AMERICAN PSYCHIATRIC ASSOCIATION

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

May 28, 2024

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS–1808–P,
Baltimore, MD 21244–8013

Re: File code CMS–1808–P; Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes

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 this opportunity to comment on the Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates. Our comments focus specifically on issues that affect the care of patients with mental health and substance use disorders (MH/SUDs).

Proposed Changes to the MS–DRG Diagnosis Codes for FY 2025

SDOH—Inadequate Housing/Housing Instability

APA supports CMS's proposal to change the severity level designation for diagnosis codes Z59.10 (Inadequate housing, unspecified), Z59.11 (Inadequate housing environmental temperature), Z59.12 (Inadequate housing utilities), Z59.19 (Other inadequate housing), Z59.811 (Housing instability, housed, with risk of homelessness), Z59.812 (Housing instability, housed, homelessness in past 12 months) and Z59.819 (Housing instability, housed unspecified) from Non Complication or comorbidity (NonCC) to Complication or Comorbidity (CC) for FY 2025.

Social determinants of health, including those related to housing, have an impact on mental health. In addition to being risk factors for mental illness including substance use disorders (e.g., discrimination, unemployment, housing instability, food insecurity, poor access to healthcare), these same exposures are frequent

consequences of serious mental illnesses and substance use disorders. These are likewise the drivers of the comorbid medical conditions that produce early mortality and significant morbidity for psychiatric patients.

Patients impacted by SDOH require additional resources during their inpatient stay. Those experiencing homelessness not only need assistance in finding housing prior to discharge, but treatment plan modifications and discharge planning may be made more complex depending on housing options and outpatient clinical resources readily available and near one another. These patients are at an increased risk for non-compliance with their medication, relapse/readmission, and suicide. This can be further compounded by a lack of social safety nets and an insufficient continuum of care in the community.

Causally Specified Delirium

APA appreciates CMS's consideration of the request to change the severity level designations of the ICD–10–CM diagnosis codes that describe causally specified delirium from CC to MCC when reported as secondary diagnoses **however we urge CMS to reconsider their proposal to maintain the current designation of CC.**

As we stated in our letter of support for the change, delirium, and encephalopathy (currently specified as a MCC) are often used interchangeably and refer to a shared set of acute neurocognitive conditions that require additional resources to treat. Every person with delirium has an underlying toxic or metabolic encephalopathy, and the vast majority of people who receive a diagnosis of toxic or metabolic encephalopathy will have delirium. As noted in a 2022 article in the Journal of the Academy of Consultation-Liaison Psychiatry, "The diagnosis of delirium is further complicated by the differing nomenclature among medical specialties. While psychiatry, geriatrics, intensive care medicine, and anesthesiology have adopted the term *delirium*, neurology and general internal medicine have favored the term *acute encephalopathy*."[1]

There is also evidence to suggest that delirium is underdiagnosed/identified and/or classified as encephalopathy. A 2023 study using a natural language processing algorithm to identify delirium episodes found a higher rate of cases at 7.36 per 100 hospitalizations vs code-based rates at 3.02 per 100 hospitalizations.[2]

This documented inconsistency has an impact on the data available for analysis; an issue that was noted by CMS in their analysis of the SDOH claims data. Diagnoses could be skewed for a number of reasons including the potential for a higher level of reimbursement that more appropriately accounts for the cost of care. There is robust literature detailing the impact of delirium on care complexity and costs,

[1] Franks J, Anderson J, Bowman E, Li C, Kennedy R, Yun H. Inpatient Diagnosis of Delirium and Encephalopathy: Coding Trends in 2011–2018. Journal of the Academy of Consultation-Liaison Psychiatry, Volume 63, Issue 5, 2022, Pages 413-422, ISSN 2667-2960, https://doi.org/10.1016/j.jaclp.2021.12.006. (https://www.sciencedirect.com/science/article/pii/S2667296021002007)

[2] St. Sauver J, Fu S, Sohn S, et al. Identification of delirium from real-world electronic health record clinical notes. Journal of Clinical and Translational Science. 2023;7(1):e187. doi:10.1017/cts.2023.610

readmissions, rates of functional decline, institutionalization, cognitive decline, subsequent dementia diagnosis, and mortality.[3,4]

A change in the status from CC to MCC is essential to recognizing the clinical importance of delirium and, crucially, the tremendous costs associated with it.[5,6] Placing delirium and encephalopathy on par with toxic (G92) and metabolic (G93.41) encephalopathy (TME) in terms of reimbursement is intended to facilitate systematic efforts to detect delirium as recommended across specialties and settings[7,8] thereby enhancing awareness of delirium and its dire impact on patients, their families, care delivery, and healthcare systems.[9] **The ultimate goal of this change is to improve the clinical care and outcomes of cognitively vulnerable patients. We urge CMS to designate delirium as a Major Complication or Comorbidity.**

Patient Safety Structural Measure RFI

Overall, APA supports the idea of the Patient Safety Structural Measure. Domain 2 highlights concerns we've identified in the workplace violence space. This is a big issue especially for mental health clinicians. APA asks that CMS provide resources to implement curriculum to improve workplace safety and not allow this to be a "check the box" exercise with variable results.

APA is concerned about the lack of partial credit within a domain. **We urge CMS to allow partial credit for the first few years to ensure the measure does not have unintended consequences.**

APA supports anything that can be done to align this measure with existing reporting structures to reduce administrative burden. We are concerned about the administrative burden the 5 domains of the measure could add. We also have concerns that community and rural hospitals will face greater burden than larger hospital systems. The Joint Commission already requires most, if not all the domains to be tracked and reported to them, as do counties, ACGME and states.

Providing resources to implement curriculum to improve workplace safety, allowing partial credit during the initial implementation to identify any unintended consequences, and reducing the administrative burden by aligning with existing reporting mechanisms, would be meaningful steps in addressing this serious issue.

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[3] Dziegielewski C, Skead C, Canturk T, et al. Delirium and Associated Length of Stay and Costs in Critically Ill Patients. Crit Care Res Pract. 2021;2021:6612187. Published 2021 Apr 24. doi:10.1155/2021/6612187

[4] Kinchin I, Mitchell E, Agar M, Trépel D. The economic cost of delirium: A systematic review and quality assessment. Alzheimers Dement. 2021 Jun: 17(6):1026-1041.doi: 10.1002/alz.12262.Epub 2021 Jan. PMID: 33480183.

[5] Slooter AJC, Otte WM, Devlin JW, et al. Updated nomenclature of delirium and acute encephalopathy: statement of ten Societies. Intensive Care Med 2020;46(5):1020-1022. DOI: 10.1007/s00134-019-05907-4.

[6] Oldham MA, Holloway RG. Delirium disorder: Integrating delirium and acute encephalopathy. Neurology 2020;95(4):173-178. DOI: 10.1212/WNL.0000000000009949.

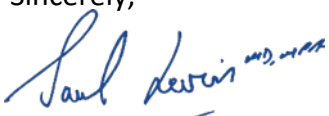
[7] National Institute for Health and Clinical Excellence. Delirium: prevention, diagnosis and management in hospital and long-term care. (Clinical guideline) (https://www.nice.org/uk/guidance/cg103).

[8] American Geriatrics Society Expert Panel on Postoperative Delirium in Older A. American Geriatrics Society abstracted clinical practice guideline for postoperative delirium in older adults. J Am Geriatr Soc 2015;63(1):142-50. DOI: 10.1111/jgs.13281.

[9] Wilson JE, Mart MF, Cunningham C, et al. Delirium. Nat Rev Dis Primers 2020;6(1):90. DOI: 10.1038/s41572-020-00223-4.

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,



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