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September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1786-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1786-P; Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Proposed Changes to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction

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 hospital outpatient prospective payment system and quality reporting programs.

We appreciate the Administration's commitment to 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. Our comments focus on supporting the adoption of evidence-based treatment for mental health and substance use disorders (SUD) through coverage and reimbursement for Intensive Outpatient Programs and Suicide Prevention in the Hospital OQR Program.

Intensive Outpatient Services (IOP)

We applaud CMS' decision to provide coverage for Intensive Outpatient Programs (IOPs). IOPs have been shown to be an effective model of care for individuals with mental health and/or substance use disorders who either require a higher level of care than standard outpatient services or a lower level of care than partial

hospitalization services.^{1,2} Virtual delivery of partial hospitalization programs (PHP), a higher level of care, have been demonstrated throughout the COVID-19 PHE to be an effective way of delivering quality care to those with serious mental illness.^{3,4} It allowed people to access high-intensity services without incurring significant costs to travel or stay elsewhere, as well as allowing patients to keep working remotely while receiving services, without reductions in effectiveness or retention. In defining the IOP benefit, CMS has the opportunity to build on this success by allowing IOP to be delivered to patients in their home and community settings if the clinician determines that it would be the appropriate modality for the specific patient. At a minimum, APA encourages CMS to allow IOP in home and community-based settings as we gather data about the effectiveness of the intervention. **APA supports Medicare coverage of IOPs (both in-person and virtual), as it is an important component in the continuum of care for patients with mental health or substance use disorders, including the ability to provide care via telehealth.**

As we have stated in prior comments, APA members have reported that Medicare rates for partial hospitalization services are inadequate to cover the cost of care. **We strongly urge CMS to set payment rates that cover the cost of providing the service.** PHPs are an important component in the continuum of care that has been shown to be effective in improving outcomes.

Solicitation of Comments on Behavioral Health and Suicide Prevention in the Hospital OQR Program

CMS seeks broad input on behavioral health as a measurement topic area in the Hospital OQR Program based on, but not limited to, the following matters: (1) priorities for measuring outcomes of outpatient behavioral health services, particularly by setting within the hospital outpatient department; and (2) quality measure approaches to improve behavioral health access in outpatient settings.

The Joint Commission's [National Patient Safety Goal 15.01.01](#), on Suicide Prevention in Health Care Settings, requires hospitals accredited by the Joint Commission to screen ED patients, and hospitalized patients in non-behavioral health beds, aged 12 and over for suicide risk "who are being evaluated or treated for behavioral health conditions as their primary reason for care." For patients in non-behavioral health outpatient care settings, the Joint Commission has no requirements for suicide risk screening. Some hospitals have implemented *universal* suicide risk screening, *i.e.*, for all patients (over a certain age, typically 10-12), either as a voluntary quality improvement initiative or as part of research. Voluntary universal screening programs include [Parkland Health and Hospital System in Dallas, since 2015](#); and [the Veterans Administration, since 2018](#). We also note that [California recently passed a law mandating universal screening of all patients in acute care hospitals starting in 2025](#)

It has been shown that universal suicide risk screening of adult ED patients [approximately doubles](#) the

¹ <https://pubmed.ncbi.nlm.nih.gov/24445620/>

² <https://pubmed.ncbi.nlm.nih.gov/35029316/>

³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9790325/>

⁴ <https://pubmed.ncbi.nlm.nih.gov/34245028/>

number (from 3 to 6%) of patients identified as needing care for acute/emergent suicide risk. Also, findings from universal ED screening programs suggest that the patients identified because of universal screening are genuine cases, in the sense of having similar risk factors, and similar downstream rates of suicide attempt and death, as the patients identified via current usual care. And, under current usual care, those rates are very high, e.g., [Californians with ED visits involving intentionally self-inflicted injury](#) were some 56 times more likely than demographically similar Californians overall to die by suicide in the next year, while Californians with ED visits involving suicidal ideation were some 31 times more likely to die by suicide in the subsequent year.

Based on available evidence, we view wider/universal suicide risk screening of ED patients – beyond the current requirements of National Patient Safety Goal 15.01.01 – as both clinically appropriate and logistically feasible. However, many practitioners and facilities are currently reluctant or unwilling to expand suicide risk screening, for several related reasons. In particular, inpatient hospitalization is often thought to be indicated for individuals identified with elevated suicide risk. Inpatient admission can theoretically provide suicidal patients with [a safe environment, comprehensive psychiatric assessment, access to psychological and pharmaceutical treatment, and improved linkage with outpatient care](#), which may reduce suicide risk. However, hospitalization presents various challenges. Perhaps most immediately, there is [a shortage of psychiatric beds, overall and especially in certain areas/communities](#). Boarding patients in the ED until an inpatient bed becomes available is [expensive, may adversely affect EDs in various ways](#). Further, there [isn't clear evidence that hospitalizing patients for suicide risk improves outcomes](#); it too may cause iatrogenic harm; and concerns about hospitalization, especially on an involuntary basis, may deter care-seeking.

Together, these factors underscore the urgency and value of expanding availability of evidence-based interventions for ED patients with suicide risk, within the ED and after discharge, as clinically appropriate alternatives to hospitalization – such as the two interventions addressed here, the [Safety Planning Intervention](#) (SPI) and the [Post-Discharge Telephonic Follow-up Contacts Intervention](#) (FCI). These are clinically effective and relatively cost-effective; logistically feasible in real-world practice, although not yet widely available as standard care; and furnishing them requires limited direct involvement by licensed behavioral health or other practitioners – an important benefit in its own right, given the widespread shortages of such providers. Crisis stabilization facilities can provide a safe and therapeutic alternative to hospital EDs and inpatient admission and are a critical component of SAMHSA's vision for crisis systems in which everyone has someone to call (988), someone to respond (mobile crisis teams), and a safe place to go (crisis facilities). Crisis facilities are typically staffed with an interdisciplinary team of psychiatrists, nurses, social workers, behavioral health technicians, and peers, and they may be freestanding or adjacent to an ED or hospital. Facility-based crisis care is associated with reduced hospitalization and ED boarding. However, crisis facilities vary widely in scope, capability, and populations served. This is because they are not currently reimbursed by Medicare and most private insurance plans but instead financed and regulated at the state level via Medicaid and SAMHSA block grant funds. We urge CMS to develop standard definitions for facility-based crisis care and payment for these services.

Currently, there is not an established infrastructure or payment mechanism to ensure that suicide screenings are conducted consistently. With respect to payments, there is no way to be appropriately reimbursed for Safety Planning Intervention (SPI), the best clinical practice and standard of care for ED patients identified with suicide risk. Specifically, there is no Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) code that may be reported separately from other services furnished during an ED visit and for which the staffing and other elements align with effective and efficient furnishing of SPI. Therefore, enabling effective and efficient implementation of SPI for ED patients -- an effective alternative to hospitalization when indicated -- will likely require a new designated payment mechanism. Adoption of SPI and FCI for suicide prevention would additionally be enhanced if their payment mechanisms could be implemented without requirements for directly-associated patient cost-sharing – in any care setting, but most importantly in ED and inpatient care. We are not aware of any current or prior implementation of either of these interventions that has required patient cost-sharing; we worry that some patients will decline consent to receive either or both of these interventions – which are designed to be furnished proactively by the health system – if patient cost-sharing is required. Zero patient cost-sharing would also streamline service delivery, because staff would not need to obtain and document active patient consent for these interventions.

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 (QualityandPayment@psych.org) Director, Reimbursement Policy and Quality.

Sincerely,

A handwritten signature in blue ink that reads "Saul Levin" with "M.D., M.P.A." written in smaller letters to the right.

Saul M. Levin, M.D., M.P.A., FRCP-E, FRCPsych
CEO and Medical Director