stakeholder input to build or build upon an existing tool that uses few and simple elements to meet the statutorily required domains.** Then, the agency can develop not only a comprehensive patient assessment tool over time but can also work with clinical oversight bodies to come up with guidance on how IPFs can use the IPF-PAI to replace other assessment processes to reduce burden and encourage consistency.

The CAA calls for IPFs to collect and submit standardized patient assessment data on the categories of functional status; cognitive function and mental status; special services, treatments, and interventions; medical conditions and comorbidities; and impairments. IPFs already collect and submit patient data relevant to at least some of these categories. For example, facilities are required to report whether a patient was provided with tobacco use treatment for the TOB-3 measure (Tobacco Use Treatment Provided or Offered at Discharge), which CMS could consider reporting of the special services, treatments and interventions domain. Similarly, for the Screening for Metabolic Disorders measure, facilities are required to report whether they measured a patient's blood glucose, blood pressure, body mass index, blood lipids and discharge disposition; CMS could consider reporting of this information to meet the medical conditions and comorbidities domain.

In summary, we urge CMS to work with stakeholders to determine a reasonable timeline for the development of the IPF-PAI even if it goes beyond the FY 2028 date prescribed by the CAA; if necessary, the agency can meet these requirements with data already collected by IPFs.

Again, we thank you for your consideration of our comments. Please contact me if you have questions, or feel free to have a member of your team contact Caitlin Gillooley, AHA's director of policy, at cgillooley@aha.org or (202) 626-2267.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President, Policy Analysis and Development