Federation of American Hospitals®

Charles N. Kahn III
President and CEO

May 28, 2024

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 2025 Inpatient Psychiatric Facilities Prospective Payment System—Rate Update (CMS–1806–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 3, 2024.

MARKET BASKET UPDATE

For FY 2025, 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 2023 forecast with historical data through the 3rd quarter of 2023. Using that forecast, the proposed IPF market basket for FY 2024 is 3.1 percent. Using data from the same period, CMS estimates an offset to the IPF market basket for total factor productivity (TFP) of 0.4 percentage points. Consequently, CMS proposes an IPF PPS update of 2.7 percent for FY 2025. For hospitals that do not successfully submit quality data under the IPFQR program, the update is reduced by 2.0

percentage points to 0.7 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 accurate 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.

Hospitals have had to weather an unrelenting cascade of market pressures during the COVID-19 public health emergency (PHE), compounded by historically high, spiraling inflation. These inflationary cost pressures for IPFs and all of America's hospitals do not seem to be captured in IGI's estimate of 3.1 percent for IPF market basket inflation for FY 2025. We are concerned that the 4-quarter rolling average and methods used to estimate inflation in IPF spending are not capturing the readily evident pandemic-initiated shocks to the health care market that are significantly driving up costs, especially labor, across the spectrum of hospital inputs. We urge CMS to consider these pandemic and inflationary triggers that do not seem to be reflected in the market basket forecast and make a one-time exception to further increase IPF rates to better adjust FY 2025 payments to IPFs to adjust for both the PHE and unaccounted for inflation.

In our public comments on the proposed FY 2023 and FY 2024 IPF update, we expressed concern that pandemic and 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 2024 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	FY 2024
Forecast Used in the Update	2.2	2.7	4.1	3.5
Actual Based on Later Utilization	2.8	5.3	4.8	3.7
Difference	-0.6	-2.6	-0.7	-0.2

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 3.9 percentage points. Preliminary data suggests that FY 2024 will also be understated. This means that the base rate for FY 2025 is at least 3.9 percentage points too low – further compounding the inadequate FY 2025 rate increase.

The FAH urges CMS to consider an adjustment for forecast error to ensure that the FY 2025 rate increase is applied to a base rate that more accurately incorporates actual inflation just

[1]OACT, 4th quarter 2023 release of the market basket information with historical data through the 3rd quarter of 2023 (Market Basket Data | CMS) for the actual update based on later utilization.

as CMS is doing in two other contexts: the proposed FY 2025 skilled nursing facility (SNF) PPS update and the proposed FY 2025 capital IPPS update.

For the FY 2025 SNF update, CMS is proposing to increase the market basket update of 2.8 percent by 1.7 percentage points for forecast error in application of the FY 2023 update.[2] For the FY 2024 capital IPPS update, CMS is proposing to increase the capital input price index (CIPI) of 2.5 percent by 0.5 percentage points for forecast error in application of the FY 2023 CIPI update.[3]

In the FY 2024 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."[4] However, CMS' policy is to adjust the SNF market basket update for forecast error if the difference between the forecast update and the actual update based on later information is more than 0.5 percentage points. For the capital IPPS update, CMS' policy is to adjust the capital input price index forecast error if the difference between the forecast update and the actual update based on later information is more than 0.25 percentage points. If CMS had a comparable policy for the IPF PPS, the update would have been adjusted upward in 3 of the last 4 years with final data still pending for the 4th year (FY 2024).

FAH is asking for a consistent policy between these payment systems. The forecast error adjustment requested to the FY 2023 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 2025 IPF PPS update because such a policy was not proposed. However, the IPF market basket update for FY 2025 has been made subject to public comment in the FY 2025 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. 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.

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[2] 89 Federal Register (FR), 23428, April 3, 20243

[3] 89 FR 36579, May 2, 2024.

[4] 88 FR 51078, August 2, 2023.

If CMS adopted the FAH's recommendation, it would be proposing an IPF update of 3.1 percent plus 0.7 percentage points for FY 2022 forecast error less 0.4 percentage points for TFP. The total update before incorporating later data for the final rule would be 3.4 percent. Even with this update, IPF rates would still be understated for cumulative inflation since FY 2021 of 3.9 percentage points.

The FAH is further concerned that the IPF update for FY 2025 includes a reduction for non-farm TFP of 0.4 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.[5] While the annual TFP offset is based on a provision of the Affordable Care Act of 2010 and is required by law, the FAH urges CMS to consider the appropriateness of this reduction when deciding whether to incorporate a forecast error adjustment to the FY 2025 IPF PPS update based on the understatement of the IPF PPS market basket baskets from FY 2021 to FY 2024 of 4.1 percentage points.

For these reasons, the FAH requests CMS adopt a one-time forecast error adjustment to the FY 2025 IPF PPS update based on the 3.9 percentage point difference in the IPF PPS market basket in FYs 2021, 2022and 2023. Adopting our suggestion would make the market basket equal to 3.1 percent plus 3.9 percentage points less 0.4 percentage points or 6.6 percent.

LABOR RELATED SHARE OF THE IPF PPS MARKET BASKET

CMS also proposes to revise the labor-related share of the standard payment conversion factor for FY 2025. CMS proposes a total labor-related share of 78.8 percent for FY 2025 that is 0.1 percentage points higher than the FY 2024 labor share of 78.7 percent. Both of these figures are based on the FY 2021-based IPF market basket and the higher labor share first adopted for FY 2024 based on incorporation of the 2021 Medicare cost report data.

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. The slight increase in the labor-related

[5] 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).

share proposed for FY 2025 results from the inflationary changes among the price proxies and the relative importance of each of the categories used in developing the IPF market basket.

The FAH supports the proposed increase in the labor-related share of the IPF market basket for FY 2025. As we indicated in our comments on the FY 2024 IPF proposed rule, CMS should 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. The current labor share based on FY 2021 cost reports may not fully reflect the increase weight of labor in the overall index that hospitals experienced due to the COVID-19 public health emergency.

WAGE INDEX

Consistent with past practice, CMS proposes to use the FY 2025 pre-floor, pre-reclassified IPPS hospital wage index for the FY 2025 IPF wage index. Each wage index assigned to an IPF is based on the labor market area in which the IPF is geographically located. IPF labor market areas are delineated based on the Core-Based Statistical Area (CBSAs) established by the OMB. Generally, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. On July 21, 2023, OMB issued Bulletin 23–01, which revises the CBSA delineations based on the latest available data from the 2020 census.

CMS is proposing to implement the new OMB delineations effective beginning with the FY 2025 IPF PPS wage index. As a result of the new proposed CBSA delineations, the proposed rule indicates that 10 providers are located in areas that were previously considered rural but would now be considered urban under the revised OMB delineations. Since the inception of the IPF PPS, CMS has provided a 17-percent payment increase for IPFs located in a rural area.

For IPFs currently located in rural areas that are proposed to be urban under the new CBSA delineations, CMS proposes to phase-out the rural adjustment over three years in 1/3 increments. This policy would allow IPFs located in counties that are classified as rural in FY 2024 becoming urban in FY 2025 to receive two-thirds of the rural adjustment for FY 2025. For FY 2026, these IPFs would receive one-third of the rural adjustment. For FY 2027, these IPFs would not receive a rural adjustment.

CMS has completed analysis of more recent cost and claims information to update the rural adjustment. The current adjustment for rural location is 1.17 or a 17 percent increase for inpatient IPF stays in rural psychiatric units or facilities. Using the 2019-2021 MedPAR data set, CMS indicates that if the adjustment for rural location were to be revised, the new factor would be 1.16 without any adjustment for IPFs that would meet the Medicare Payment Advisory Commission's (MedPAC) definition of a Medicare Safety Net Index (MSNI) hospital. The MSNI is a methodology developed by the MedPAC for the IPPS that identifies hospitals that may be considered "safety net" providers eligible for additional payment. With an MSNI adjustment, the rural adjustment factor would be 1.19. (Note below that the FAH explains in more detail why we do not believe CMS should apply an MSNI adjustment within the IPF PPS).

As CMS is revising the patient level adjustments to the IPF PPS, it is not proposing to update the facility level adjustments (other than the wage index) in order to minimize the scope of changes that would impact providers in any single year. **The FAH supports CMS' proposal to phase-out the rural adjustment for rural IPFs becoming urban over three years and to update the rural adjustment when CMS is proposing to update other IPF facility-level adjustments.**

Changes to use the proposed CBSA delineations may change an IPF's wage index relative to using the current CBSA delineations. In the past, CMS has proposed a transition to new wage indexes based on the revised CBSA delineations. However, CMS no longer believes a transition is necessary as it adopted a 5 percent cap on reductions to an IPF's wage index in a single year beginning with FY 2023. CMS is not proposing a transition to the IPF wage index using the new CBSA delineations but will instead apply its current policy of limiting the single year reduction to a hospital's wage index to 5 percent.

The FAH appreciates CMS' recognition of how disruptive drops in the area wage index can create significant challenges for IPFs. For this reason, 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.**

In the wage index tables accompanying the FY 2025 IPF proposed rule, CMS provides the crosswalk between the FY 2024 CBSA delineations and the proposed FY 2025 CBSA delineations. The FAH found 178 areas where the wage index shown will decrease more than 5 percent. **We encourage CMS to release wage index tables in the final rule that incorporate the 5 percent decrease cap in order to avoid errors in the payment rates established by the Medicare Administrative Contractors (MAC).**

For the inpatient prospective payment system (IPPS) rule, Table 2 of the proposed and final rules provide, among other information, the wage index for each hospital by CMS certification number (CCN). This information is helpful to hospitals to identify the wage index they have been assigned without having to know their CBSA code. **The FAH requests that CMS provide a wage index table with the FY 2025 IPF final rule that provides the wage index for each hospital by CCN similar to Table 2 of the IPPS rule.**

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.

The FAH appreciates CMS' much needed efforts to address the problems and financial challenges that rural hospitals face. CMS policy must ultimately ensure that Medicare payment formulas do not operate to magnify the stress on the rural health delivery system and contribute to access issues for Medicare beneficiaries living in rural areas. For the IPPS CMS has proposed to continue its policy of increasing the wage index values for hospitals with a wage index value in the lowest quartile of the wage index values across all hospitals. For hospitals in the lowest quartile, CMS has temporarily increased the hospital wage index values below the 25th percentile by half of the difference between the hospital's wage index value and the 25th percentile wage index value. The FAH encourages CMS to consider developing and applying a corresponding low wage index hospital policy for rural and low wage index IPFs to ensure that IPFs in low wage index and rural areas, which typically draw from the same labor pool as IPPS hospitals, have adequate resources to continue to provide access to care for vulnerable Medicare beneficiaries that need inpatient psychiatric care. ***The FAH also urges CMS to implement this policy without applying a budget neutrality adjustment to the IPF PPS standardized amounts, as we believe such budget neutral adjustments are not required.***

PATIENT LEVEL ADJUSTMENTS

The current payment adjustment factors were derived from a regression analysis of 100 percent of the FY 2002 Medicare Provider and Analysis Review (MedPAR) data file, which contained 483,038 cases. Section 1886(s)(5)(D) of the Act, as added by section 4125(a) of the CAA, 2023 requires that the Secretary implement revisions to the methodology for determining the payment rates under the IPF PPS for psychiatric hospitals and psychiatric units, effective for FY 2025.

Consistent with this statutory provision, CMS has developed proposed adjustment factors based on a regression analysis of IPF cost and claims data. The primary sources of this analysis are 2019 through 2021 MedPAR files and FY 2019 through FY 2021 Medicare cost report data (or its most recent cost report going back to FY 2018 if the provider did not have a cost report for any of those years).

The FAH has reviewed these patient level adjustments and has largely been able to replicate CMS' analysis. As a matter of policy, **the FAH agrees that patient level adjustments that were first derived from 2002 data and have been applied since the initiation of the IPF PPS in FY 2005 should be updated based on more current data.**

FACILITY LEVEL ADJUSTMENTS

CMS modeled but it is not adopting facility-level adjustments for rural location and teaching at this time because of concerns about the magnitude of the patient level adjustments being proposed for adoption in FY 2025. To improve payment stability from year-to-year, CMS

expects to update facility-level adjustment in a future year. **The FAH supports CMS waiting until a future year to update the facility-level adjustments for rural location and teaching**.

The proposed rule also requested comments on whether CMS should adopt an MSNI adjustment in the IPF PPS. As explained earlier, the MSNI is a methodology developed by the MedPAC for the IPPS that identifies hospitals that may be considered "safety net" providers eligible for additional payment. IPPS does not currently use the MSNI to make adjustments to payments.

In contrast to other Medicare hospital payment systems, the IPF PPS does not have an adjustment that recognizes higher intensity of inpatient services when hospitals serve a disproportionate share (DSH) of low-income patients. Section 1886(s) of the Act does not require any specific adjustment of this type, nor does it require the use of any particular methodology. CMS has explored a DSH adjustment for the IPF PPS, but prior regression analyses have not supported adopting one.

Under the IPPS, the DSH adjustment allows for additional Medicare inpatient hospital spending and is not required to be budget neutral. The implication of the discussion in the IPF proposed rule is that if CMS were to adopt a DSH-like adjustment for the IPF PPS, the adjustment would be budget neutral relative to not applying the adjustment.

If CMS were to adopt an MSNI adjustment, it would significantly redistribute IPF payments, reducing payments to IPFs with a lower MSNI and increasing payments to IPFs with a higher MSNI. CMS estimates the reduction to the IPF PPS Federal per diem base rate would be $245, a reduction of nearly 28 percent. The average payment increase or reduction for some categories of hospitals could be as much as 3.1 percent according to CMS modeling.

The FAH believes it is premature to consider an MSNI adjustment for the IPF PPS but that if an MSNI is proposed, it should allow for additional Medicare spending to safety net hospitals and not be at the expense of other hospitals.

CMS itself suggests in the proposed rule that it is premature to adopt an MSNI adjustment. The proposed rule indicates that data reported by IPFs to determine an MSNI adjustment may be incomplete. First, both uncompensated care (UCC) amounts and total revenue amounts are reported at the hospital level only. As a result, CMS was only able to calculate a ratio for IPF units based on the overall ratio of the hospital's UCC to its revenues. This assumes that a hospital's overall UCC ratio would be comparable to that of its IPF unit. Further, most freestanding IPF hospitals are not reporting any UCC, which leads to lower MSNI values for these IPFs. Clearly, more work is needed before any kind of adjustment for serving low-income patients, much less the MSNI is adopted.

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. For FY 2025, CMS proposes to continue to set the

fixed loss threshold amount so that outlier payments account for 2 percent of total payments made under the IPF PPS.

Based on an analysis of the FY 2023 IPF claims and the FY 2024 rate increases, CMS estimates that outlier payments for FY 2024 will be 2.1 percent of total payments or 0.1 percentage points higher than the target of 2.0 percent. For FY 2025, CMS proposes to increase the fixed loss threshold from $33,470 in FY 2024 to $35,590 in FY 2025 or approximately 6.3 percent. CMS will update the proposed outlier threshold in the final rule based on later data.

The proposed increase in the fixed loss threshold for FY 2025 is relatively modest compared to prior years. Nevertheless, the FAH remains concerned that an increase of 6.3 percent in the outlier fixed loss threshold is higher than the proposed update to IPF rates of 2.7 percent. For the FY 2022 and FY 2023 IPF PPS, CMS adopted an alternative methodology for determining the fixed loss threshold that involved 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 mitigated the proposed increase in the fixed loss threshold in these years.

The FAH requests that CMS again consider removing those IPFs with extremely high or low costs per day (3+ standard deviations from the mean) in the final rule as a means of mitigating the increase in the outlier fixed loss threshold.

ALL-INCLUSIVE RATE PROVIDERS

Many IPFs have chosen an 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. In the FY 2025 IPF proposed rule, CMS is "clarifying the eligibility criteria to be approved to file all-inclusive cost reports." Under this clarification, only government-owned or tribally owned facilities will be permitted to file an all-inclusive cost report for cost reporting periods beginning on or after October 1, 2024.

CMS' policy is not a clarification. It is clearly a change in policy. The proposed rule indicates that in 2012 and 2013, over 20 percent of IPF stays showed no reported ancillary charges, such as laboratory and drugs charges on claims. While CMS indicates that most hospitals that were approved to file all-inclusive cost reports were Indian Health Services (IHS) hospitals, government-owned psychiatric and acute care hospitals, and nominal charge hospitals, the Medicare Administrative Contractors (MACs) have allowed many other IPFs to file all-inclusive cost reports for years as evidenced by the percentage of IPF stays with no reported ancillary charges on claims.

Many FAH-member IPFs use the all-inclusive reporting option. For those using the all-inclusive reporting option, their clear objective is to reduce the 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 systems.

Many IPFs made the operational decision not to generate a charge for certain types of ancillary services given they are not sufficiently significant to warrant the administrative burden associated with developing distinct charges. 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.

Many FAH IPF members' 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 burdens and allows operational focus to remain centered on the clinical care of patients.

Whether CMS construes the requirement to prohibit all-inclusive billing as a change or clarification, it is infeasible to make the requirement effective for cost reports beginning on or after October 1, 2024. 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 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.

In addition, some all-inclusive providers will also be forced to implement an interim, manual approach before full compliance becomes achievable. Where compliance with the ancillary billing requirement on an automated basis is not possible, FAH members would incur significant administrative costs associated with a *manual* ancillary billing process.

The manual ancillary billing charge capturing process includes the following:

1. The patient chart is pulled for charge review.
2. The chart is reviewed to identify the ancillary service(s) provided.
3. The identified service(s) is noted for ancillary billing and a charge ticket is created.
4. The ancillary billing charge ticket information is then entered into the electronic patient system for billing purposes and claim generation.

The administrative burden of this manual process is significant and will vary depending on hospital volumes. However, our members estimate that each chart review could take approximately two hours – adding an average of 7,000 work hours per year, with certain high-volume hospitals experiencing an increase of 17,000 work hours per year. The incremental costs associated with this activity will approximate $300,000 annually, whereby in certain high-volume hospitals this cost will balloon to approximately $700,000 per year.

The complexity and cost of this transition validate that for all-inclusive IPFs the clear objective in selecting this option was 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 health information systems, which unfortunately applies to many IPF providers due to their exclusion from eligibility for HIT funds in the HITECH Act of 2009.

As noted above, the FAH disagrees that CMS' proposal is a clarification and not a change in policy. **The FAH strongly disagrees with CMS adopting this change in policy prohibiting all-inclusive rate billing as it 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**.

However, if CMS insists on finalizing its proposed change in policy to prohibit all-inclusive rate billing except for government-owned, tribal and IHS facilities, the FAH strongly advises that CMS provide a longer period than until October 1, 2024 to adopt this policy. As noted above, the MACs have allowed many IPFs—including many FAH members—to file all-inclusive cost reports for years. It is simply not feasible for these IPFs to develop the administrative infrastructure to shift away from all-inclusive reporting by October 1, 2024. **The FAH recommends that CMS provide no less than a 2-year window until October 1, 2026 for IPFs to no longer file all-inclusive rate cost reports.**

INPATIENT PSYCHIATRIC FACILITY QUALITY REPORTING (IPFQR) PROGRAM

CMS is proposing the inclusion of the new, claims-based 30-Day Risk-Standardized All-Cause ED Visit Following an IPF Discharge measure (the IPF ED Visit measure) in the IPFQR program beginning with the CY 2025 performance period/FY 2027 payment determination. The Consensus-Based Entity (CBE) Cost and Efficiency Endorsement Committee met on January 31, 2024, and did not reach consensus regarding the IPF ED Visit measure, with 60.6 percent voting in favor of endorsement or endorsement with conditions and the remaining members voting to not endorse, which is below the 75 percent threshold necessary for the endorsement of the measure.

The FAH expresses concern regarding CMS' decision to propose this measure for use in the IPF QRP despite the measure's failure to secure an endorsement from the CBE. The Fall 2023 technical report[6] revealed a lack of consensus surrounding the measure's endorsement, primarily due to apprehensions about its validity. Specifically, there are concerns that the measure may not accurately capture emergency department visits related to behavioral health, and the potential for inaccurate coding of behavioral health diagnoses could further undermine its validity. The FAH finds CMS' sole justification for including the measure in the absence of endorsement-that no equivalent measure is currently included in the program- insufficient. **The FAH strongly believes this measure should not be considered for inclusion into the IPF QRP until the questions surrounding its validity are satisfactorily addressed and the measure achieves endorsement.**

[6] https://p4qm.org/sites/default/files/Cost%20and%20Efficiency/material/EM-Fall-2023-Cost-and-Efficiency-Final-Technical-Report-508.pdf

IMPACT ANALYSES

The FAH appreciates the significant work CMS must complete to update the IPF payment system, including the area wage index, patient-level adjustment factors, and discussion of the facility adjustment factors, related to the proposed FY 2025 IPF PPS proposed rule. The updates led to significant changes at the case and facility level. While CMS produced an impact file by type of facility, CMS did not produce an IPF-specific impact file so that individual IPFs can quickly assess the impact of CMS' proposed changes for FY 2025. Given the significant changes in this rule we urge CMS to publish a facility-specific impact file with IPF-specific details on the impact of the rule and the unique payment factors used to estimate the rule's implications for each IPF. This request is consistent with impact files produced annually for the inpatient prospective payment system for acute hospitals and the inpatient rehabilitation facility prospective payment system.

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The FAH appreciates the opportunity to offer comments on the FY 2025 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,