Federation of American Hospitals®

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President and CEO

June 5, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

RE: FY 2024 Inpatient Psychiatric Facilities Prospective Payment System—Rate Update (CMS–1783–P)

Dear Administrator Brooks-LaSure,

The Federation of American Hospitals ("FAH") is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding its proposed rule, Inpatient Psychiatric Facility (IPF) Prospective Payment System—Rate Update ("Proposed Rule") published in the Federal Register on April 10, 2023.

MARKET BASKET UPDATE

For FY 2024, CMS proposes to update the 2021-based IPF market basket to reflect projected price increases according to the IHS Global Inc.'s (IGI) 4th quarter 2022 forecast with historical data through the 3rd quarter of 2022. Using that forecast, the proposed IPF market basket for FY 2024 is 3.2 percent. Using data from the same period, CMS estimates an offset to the IPF market basket for total factor productivity (TFP) of 0.2 percentage points. Consequently, CMS proposes an IPF PPS update of 3.0 percent for FY 2024. For hospitals that do not

successfully submit quality data under the IPFQR program, the update is reduced by 2.0 percentage points to 1.0 percent. For the final rule, CMS will use later data on the market basket and TFP.

The FAH has serious concerns that the proposed market basket forecast is neither accurately nor adequately capturing the unique factors influencing the hospital and health care market today in general, and the market in which IPFs compete. The scope and scale of the COVID-19 pandemic is unprecedented in our times with the constant barrage of challenges and pressures that hospitals have and continue to face. Chronic, preexisting nurse and caregiver shortages have exploded during the pandemic fueled by increased demand and workforce burnout from, among other factors, quarantines, surges, and stress. Workforce shortages have been particularly challenging for psychiatric hospitals struggle to meet the growing pressures to address our national's mental and behavioral health needs.

In our public comments on the proposed FY 2023 IPF update, we expressed concern that inflationary cost pressures hospitals have been experiencing are not being captured in the IPF market basket. These concerns have been borne out by recent data released by the CMS' Office of the Actuary (OACT). The below table shows the market basket forecast used for the FY 2021 through FY 2023 IPF PPS update compared to the actual inflationary increase experienced by IPFs based on later data:

IPF Market Basket[1]	FY 2021	FY 2022	FY 2023
Forecast Used in the Update	2.2	2.7	4.1
Actual Based on Later Utilization	2.9	5.3	4.6
Difference	-0.7	-2.6	-0.5

As this table reflects, market basket updates to IPFs for FY 2021 through FY 2023 are understating the IPF base rate by a total of 3.8 percentage points for these years. The FAH urges CMS to consider an adjustment for forecast error to ensure that the FY 2024 rate increase is applied to a base rate that more accurately incorporates actual inflation in FY 2022 just as CMS is doing in two other contexts: the proposed FY 2024 skilled nursing facility (SNF) PPS update and the proposed FY 2024 capital IPPS update.

For the FY 2024 SNF update, CMS is proposing to increase the market basket update of 2.7 percent by 3.6 percentage points for forecast error in application of the FY 2022 update.[2] For the FY 2024 capital IPPS update, CMS is proposing a forecast error adjustment of 0.9 percentage points for an underestimate of FY 2022 capital inflation.[3] If CMS adopted the FAH's recommendation, it would be proposing an IPF update of 3.2 percent plus 2.6 percentage points for FY 2022 forecast error less 0.2 percentage points for TFP. The total update before incorporating later data for the final rule would be 5.6 percent.

[1] OACT, 4th quarter 2022 release of the market basket information with historical data through the 3rd quarter of 2022 (Market Basket Data | CMS) for the actual update based on later utilization.
[2] 88 Federal Register, 21321, April 10, 2023
[3] 88 Federal Register 27229, May 1, 2023.

The FAH is further concerned that the IPF update for FY 2024 includes a reduction for non-farm TFP of 0.2 percent. The COVID-19 pandemic has had unimaginable impact on US productivity and most estimates of labor productivity highlight uncharacteristic reductions. Even before the pandemic, OACT indicated that hospital productivity will be less than general economy wide productivity that is being used as an offset to the hospital market baskets.

In a memorandum dated June 2, 2022, OACT stated: "over the period 1990-2019, the average growth rate of hospital TFP using the two methodologies ranges from 0.2 percent to 0.5 percent, compared to the average growth of private nonfarm business TFP of 0.8 percent." The memorandum also indicates that an assumed future rate of hospital industry productivity growth of 0.4 percent per year remains reasonable compared to an assumed rate of productivity growth in the private nonfarm business sector of 1.0 percent.[4] While the annual TFP offset is based on a provision of the Affordable Care Act of 2010 and is required by law, FAH urges CMS to consider the appropriateness of this reduction when deciding whether to incorporate a forecast error adjustment to the FY 2024 IPF PPS update based on the understatement of the FY 2022 IPF PPS market basket.

In the FY 2023 IPF PPS final rule, CMS declined to provide an adjustment for forecast error indicating that "due to the uncertainty regarding future price trends, forecast errors can be both positive and negative."[5] However, for both the proposed SNF PPS update and the capital IPPS update, CMS provides for a forecast error adjustment when the difference between the update for a year and the actual level of the market basket based on later data differs by more than a threshold amount (0.25 percentage points for the capital IPPS and 0.5 percentage points for the SNF PPS).

The forecast error adjustment requested to the FY 2021 IPF PPS update was relatively small at 0.7 percentage points—although still above the 0.5 percentage point threshold for a forecast error adjustment for the SNF PPS. However, forecast error for the FY 2022 IPF PPS update is significantly larger at 2.6 percentage points; well in excess of the threshold for an adjustment under either the SNF PPS or the capital IPPS.

For both the SNF PPS and the capital IPPS, CMS is making the forecast error adjustments based on a threshold level of difference between the update and the market basket that was adopted through rulemaking in prior years. CMS may argue that it is not permitted by rulemaking procedures under section 1871 of the Act to adopt a forecast error adjustment for the FY 2024 IPF PPS update because such a policy was not proposed. However, the IPF market basket update for FY 2024 has been made subject to public comment in the FY 2024 IPF PPS proposed rule. The FAH's suggestion is a logical outgrowth of a policy adjustment that is subject to public comment consistent with section 1871(a)(4) of the Act.

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[4] Paul Spitalnic, Stephen Heffler, Bridget Dickensheets and Mollie Knight, "Hospital Multifactor Productivity: An Update Presentation of Two Methodologies Using Data through 2019." Hospital Multifactor Productivity: An Updated Presentation of Two Methodologies Using Data through 2019 (cms.gov).

[5] 87 FR 46850, July 29, 2022.

If CMS were to reject any comment that makes a suggestion to revise a market basket policy that was not explicitly proposed, there would be no point in making a public comment. CMS could reject any suggestion as being out-of-scope of the proposed rule as CMS did not make any explicit proposals to change its methodology for determining the market basket. As the FAH's comment is a logical outgrowth of a policy subject to public comment, CMS may certainly adopt our suggestion consistent with the rulemaking procedures in section 1871 of the Act.

For these reasons, the FAH requests CMS adopt a one-time forecast error adjustment to the FY 2024 IPF PPS update based on the 2.6 percentage point difference in the IPF PPS market basket in FY 2022 in light of the exceptional challenges related to the COVID-19 pandemic, workforce shortages and inflation. Adopting our suggestion would make the market basket equal to 3.2 percent plus 2.6 percentage points less 0.2 percentage points or 5.6 percent.

REBASING AND REVISING OF THE IPF PPS MARKET BASKET

Beginning with FY 2024, CMS is proposing to rebase and revise the 2016-based IPF market basket cost weights to a 2021 base year reflecting 2021 Medicare cost report data submitted by both freestanding IPFs and distinct part IPF units within hospitals. CMS believes that 2021 represents the most recent and complete set of Medicare cost report data available. The cost reports are for providers with cost reporting periods beginning on or after October 1, 2020 and before October 1, 2021.

The proposed rule details the methodology used to rebase the market basket, which is generally the same methodology CMS used in creating the current 2016-based IPF market basket. That involves using Medicare cost report data to calculate weights for seven cost categories: Wages and Salaries; Employee Benefits; Contract Labor; Pharmaceuticals; Professional Liability Insurance; Home Office Contract Labor; and Capital. A residual category captures all remaining costs.

As CMS does customarily when it rebases and revises the IPF market-basket, CMS also proposes to revise the labor-related share of the standard payment conversion factor for FY 2024. CMS proposes a total labor-related share of 78.5 percent for FY 2024 that is 1.1 percentage points higher than the FY 2023 labor share of 77.4 percent. The higher labor-related share is primarily due to the incorporation of the 2021 Medicare cost report data, which increased the compensation cost weight by approximately 0.8 percentage point compared to the 2016-based IPF market basket (0.7 percentage points for employee benefits and 0.1 percentage points for wages and salaries).

The increase in the labor-related share is a result that the FAH expected given our concerns about labor costs increasing at a higher rate than other hospital costs during the pandemic. It follows that the labor-related share of total IPF costs would increase as a result of labor shortages that have increased employed hospital clinical staff wages as well as forcing hospitals to rely on higher cost contract clinical staff.

In general, the FAH is supportive of CMS' proposal to both rebase and revise the IPF PPS market basket and revise the labor-related share of the standardized payment conversion factor. However, CMS' proposal to rebase and revise the labor-related moves the base year for the IPF market basket to 2021 which may not fully incorporate the structural cost changes that IPFs have experienced since the pandemic. The FAH urges CMS to consider a shorter period than 5 years for the next rebasing and revising of the IPF market basket and revision to the standard payment conversion factor labor share. **Our recommendation would be that CMS plan to rebase and revise the IPF market basket and labor-share in two years so that it is based on an FY 2023 year that more fully incorporates changed cost structures resulting from the pandemic as well as the dynamics of the evolving hospital workforce shortage.**

WAGE INDEX

For FY 2023 and future years, CMS finalized a permanent cap of 5 percent on reductions to the wage index for any reason. CMS believes providers generally experience fluctuations in the wage index annually of less than 5 percent. The FAH appreciates CMS' recognition of how disruptive volatile drops in the area wage index can create significant challenges for IPFs and the FAH strongly supports a 5 percent stop-loss to minimize annual reductions in the area wage index value and to help mitigate wide annual swings that are beyond a hospital's ability to control. **The FAH urges CMS to adopt the 5 percent stop-loss in a non-budget neutral manner.**

The wage index values of the existing hospitals subject to the cap will continue to differ significantly from the currently published tables. Existing providers must refer to the rate-setting file to verify their correct wage index values to ensure the MACs are updating the correct values in the system. **We encourage CMS to release wage index tables in the Final Rule that incorporate the cap on CBSA's that meet the 5 percent decrease criteria, in order to avoid errors in the payment rates established by the Medicare Administrative Contractors (MACs).**

Additionally, the FAH is concerned that the application of the concurrent pre-floor, pre-reclassified IPPS hospital wage index as the basis for the IPF wage index is inappropriate in circumstances where the pre-floor, pre-reclassified IPPS hospital wage index is based on data from a hospital that has subsequently closed. In these anomalous situations, the closed hospital data is more likely to be unreliable such that the application of the pre-floor, pre-reclassified IPPS hospital wage index would result in an inappropriately deflated wage index value. Moreover, the closure of the only IPPS hospital in the CBSA would suggest that the community is currently underserved, making it particularly appropriate to ensure that aberrant wage index data does not serve as an impediment to new IPF services in a community. **To address this situation, the FAH urges CMS to exercise its authority to remedy this data anomaly and appropriately refine the IPF PPS by applying the pre-floor, pre-reclassified IPPS hospital wage index for the CBSA in which the nearest IPPS hospital is located where the pre-floor, pre-classified IPPS hospital wage index for the CBSA in which the IPF is located only includes data from a closed IPPS hospital.**

HIGH-COST OUTLIERS

The outlier policy is an important component of the IPF PPS that helps ensure that payments for high cost patients more accurately reflect the more intensive level of services they receive, thereby supporting access to care. The Proposed 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). The FAH 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.

Implementing the lower threshold aligns with the IPF PPS outlier concern raised last year by the Medicare Payment Advisory Commission (MedPAC): "…a threshold that is too high might risk underpaying some high-cost patients who fall under the threshold." 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. **The FAH has similar concerns and we urge CMS to finalize the alternative option in setting the fixed outlier threshold for IPF PPS.**

REQUEST FOR INFORMATION ON ALL-INCLUSIVE REPORTING OF IPF CHARGES

The Consolidated Appropriations Act of 2023 (CAA) requires CMS to collect information related to IPF reporting of charges for ancillary services, such as laboratory services and drugs. This request for information pertains to those specific IPFs that have chosen the option allowed by the agency to submit claims without specific details on ancillary services received by the patient – commonly referred to as all-inclusive reporting. This data collection will be used by CMS as it considers whether to continue allowing the all-inclusive reporting option in the future. **Many FAH member IPFs use the all-inclusive reporting option and we urge CMS to continue this ability in the future.**

For all-inclusive reporters, their clear objective in selecting the all-inclusive option is to reduce administrative burden and lower costs. This objective is a prominent concern across the entire healthcare delivery system, and is especially acute for behavioral health providers that often lack the efficiencies gained through sophisticated health information technology (HIT) systems, which unfortunately applies to many IPFs.

Many IPFs made the operational decision not to generate a charge for these types of ancillary services given they are not sufficiently significant to warrant the administrative burden associated with ancillary charging activity. Furthermore, in general, the industry standard is for IPF's to negotiate Per Diem rates with commercial payers where certain ancillary charges (such as laboratory and drugs) are not a material determinate in the acceptance of certain per diem rates from a payer. As a result, and in the interest of being operationally efficient, these providers do not generate ancillary charges on their claims since payment is not impacted.

The absence of separate ancillary charges does not correlate to the assumption that ancillary services were not provided to the patient. In the majority of cases, if not in all cases, the hospital will use its patient order entry (POE) system to order a laboratory test or drugs ordered by a physician and those services are documented in the patient medical record. However, some FAH member hospitals and health systems have made the operational decision not to generate a charge for these types of ancillary services given they are not sufficiently significant to warrant the administrative burden associated with this ancillary charging activity. **It's critical that CMS know the omission of certain ancillary charges on the claim does not by default mean the ancillary service (e.g. laboratory testing and drugs) was not provided to the patient. All patient care decisions are dictated by the treating physician and fully documented in the patient medical record. The fact that an ancillary charge was not generated in the billing system does not impact the clinical decisions regarding the treatment of patients.**

The FAH has been studying data on IPFs in response to the CAA's call for CMS to revise the IPF PPS and in response to the MedPAC's recent work on IPFs. Our analysis of IPFs did not identify any significant trend or difference between IPFs with and without the all-inclusive reporting option. Both reporting categories of IPFs had readmission rates that were comparable to the national average. Additionally, there did not appear to be any discernable correlation when we analyzed other key differences such as number of outlier cases, costs per case, or other factors. While we are still early in our analysis, the use of the all-inclusive rate appears to be less important in key performance indicators than other factors such as unit/freestanding status, bed size, and ownership status. **An IPF's status as an all-inclusive reporter does not appear to be a reliable metric on which to base assumptions about an IPF's operations and/or patient care.**

CMS requested information on what the appropriate level of ancillary services on a claim should be. However, because ancillary services provided to patients are directly correlated to the physician orders, there should be no expectation for an "appropriate" level of charges on the claim given the decision to provide ancillary services will vary from patient to patient based on the physician's initial and on-going assessment. Establishing an "appropriate" level of ancillary charges on each claim would likely create frequent and false misinterpretation of claims data.

While we oppose any changes to the current all-inclusive reporting option, should CMS consider any adaptations, we urge CMS to consider the full scope of this impact, including protocol changes that would be needed with other payers that also currently allow all-inclusive reporting. **Further, the FAH opposes any type of payment penalty for IPFs that choose this allowed approach, or for all-inclusive claims with minor technical errors that are fixable.**

Many FAH psychiatric member's contracting experience with Medicare Advantage (MA) plans (as well as with most commercial payers) are structured as all-inclusive billing and payment arrangements. This all-inclusive structure is preferred by both MA plans and psychiatric hospitals as it eliminates unnecessary administrative burden and allows operational focus to remain centered on the clinical care of patients. A CMS change to penalize or prohibit all-inclusive billing would create significant and unnecessary administrative burden (including massive contracting rework for both hospitals and plans) as well as require a material initial and on-going financial burden to many psychiatric hospitals.

Implementing a transition away from all-inclusive reporting would require retooling internal systems such as interfacing clinical ancillary systems (where physician patient orders originate) with the charge description master (CDM) so that an ancillary charge can be generated on the patient billing claim. In fact, some members have estimated that the approximate initial cost of modifying internal systems to transition from all-inclusive reporting would be $250,000 to $300,000 per hospital along with on-going annual maintenance fees of up to $40,000 per hospital.

ALLOWING DISTINCT PART UNITS MID-COST REPORTING PERIOD

The FAH strongly supports the proposed amendment to 42 CFR 412.25(c) and appreciates CMS' recognition that the existing limitation on mid-cost reporting status changes from not excluded to excluded arose from particular administrative difficulties associated with cost-based reimbursement that are no longer material. In light of the adoption of a prospective payment system for IPFs and Inpatient Rehabilitation Facilities (IRFs) and the costs associated with the current rule, it is appropriate to provide hospitals with greater flexibility and amend section 412.25(c) to permit a hospital to open a new excluded unit or to change the status of a unit to excluded at any time within the cost reporting year with written advance notice to the MAC, as proposed.

Current regulations at 42 CFR 412.25(c) specify when the status of an excluded IRF or IPF unit may be changed from "not excluded from the IPPS" to "excluded from the IPPS" and be paid under the IRF or IPF PPS or vice versa. Currently the status of change from not excluded to excluded from the IPPS may only be done at the start of the cost reporting period. If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the IPPS before the start of a hospital's next cost reporting period. However, the status of change from excluded to not excluded from the IPPS may be done at any time during a cost reporting period, subject to certain conditions

CMS provides background for these policies, which were implemented before the establishment of the IRF PPS and the IPF PPS and were established to address the administrative complexity associated with cost-based reimbursement for excluded IRF and IPF units. Stakeholders have observed that only permitting status changes from not excluded to excluded to be made before the start of a cost reporting period is no longer necessary, creates an unnecessary burden, and does not take into account challenges hospitals face completing construction projects to expand capacity before the start of a cost reporting period.

Noting that cost allocation is no longer used for payment purposes because IRF and IPF units are paid under the IRF PPS and IPF PPS respectively, CMS appropriately concludes that the restriction that limits an IPF or IRF unit to being excluded from the IPPS only at the start of a cost reporting period is no longer necessary. Moreover, the existing rule imposes unnecessary costs on providers, particularly with respect to new construction that cannot be effectively and efficiently timed based on the cost reporting period. Thus, it proposes to revise its regulations at §412.25(c)(1) to establish a uniform rule for status changes for IRF and IPF units that would permit the unit's status to be changed from not excluded to excluded (or excluded to not excluded) at any time during a cost reporting period.

The hospital would be required to notify the MAC and the CMS Regional Office in writing of the change at least 30 days before the date of the change, and it would have to maintain the information needed to accurately determine costs that are or are not attributable to the IRF or IPF unit. Additionally, any change in the status of an IRF or IPF unit (i.e., from not excluded to excluded or vice versa) that is made during a cost reporting period must remain in effect for the rest of that cost reporting period.

The FAH strongly supports this proposal allowing units to open, operate, and be paid under the applicable PPS mid-cost reporting period. The current policy is no longer necessary since IRFs and IPFs have their own prospective payment systems and the current approach creates unnecessary burden, and does not take into account the vast challenges hospitals face completing construction projects to expand capacity before the start of a cost reporting period.

SOCIAL DRIVERS OF HEALTH

The FAH is committed to working with CMS on what must be a continuous and sustained effort to ensure health care equity nationwide. The FAH acknowledges that CMS' request for public comments on how the reporting of diagnosis codes in categories Z55-Z65 may improve our ability to recognize severity of illness, complexity of illness, and/or utilization of resources under the MS-DRGs. We commend CMS for reaching out to stakeholders and concur with CMS that the questions about determining impact of Z codes on the patient's health, severity, or complexity of illness as well as resource utilization should be explored. The FAH encourages CMS to continue considering an approach to improve health equity data that encompasses a combination of modes for intake (e.g., abstracted measure, ICD-10-CM SDOH Z code, assessment, quality measure, etc.) in a manner in which the most meaningful data may be effectively obtained.

We agree with CMS that there is uncertainty in the current data and that there are multiple contributing factors. The FAH recommends that CMS continue to work with key industry stakeholders to establish SDOH diagnosis consistency with identification, documentation, definitions, guidelines, as well as infrastructure to allow the data to be reported.

The FAH encourages CMS to methodically approach the requirement for reporting SDOH codes. If the decision is to move forward with mandatory reporting, the FAH recommends using homelessness as the required condition. Based on an incremental approach, the industry and CMS can further evaluate the challenges associated with reporting ICD-10 codes representing SDOH.

The FAH recognizes that there are some states that require reporting of homelessness with varied definitions. CMS must provide clear definition for homelessness and should work, where possible, to ensure the state reporting requirements align with the Medicare definition.

The FAH strongly recommends that for consistent reporting of homelessness as well as other SDOH that clear definitions and documentation requirements be defined as well as infrastructure to support the new reporting requirement. The FAH has outlined key considerations that CMS will need to provide and/or address:

- Provide consistent definitions for those reporting the homelessness diagnoses to ensure consistency. For example, how should one consider someone that lives in a nomadic life in a van, such as that depicted in the film Nomadland? Would this be unsheltered homelessness (Z5902) or Inadequate housing (Z591), Housing Instability, housed with risk of homelessness (Z59.811)). CMS should work with other stakeholders to publish FAQs PRIOR to implementation of this requirement.

- Recognize that the requirement of the SDOH diagnosis codes would likely require changes to the institutional diagnosis code data fields with the electronic and paper billing forms. There would be a need to expand and/or prioritize the diagnoses that are reported within UB/5010 Claims Form as well as the MedPAR Data. Often, complex care requires reporting a significant number of diagnosis codes on the claim and it is not uncommon to use all the available fields.

- It would be necessary for providers to prioritize which codes will make it to the claim to ensure diagnoses needed for multiple programs are included (e.g. code designations such as Major Comorbidity or Complication (MCC), Comorbidity/Complication (CC)).

- Provide guidance on handling discrepancies in the provided information. It is not uncommon for responses to differ based on who captured the information or the timeframe. This can be impacted by the patient's willingness to discuss and provide private information related to their personal living conditions. For example, the patient or family may provide different information to social worker versus a nurse or treating physician which results in conflicting documentation. Responses may also be collected with various intake forms that ask about homelessness in the last twelve months and the patient may answer "yes" as they were homeless the first six months but not the most recent six months.

- Consider multiple intake options for SDOH in addition to ICD-10-CM SDOH Z codes such as abstracted measure, or some other reporting measure especially when there are broad definitions to consider within the documentation.

- Provide instructions that there will be certain circumstances when a claim that includes a homelessness diagnosis code may also include a patient "address" and that these claims should not be rejected nor denied. There have been instances reported where payers are denying claims with homelessness included as a diagnosis on the claim form when an address has been provided. Homeless patients often provided an address that may be from a shelter, may be for mail only, a family member's address, or even a false address.

- CMS should reinforce the Official Coding Guidelines that allow source documentation for SDOH code to be based on non-provider documentation such as nursing staff or self-reported by the patient. The guidelines may require further revision for required reporting. Currently the Official Coding Guidelines indicate "Codes describing social determinants of health (SDOH) should be assigned when this information is documented. For social determinants of health, such as information found in categories Z55-Z65, persons with potential health hazards related to socioeconomic and psychosocial

circumstances, code assignment may be based on medical record documentation from clinicians involved in the care of the patient who are not the patient's provider since this information represents social information, rather than medical diagnoses".

We again urge CMS to start with an incremental approach to reporting SDOH Z-codes. A requirement to report one code category, e.g., homelessness, could assist in determining provider burden, system impact and unintended consequences. If CMS were to require the reporting of all SDOH Z codes, there would be tremendous operational and technology impacts. The requirement also impacts IPF staff with additional resources for training, documentation, productivity, and consistent reporting. It is common that patients have more than one SDOH. For example, if a patient is homeless, it is logical they may have other SDOH diagnoses such as food instability, unemployment, and/or social isolation.

In conclusion, the FAH appreciates CMS request for comments on reporting of SDOH ICD-10 codes. As mentioned previously, we urge CMS to be methodical and thoughtful as they consider this reporting. For example, determine what items need to be proactively addressed prior to making any of the reporting of SDOH codes a requirement. Additionally, this should be an incremental approach by starting with only one select category, specifically homelessness. In conjunction with the requirement, CMS should designate homelessness as a CC as they have proposed in the inpatient PPS which will appropriately reimburse providers and capitalize on the MS-DRG logic that the condition will be captured on the claim form to gain the incremental benefit of furthering data collection on health equity and disparities.

Also, the FAH reiterates that required reporting of SDOH beyond homelessness to other SDOH codes should not be contemplated at this time. This should be considered only after making data available for review and comment. There are many items that require further definition and clarification before CMS' vision for improved reporting of SDOH for use by CMS can move forward.

IPF QUALITY REPORTING PROGRAM (QRP)

Recently, CMS released the "Universal Foundation" of quality measures as the approach it will take to identify future measure concepts across CMS quality programs with the goals of focusing provider attention and reduce provider burden, as well as identify disparities in care, prioritize development of interoperable, digital quality measures, allow for cross-comparisons across programs, and help identify measurement gaps. This approach, in theory, builds from CMS' Meaningful Measures 2.0 framework and drives the development and updating of the National Quality Strategy.

The CMS Meaningful Measures 2.0 framework was designed to address measurement gaps, reduce burden, and increase efficiency by using only high-value quality measures, align measures across public and private programs and partners, prioritize outcome and patient-reported measures, transform measures to be fully digital and reflect social and economic determinants. The FAH offers the following general themes for consideration when implementing additional measures into the IPF QRP:

- Focus on IPF-specific health care priorities: The measures should focus on salient healthcare issues for this setting of care. These may relate to novel, urgent concerns or longstanding challenges for which there has not been much progress.

- Does not add unnecessary burden: Quality reporting is not "burden-free," as data collection and surveillance is vital to care improvement; rather, quality measurement should not interfere with the provision of high-quality care by requiring unnecessary administrative busywork.

- Consists of complementary measures: The complete list of measures should be complementary and demonstrate the patient journey rather than providing a list of measures from which to pick and choose; together, the measures should provide a well-rounded assessment of performance across the organization and to the extent possible, improve patient outcomes.

- Fully tested for the IPF setting: CMS' definition of "fully developed" includes empiric validity testing for the setting in which the measure will be used. Recently, we've seen CMS adopt more structural and process measures that haven't been fully tested for the program or setting of care in which the measure is implemented.

- Invest in the infrastructure for the behavioral health setting: Many IPFs lack the capacity for interoperable exchange of patient health information and lack the ability to send or receive interoperable data. The majority of IPFs still rely on outdated communication methods including faxes, emails, and phone calls.

- Modernize IPF Conditions of Participation: The Medicare conditions of participation for IPFs, including "B-tag" requirements – a detailed set of standards related to IPF patient evaluations, medical records, and staffing need to be revised and/or eliminated. These highly prescriptive and outdated guidelines are often the basis for citations for noncompliance with documentation requirements.

▪ **Proposal to Adopt the Facility Commitment to Health Equity Measure**

CMS proposes to adopt an attestation-based structural measure, Facility Commitment to Health Equity (FCHE), to address health equity beginning with the CY 2024 reporting period / FY 2026 payment determination.

The FAH continues to have general and IPF-specific concerns about this measure. For example, we note that CMS still has not provided sufficient evidence to establish a linkage between the measure and improved health outcomes. The purpose and value of collecting data for a measure that has no demonstrable link to better outcomes imposes unnecessary burden on providers, particularly to create documentation to support affirmative attestation responses for each of the measure's many elements. Further, the measure is only in its first year of reporting in the HIQR Program, so no experience on actual use of the measure by hospitals is available to inform its implementation by IPFs.

We also note several elements would be extremely problematic for IPFs, such as the requirement for entry of social risk factor information collected from patients as structured interoperable elements using certified electronic health record technology (CEHRT). Due to

funding issues,[6] many IPFs still lack CEHRT capabilities and this substantial IPF subset would be unable to attest affirmatively to this item and thereby to the measure's data collection domain. Successful attestation would reflect monetary (CEHRT funding) rather than equity-related factors. Since the FCHE measure is "all or none" – that is, there is no partial credit option – these IPFs would fail the entire measure based on their lack of CEHRT, even if they satisfied all of the remaining elements.

We do not support adoption of a Hospital Commitment to Health Equity (HCHE)-type measure into the IPF QRP before 1) a linkage between the HIQR HCHE measure and improved health outcomes is shown by CMS or is adequately documented in peer-reviewed publications; 2) sufficient experience is accrued with the measure's implementation and use in the HIQR Program to identify and resolve operational challenges for CMS and providers as well as unintended consequences; and 3) the measure is appropriately respecified to allow reporting by all IPFs. Endorsement by the Consensus-Based Entity (CBE) should also be achieved prior to implementation in this program.

- **Proposal to Adopt the Screening for Social Drivers of Health Measure Beginning with Voluntary Reporting of CY 2024 Data Followed by Required Reporting Beginning with CY 2025 Data/FY 2027 Payment Determination**

CMS proposes to adopt the Screening for Social Drivers of Health measure beginning with voluntary reporting of CY 2024 data followed by required reporting beginning with CY 2025 data / FY 2027 payment determination.

The FAH supports the development and implementation of measures that seek to address inequities in care and those factors that may directly or indirectly impact an individual's ability to achieve positive health outcomes. Regrettably, the FAH does not support the inclusion of this measure in the program for several reasons.

We do not believe that the measure as specified provides evidence to demonstrate that screening of these specific factors in the inpatient psychiatric setting is linked to improvements in health outcomes nor is it clear on the degree to which the selected factors are aligned with the work of the Health Level 7 (HL7) Gravity Project. It also assesses the rate of screens completed by a facility in the absence of any information on the degree to which the facility has been equipped with the necessary resources and tools to address the individual's needs for any one of the selected factors. Any implementation of this measure is premature until these resources and tools are widely available, and the measure currently does not exclude patients whose length of stay is only one or two days, which makes it far more difficult for a facility to administer this screening in addition to all of the other important clinical activities that may take place during an admission.

[6] IPFs were not eligible to receive the incentive payments to purchase and implement CEHRT that were made available through the HITECH Act of 2009.

This measure must be standardized through the HL7 Gravity project, provide the necessary denominator exclusions, and fully tested for feasibility, reliability, and validity. The FAH believes that these questions and concerns must be addressed and endorsement by the CBE should be achieved prior to implementation of this measure in the IPF QRP.

- **Proposal to Adopt the Screen Positive Rate for Social Drivers of Health Measure Beginning with Voluntary Reporting of CY 2024 Data and Followed by Required Reporting Beginning with CY 2025 Data / FY 2027 Payment Determination**

CMS proposes to adopt the Screen Positive Rate for Social Drivers of Health measure beginning with voluntary reporting of CY 2024 data followed by required reporting beginning with CY 2025 data / FY 2027 payment determination.

The FAH does not support the inclusion of this measure in the program for several reasons. Specifically, we do not believe that the measure as specified provides evidence to demonstrate that reporting of the positivity rate for one or more of these factors in the inpatient psychiatric setting is linked to improvements in health outcomes nor is it clear on the degree to which the selected factors are aligned with the work of the Health Level 7 (HL7) Gravity Project. It also assesses the rate of positive screens in the absence of any information on the degree to which a facility has been equipped with the necessary resources and tools to address the individual's needs for any one of the selected factors. Any implementation of this measure is premature until these resources and tools are widely available, and the measure currently does not exclude patients whose length of stay is only one or two days, which makes it far more difficult for a facility to administer this screening in addition to all of the other important clinical activities that may take place during an admission.

This measure's proposed measure calculation will report five separate rates based on the total number of patients 18 years and older on the date of admission screened for all five factors. The FAH does not support this flawed methodology and it is not clear whether this approach will yield reliable and valid comparisons. In addition, this measure must be standardized through the HL7 Gravity project, provide the necessary denominator exclusions, and fully tested for feasibility, reliability, and validity.

The FAH believes these questions and concerns must be addressed and endorsement by the CBE should be achieved prior to implementation of this measure in the IPF QRP.

- **Proposal to Adopt the Psychiatric Inpatient Experience (PIX) Survey Beginning with Voluntary Reporting of CY 2025 Data and Required Reporting Beginning with CY 2026 Data / FY 2028 Payment Determination**

CMS proposes to adopt the Psychiatric Inpatient Experience (PIX) Survey beginning with voluntary reporting of CY 2025 data and required reporting beginning with CY 2026 data / FY 2028 payment determination.

The FAH supports the inclusion of a measure evaluating an individual's experience with their care by an IPF but requests that CMS ensure that the conditions placed on the measure by

the Measure Application Partnership (MAP) be addressed prior to any implementation of this measure. Specifically, we note the conditions called for endorsement by the CBE and that additional testing be completed including broader testing in a variety of settings, an analysis of the timing of survey administration (pre- versus post-discharge), an analysis of other factors that may drive differences in performance (e.g., involuntary commitments, patient factors), and a consideration of how the proportion of involuntary versus voluntary admissions affects the measured outcome.

- **Proposed Modification of the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure Beginning with the Quarter 4 CY 2023 Reporting Period / FY 2025 Payment Determination**

CMS proposes to modify the COVID-19 Vaccination Coverage Among HCP measure to replace the term "complete vaccination course" with the term "up-to-date" in the HCP vaccination definition beginning with the fourth quarter of the CY 2023 reporting period / FY 2025 payment determination. CMS also proposes to update the numerator to specify the time frames within which an HCP is considered "up-to-date" with recommended COVID–19 vaccines, including booster doses.

The FAH supports the intent of this measure but we remain concerned that the current specifications are flawed given the lack of a stable definition of "up to date" and that the numerator, which refers the end user to a document with varying definitions of "up to date," could negatively impact the reliability and validity of the measure. A standardized way to collect this information must be made available. The FAH continues to believe that it is too soon to include a measure on COVID-19 vaccinations since the underlying evidence for this measure is still emerging and methods to address measure collection challenges related to anticipated "booster" shots will likely be required.

Should CMS choose to move forward with this measure, we recommend that it be aligned with the requirements of the Hospital Conditions of Participation (COPs) and allow not only medical contraindications but also capture when individuals decline vaccination. We also recommend CMS revise the measure specifications to require data to be submitted in monthly or quarterly periods instead of one week a month for each quarter, in line with other Quality Reporting Program measures. The updated specifications and testing results must also be endorsed by the CBE prior to implementation in the IPF QRP.

- **Proposed Removal of the Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS-5) (previously endorsed under CBE #0560) Measure Beginning with FY 2025 Payment Determination**

CMS proposes to remove the Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS-5) (CBE #560) measure with the reasoning that the measure removal factor two (that is, measure does not align with current clinical guidelines or practice) applies due to the American Psychiatric Association's updated guidelines for patients with schizophrenia. The FAH agrees with removing this measure given the lack of alignment with the current evidence.

- **Proposed Removal of the Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention (TOB-2/2a) for FY 2025 and Subsequent Years**

CMS proposes to remove the Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention (TOB-2/2a) since the overall cost associated with retaining both measures (TOB-2/2a and TOB-3/3a) outweighs the benefit of having two measures to address treatment for the same comorbidity among the same patient population. The FAH agrees with removing this measure given the lack of variation in performance scores and the loss of endorsement by the CBE.

Data submission requirements for FY 2026 & 2027 payment determination and subsequent years

- **Proposed Data Validation Pilot Beginning with Data Submitted in 2025**

CMS is proposing a data validation pilot beginning with data submitted in CY 2024 (reflecting care provided during CY 2023). The FAH supports the importance of data validation for the IPFQR program as is done for other CMS quality programs. We appreciate that CMS delayed the implementation of this plan until IPFs began collecting patient-level data and continues to ensure that the burden on facilities is minimized.

- **Quality Measure Sampling Requirements**

CMS proposes that several of the measures proposed for adoption would not be eligible for sampling (i.e., Facility Commitment to Health Equity, Screening for Social Drivers of Health, Screen Positive Rate for Social Drivers of Health). CMS proposes that for the PIX survey measure IPFs would need to develop sampling plans that ensure that IPFs are able to submit data for 300 completed PIX surveys per year.

The FAH encourages CMS to evaluate the potential data collection burden with the addition of these four measures and requests that they consider whether a sampling methodology should be applied to the Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health. These two measures are complex in their requirements and will require significant data collection. IPFs will need time to educate staff and providers to ensure reliable and valid data collection and reporting. By applying a sampling approach to these measures, it will allow facilities to gain experience while minimizing data collection burden and ensuring reliable and valid performance scores.

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The FAH appreciates the opportunity to offer comments on the FY 2023 IPF PPS proposed rule. If you have any questions or would like to discuss further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,