AMERICAN PSYCHIATRIC ASSOCIATION

800 Maine Avenue, S.W.
Suite 900
Washington, D.C. 20024

May 28, 2024

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
File Code: CMS-1806-P
Baltimore, MD 21244–8010

Re: CMS–1806–P; Medicare Program; FY 2025 Inpatient Psychiatric Facilities Prospective Payment System—Rate Update

Dear Administrator Brooks-LaSure:

The American Psychiatric Association (APA), the national medical specialty society representing over 38,900 psychiatric physicians and their patients, would like to take the opportunity to comment on the FY 2025 Inpatient Psychiatric Facilities (IPF) Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2024 (FY 2025). Our comments focus on key payment provisions and issues related to quality improvement in the Inpatient Psychiatric Facility Quality Reporting Program (IPFQR).

We appreciate the Administration's ongoing support for patients with mental illness and substance use disorders, reflected in the positive payment adjustments contained within this proposed rule. As we've noted previously, current reimbursement for inpatient psychiatric units fails to cover the full cost of providing care. These negative margins have contributed to the well-documented decline in the number of acute psychiatric inpatient beds over the past decade, delaying or impeding access to care for patients, including Medicare beneficiaries.[1] This results in patients boarding in emergency departments or being discharged prematurely; in worst-case scenarios, inaccessible treatment results in homelessness or involvement with the criminal justice system. If reimbursement rates for psychiatric hospitalizations continue to fail to cover the cost to deliver care this treatment option may cease to be available. **As CMS contemplates additional refinements, we urge you to ensure that mechanisms are put in place to capture costs (i.e.,**

[1] APA Report on "The Psychiatric Bed Crisis in the US: Understanding the Problem and Moving Toward Solutions", May 2023. https://www.psychiatry.org/psychiatrists/research/psychiatric-bed-crisis-report

**staffing, capital expenses, pharmaceuticals, emerging evidence-based interventions) accurately now and in the future with as little administrative burden as possible.**

**Increase in the Electroconvulsive Therapy (ECT) Payment per Treatment**

**We strongly support CMS's proposal to positively update payment rates for ECT.** ECT has proven to be a safe and effective treatment for patients with psychiatric illness including severe depression, mania, catatonia and suicidal thoughts or behaviors, and has been shown to be particularly effective in the geriatric population.[2] ECT is widely viewed as the most efficacious treatment available for severe mood disorders. Despite this, over recent decades hospitals have become less likely to offer ECT, [3,4,5] and substantial socio-demographic inequities exist in the ability of patients to receive treatment with ECT.[6,7,8] The decline in providing ECT in the inpatient setting not only impacts patients receiving care while hospitalized but also results in a decrease in ECT post-discharge. An increasing number of hospitals have limited ECT to hospitalized patients; effectively ending access to patients who receive ECT on an ambulatory basis, including those requiring maintenance ECT post discharge.

Increasing payments for ECT will enhance patient access to this evidence-based mode of treatment by ensuring its sustainability within the inpatient setting. This, in addition to supporting our request to add ECT to the list of covered procedures in the Ambulatory Surgical Center setting, increases the likelihood that patients can complete their course of treatment. These steps not only improve patient outcomes but have been shown to reduce hospital admissions and readmissions[9] and align with CMS's commitment to improving healthcare outcomes and access for patients with psychiatric conditions. **We urge CMS to adopt the proposed payment rates.**

---

[2] Meyer JP, Swetter SK, Kellner CH. Electroconvulsive Therapy in Geriatric Psychiatry: A Selective Review. Clin Geriatr Med. 2020;36(2):265-279. doi:10.1016/j.cger.2019.11.007

[3] American Psychiatric Association: The practice of electroconvulsive therapy: recommendations for treatment, training, and privileging (A task force report of the American Psychiatric Association), Third Edition. Washington, DC, American Psychiatric Association, 2024.

[4] Demchenko I, Blumberger DM, Flint AJ, Anderson M, Daskalakis ZJ, Foley K, Karkouti K, Kennedy SH, Ladha KS, Robertson J, Vaisman A, Koczerginski D, Parikh SV, Bhat V. Electroconvulsive Therapy in Canada During the First Wave of COVID-19: Results of the "What Happened" National Survey. J ECT. 2022 Mar 1;38(1):52-59. doi: 10.1097/YCT.0000000000000801. PMID: 34519681; PMCID: PMC8875437.

[5] Maixner DF, Weiner R, Reti IM, Hermida AP, Husain MM, Larsen D, McDonald WM. Electroconvulsive Therapy Is an Essential Procedure. Am J Psychiatry. 2021 May 1;178(5):381-382. doi: 10.1176/appi.ajp.2020.20111647. PMID: 33979536.

[6] Slade EP, Jahn DR, Regenold WT, Case BG. Association of Electroconvulsive Therapy With Psychiatric Readmissions in US Hospitals. JAMA Psychiatry. 2017;74(8):798-804. doi:10.1001/jamapsychiatry.2017.1378

[7]Dennis PA, Thomas SN, Husain MM, Dennis NM. Racial Disparities in the Administration of ECT in Texas, 1998-2013. J ECT. 2019;35(2):103-105. doi:10.1097/YCT.0000000000000555

[8] Black Parker C, McCall WV, Spearman-McCarthy EV, Rosenquist P, Cortese N. Clinicians' Racial Bias Contributing to Disparities in Electroconvulsive Therapy for Patients From Racial-Ethnic Minority Groups. Psychiatr Serv. 2021;72(6):684-690. doi:10.1176/appi.ps.202000142

[9] Ibid.

**RFI for Patient Assessment Index**

APA has concerns about the development of a Patient Assessment Index (PAI) in the inpatient psychiatric facility setting as the reasons for admission of patients with mental health or substance use disorders vary widely as do their needs. The reporting requirements for this measure have the potential to add a significant administrative burden. We understand the previous implementation of this index in the post-acute care setting was problematic. We think it would be equally difficult to implement the index in the IPF setting as well.

**If CMS proceeds with the development of the PAI, APA would like to emphasize the importance of ensuring measurements are standardized only in areas that are more easily universally measured. We recommend focusing on the measurement of function rather than symptoms, as existing symptom measurement strategies would not be sufficiently broadly applicable to meaningfully assess or improve quality in care.**

In response to CMS's question "Are there PAIs currently available for use, or that could be adapted or developed for use in the IPF-PAI, to assess patients': (1) functional status; (2) cognitive function and mental status; (3) special services, treatments, and interventions for psychiatric conditions; (4) medical conditions and comorbidities; (5) impairments; (6) health disparities; or (7) other areas not mentioned in this RFI?" APA identified the functional status category above as the one area we think standardized measures could be implemented. Cognitive function and mental status are quite variable, and the same tools cannot and should not be used for every patient. This applies even more for special services, treatments, and interventions for psychiatric conditions. As an example, a patient presenting with delusions and hallucination would be assessed very differently from a patient presenting with suicidal ideation and severe depression or a patient with Post-Traumatic Stress Disorder. Comorbidities, impairments, and disparities all require individualized consideration and would be difficult to standardize.

It is also important for CMS to only consider standardized tools in the public domain and not those that are proprietary or incur a cost for utilization. Some examples of public domain measures of function include the Friendship (NIH toolbox), Companionship (PROMIS), Social Isolation (PROMIS), Physical Function (PROMIS), Ability to Participate in Social Roles and Activities (PROMIS). Most of these can be found at https://www.healthmeasures.net/.

**Proposed Addition of the 30-day ED Visit Quality Measure in IPFQR**

APA is concerned that adoption of this measure in the IPFQR will have several unintended consequences. If the overall goal is to reduce hospital admission and Length of Stay (LOS), Emergency Department (ED) visits should not be seen as a failure. If clinicians are penalized for ED visits, they may keep a patient in the hospital longer initially which would likely be more costly

than an ED visit. While establishing outpatient follow-up is the priority, resources in some communities are limited. Patient SDOH factors such as being unhoused, without a phone, without transportation, etc. can also limit the patients' ability to seek outpatient care.

In addition, attribution could be a major problem. Many private inpatient psychiatric facilities do not have an affiliated ED. With interoperability still a huge barrier between hospital systems, it is difficult for a clinician to be aware when a patient is seen in the ED and should not be penalized for it.

As noted in the proposed rule, the measure was not endorsed by the CBE. They cited concerns over inpatient clinicians being able to influence follow-up care, and 40% of the group voted not to endorse the measure.

CMS states "As discussed in section V.B.2.a of this proposed rule, an all-cause measure would complement the IPF Unplanned Readmission measure, would emphasize whole-person care, and would capture visits to the ED for patients with physical symptoms associated with mental health conditions. Additionally, evidence shows that there are interventions that reduce post-discharge acute care. These include adopted care transition models, proactively connecting patients with post-discharge providers, identifying and addressing patients' barriers to post-discharge care, and focusing on providing patient-centered care and improving patient experience of care." There are already 3 measures being tracked that look at discharge and readmission: (1) Follow-up After Psychiatric Hospitalization (FAPH); (2) Medication Continuation Following Inpatient Psychiatric Discharge; and (3) Thirty Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization (CBE #2860, the IPF Unplanned Readmission measure). Each of these measures serves a unique role in assessing care coordination and post-discharge outcomes. **Adding an ED visit measure is overly punitive and will not improve the quality of care for patients discharged from psychiatric facilities.**

Thank you for your review and consideration of these comments. If you have questions or want to discuss these comments in more detail, please contact Becky Yowell (byowell@psych.org) Director, Reimbursement Policy and Quality.

Sincerely,

Saul Levin, MD, MPA, FRCP-E, FRCPsych
CEO & Medical Director
American Psychiatric Association