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

Re: FY 2023 Inpatient Psychiatric Facilities Prospective Payment System-Rate Update
and Quality Reporting-Request for Information

Dear Administrator Brooks-LaSure:

The American Psychiatric Association (APA), the national medical specialty society representing over 37,000 psychiatric physicians and their patients, would like to take the opportunity to comment on the FY 2023 Inpatient Psychiatric Facilities Prospective Payment System-Rate Update and Quality Reporting-Request for Information. While we support CMS's proposed wage increases, we write to encourage CMS to take a broader view when considering updates to the reimbursement methodology for inpatient psychiatric facilities (IPF). This is in line with the comments made by President Biden in his 2022 state of the Union Address where he stated that the administration's focus is on supporting our nation's mental health through increasing the capacity of services, connecting more people to care and attending to an environment that supports health and mental health. Access to psychiatric beds is a critical component in the continuum of care.

CMS Proposals

The APA supports the proposed positive update as well as the plan to establish a permanent mitigation policy to ensure that the impacts of year-to-year changes do not unduly harm specific facilities. We are particularly concerned about those facilities in rural areas given the tenuous state of inpatient care, any negative adjustment could have a detrimental impact on access to care.

Future Funding

As CMS considers adjusting the IPF PPS methodology, as summarized in the report from The Bizzell Group, LLC, **we encourage CMS to take a broader view across the full continuum of care and support funding for all levels of care including residential care, partial hospitalization, intensive outpatient services, and crisis services. The presence or lack of services directly impacts the need for access to inpatient care.** Spending funds to support prevention and early identification of mental health and substance use disorders, as well as access to a broad range of services improves treatment outcomes and reduces future medical costs.

As hospital costs continue to rise and as health care inflation exceeds the general rate of inflation, reimbursement in psychiatric inpatient units typically cover only half of the total costs of care. As long as the units cover their direct costs and make some incremental contribution to the margin, there is some economic basis for their retention. But as hospitals' overall economic situation deteriorates, units that do not come close to covering their full cost allocations look like prime targets for replacement by more profitable services. The additional regulatory and legal environment applicable to psychiatry requires additional and uncompensated support from hospitals. The recent focus on ligature by CMS and the Joint Commission, while clearly important for patient safety, often required extensive and costly renovations which made psychiatric units even more disadvantaged and accelerated downsizing and closures. Consequently, the number of acute psychiatric inpatient beds has decreased steadily over the past decade. If reimbursement rates for psychiatric hospitalizations do not cover the cost to deliver care, this treatment option may cease to be available, and a less appropriate setting, such as correctional facilities, may become the alternative "treatment setting" for individuals with severe mental illness.

In an upcoming APA Presidential Task Force Report titled "The Psychiatric Bed Crisis in the US: Understanding the Problem and Moving Toward Solutions" it is noted that only through substantial increases in reimbursement will acute-care hospitals once again consider increases to inpatient psychiatric services. Physician and other clinician and network investments by hospitals and health systems are often predicated on the profitability of inpatient or ambulatory procedural care. In general, given the competition for physicians overall and especially the current demand for psychiatrists, hospitals and health care systems will not be willing to invest limited capital for psychiatric beds, integrated electronic records or psychiatrists unless the overall hospital payment model for inpatient psychiatry is reformed.

The use of prior authorization, concurrent review and stringent medical necessity requirements by public and private payers often results in delays for patients in receiving necessary care and leads to additional administrative costs and contributes to boarding of patients in the emergency room. In a 2016 survey conducted by the American College of Emergency Physicians, 48% of their member respondents said that psychiatric patients are boarded one or more times a day in their emergency department. When asked how long the longest patient waiting in the emergency department for an inpatient bed was boarded, nearly 38% of respondents said 1 to 5 days.

As we've stated in previous comments, **APA urges CMS to eliminate the long-standing Conditions of Participation (COP) required by CMS for an organization to bill Medicare and Medicaid.** The COP include substantial administrative burdens that are no longer relevant and are not required of any other discipline.

CMS Health Equity RFI

APA applauds CMS's commitment to addressing health equity in its quality and measurement programs. Identifying health disparities and addressing gaps in care are vitally important goals, and we support efforts to find the most useful and appropriate methods for collecting data on disparities and social determinants of health.

As suggested in the RFI, CMS should work to ensure that measurement of disparities is based on reliable, accurate, and actionable data that allows providers to implement concrete solutions and track progress over time. This will require alignment and standardization of approaches to data collection, and use of consistent definitions and standards. At the same time, we would urge CMS to balance the need for data with efforts to reduce the burden of data collection. Progress on collecting relevant data will likely depend on substantial changes and new investments in systems, workflow, personnel, and HIT infrastructure; providers will need support and flexibility in making and sustaining these changes.

As data collection activities evolve, we hope there will be opportunities to find ways of accounting not just for race, ethnicity, and dual status, but also variables such as education, housing status, access to healthy foods, and other pertinent social risk factors.

Regarding principles for prioritizing measures for disparities reporting across programs, we agree with the approach of prioritizing measures with identified disparities in treatment or outcomes; this will allow CMS to bring attention to inequities in these areas and incentivize institutions to improve.

Regarding the Health Equity Summary Score (HESS) measure, we would suggest that future iterations of the measure, or similar measures, incorporate behavioral health components (e.g., screening, assessment, and follow-up for depression and other mental health conditions). Racial/ethnic, gender, and sexual minorities often suffer from poor mental health outcomes, which can result from inaccessibility of high-quality mental health care services, cultural stigma surrounding mental health care, discrimination, and overall lack of awareness about mental health. Measures assessing the equity of care should account for these disparities to help improve the accessibility and delivery of mental health services for underserved populations.

As the country continues to grapple with the effects of a multiyear global pandemic, APA would like to work collaboratively with CMS to ensure those suffering with mental health and substance use disorders have access to the quality care. We look forward to sharing the APA Presidential Task Force report with you once it is publicly available.

Thank you for your review and consideration of these comments. If you have any questions or would like to discuss any of these comments, please contact Rebecca Yowell (byowell@psych.org) Director, Reimbursement Policy and Quality.

Sincerely,



Saul M. Levin, M.D., M.P.A., FRCP-E, FRPsych
CEO and Medical Director
American Psychiatric Association