



**American Hospital
Association**

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June 25, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1588-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital PPS and FY 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers; Proposed Rule (Vol. 77, No. 92), May 11, 2012

Dear Ms. Tavenner:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our nearly 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) hospital inpatient prospective payment system (PPS) proposed rule for fiscal year (FY) 2013.

This letter addresses only the inpatient psychiatric facility quality reporting (IPFQR) program proposals contained in the inpatient PPS proposed rule. The AHA submitted two separate letters concerning the agency's proposals on the inpatient and long-term care hospital payment systems. With regard to the IPFQR program, we strongly support the reporting of quality measures by inpatient psychiatric units and hospitals, and we support many of CMS's detailed proposals. However, we are concerned that the inpatient psychiatric facility (IPF) units within general acute hospitals, which represent more than two-thirds of IPFs, will have difficulty beginning the IPFQR program on October 1 because IPF units have never before reported quality measures. As we have seen with other quality reporting programs, providers need adequate time to build the infrastructure necessary to accurately collect and report data, and these IPFs cannot accomplish this task by October 1. Therefore, **we urge CMS to delay implementation of data collection for the IPFQR program for six months until April 1, 2013.**

Our detailed comments are attached. If you have any questions, please feel free to contact me or Lisa Grabert, senior associate director for policy, at (202) 626-2305 or lgrabert@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President



INPATIENT PSYCHIATRIC FACILITY HOSPITAL QUALITY REPORTING

The Patient Protection and Affordable Care Act (ACA) mandated that reporting of quality measures for IPFs begin no later than FY 2014, which begins October 1, 2013. Failure to report quality measures will result in a 2 percent payment penalty to the IPF's annual market basket update. According to CMS's proposed rule, data reporting on quality measures for IPFs is slated to begin with discharges occurring on or after October 1, 2012. CMS proposes six measures to be used to begin the IPFQR Program. Hospitals' experience with data collection and public reporting of quality metrics demonstrates that it takes time to identify and train staff, develop and refine a data collection and validation process and otherwise prepare to report data.

We are concerned that the majority of IPFs will not be ready to begin the IPFQR program on October 1 because they have had inadequate time to prepare. Thus, we urge CMS to delay the start of the data reporting to CMS by six months until April 1, 2013. Further, we urge CMS to engage in a communication campaign at least six months prior to the beginning of the data collection period to alert IPFs that they must report quality measures. The May 11 release of the proposed rule was the first formal communication from CMS to IPFs that the IPFQR program would begin on October 1. Giving IPFs less than five months advance notice is unacceptable. Several quality reporting programs were mandated by the ACA to begin no later than FY 2014. For two of those programs, the long-term care hospital and inpatient rehabilitation facility quality reporting programs, CMS used the FY 2012 rulemaking cycle to propose the initial program parameters. However, CMS did not include proposals for the IPF program in last year's rulemaking cycle. As a result, IPFs have not had proper notice that the IPFQR program would begin with discharges on October 1. By delaying the start of the IPFQR program until April 1, 2013, CMS could use the much-needed additional time to educate IPFs on the new program.

Helping Hospitals Understand Program Eligibility. **We urge CMS to partner with the AHA on educating hospitals about which entities are required to participate in the IPFQR program.** It is the AHA's understanding that the majority of freestanding IPFs understand they are required to report quality measures to CMS, because the freestanding IPFs that are accredited by The Joint Commission (TJC) have been educated by the Commission about CMS's pending measure requirements. Freestanding IPFs represent approximately one-third of all eligible IPFs for the IPFQR program. However, we believe that the majority of IPFs that are units within acute inpatient hospitals – representing two-thirds of IPFs – are unaware of CMS's new quality reporting requirements because they are not currently reporting any quality measures. In our conversations with TJC, we understand that there are only approximately 62 out of more than 1,200 within-unit IPFs that are reporting quality measures to TJC.

Further, these within-unit IPFs may not know that the ACA requirement applies to them because they do not fully understand the nuance of how services are billed. Some within-unit IPFs bill under the IPF PPS and others bill under the inpatient PPS. Only those within-unit IPFs that bill using the IPF PPS are required to submit quality measures to the IPFQR program. CMS has a list of all within-unit IPFs who bill under the IPF PPS. We urge CMS to notify these within-unit IPFs that they are required to participate in the IPFQR program. The AHA also intends to issue a *Quality Advisory* to its members instructing within-unit IPFs to contact their billing departments to ascertain

under which payment system services are billed to determine whether these IPFs are required to participate in the IPFQR program.

Program Start and Data Reporting Timeframes. We believe that the requested six-month delay for beginning the IPFQR program corresponds well with CMS's proposals for data reporting in this program. We discuss each of the data reporting timeframes below.

Removal of FY 2014 Data Reporting Requirements. **We do not support the data reporting period, submission period or preview period CMS has proposed for FY 2014.** For FY 2014, CMS proposed to include reporting on discharges from October 1, 2012 through March 31, 2013. As referenced above, IPFs need a minimum of at least six months advance notice of an impending quality reporting requirement. In our view, the data reporting periods will only work if CMS begins by initiating the requirement in April and continues as follows:

- For FY 2014 payment, the data reporting period would begin with discharges on or after April 1, 2013. Any IPF that has registered and begun to collect data would qualify for a full update.
- For FY 2015 payment, the data reporting period would be April 1, 2013 through December 31, 2013, and IPFs would be required to successfully submit data on patients discharged during this period and to allow their performance rates to be publicly displayed unless there were too few cases to protect patient confidentiality and ensure some reliability of the performance scores.
- For FY 2016 payment, the data reporting would include all patients discharged between January 1, 2014 and December 31, 2014.

Delay of FY 2016 Data Reporting Requirements. **We urge CMS to delay finalizing the specific data reporting requirements for the FY 2016 IPFQR program until the FY 2014 rulemaking cycle.** It is not necessary to finalize requirements for the FY2016 program at this time, and that will enable the agency to be more flexible if the data collection efforts do not go as well as planned.

Accepting Data from The Joint Commission. **We urge CMS to work with TJC to establish a process where data can be transmitted directly.** Approximately one-third of IPFs report the proposed measures to TJC as a core measure requirement for accreditation. Rather than require these IPFs to also submit data to CMS, we urge CMS to partner with TJC to establish a process where the data can be automatically exchanged. This will significantly reduce the burden of data reporting for accredited IPFs.

Submission of Aggregate Data. **We support CMS's proposal to require aggregate data (numerator, denominator and exclusions) for the IPFQR program.** Unlike other quality reporting programs, CMS proposes to require aggregate data submission in the IPFQR program, rather than individual patient-level data. CMS is proposing collection of aggregate data to more closely align with data collection methods proposed in Stage 2 of the meaningful use program. Although CMS is requiring only aggregate data, this does not reduce any burden on hospitals. IPFs are still required to collect individual data on each patient.

Measures. CMS proposes six measures to begin the IPFQR program. The measures are discussed below in pairs.

Hours of Physical Restraint and Seclusion Use. **We support the proposed measures for hours of restraint and seclusion use.** These measures capture the total number of hours for all psychiatric inpatients who are maintained in physical restraint or held in seclusion divided by the total number of psychiatric inpatient hours.

Patients Discharged on Multiple Antipsychotic Medications. **We support the concept of these measures; however, we do not support inclusion of these measures without several key modifications.** We urge CMS to work with the measure developer to capture the concept of these measures differently. Currently, there are two measures to capture prescription of antipsychotic medications. The first measure captures the overall rate of patients who are discharged with two or more antipsychotic medications. For this measure, CMS states that lower rates are indicative of higher quality.

The second measure captures the same information but considers “appropriate justification” for discharging patients on multiple antipsychotics for three reasons: 1) documentation of a history of a minimum of three failed trials of monotherapies; 2) documentation of a recommended plan to taper to monotherapy or documentation of a plan to decrease the dosage of one or more antipsychotic medications while increasing the dosage of another antipsychotic medication to a level that manages the patient’s symptoms with one antipsychotic medication (that is, cross-taper); and 3) documentation of augmentation of Clorzapine. For this measure, CMS states that higher rates are indicative of higher quality.

CMS states that when taken together, these measures help reduce unnecessary use of multiple antipsychotics. However, we are concerned that reporting these measures together will confuse the public. One measure recognizes better performance with a lower rate, and the other measure recognizes performance with a higher rate. It is difficult to report two measures with very different performance goals in tandem and expect the public to fully grasp the goal of the measures. Rather than focus on two measures, we urge CMS to work with the measure developer to capture these concepts in one measure. The numerator should capture the overall rate of patients who are discharged with two or more antipsychotic medications with exclusions for each of the “appropriate justifications” referenced above. The denominator would remain the same.

Post-discharge Planning. CMS proposes two post-discharge measures. **We support the post-discharge measure for transitioning a care plan, with one modification; however, we do not support the creation of a post-discharge plan measure.** The first measure captures psychiatric inpatients for whom the post-discharge continuing care plan was transmitted to the next level of care. This measure includes the following exclusions: patients who died; patients with an unplanned departure resulting in discharge due to elopement; patients who refused (or whose guardians refused) aftercare; patients who refused to sign (or whose guardians refused to sign) authorization to release information; and patients with an unplanned departure resulting in discharge due to failing to return from leave. Our members have raised concerns that the measure may not exclude patients from whom there is no next level of care available. For example, many psychiatric

facilities treat uninsured homeless patients. These patients may not have any options within a community to pursue effective follow-up care. We urge CMS to work with the measure developer to add an exclusion to the measure to allow IPFs to handle this situation. The second measure captures whether a post-discharge care plan was created for all discharged patients. While we support the concept of this measure, we do not support the measure because it is simply a “check-the-box” measure that does not accurately assess important steps in delivering high quality care.

Registering for the Program. We support all of CMS’s proposals regarding registration for the IPFQR program. IPFs need to register for the quality reporting program on QualityNet (www.qualitynet.org). After logging into QualityNet, IPFs must designate an Administrator and complete a Notice of Participation (NOP). The NOP must be submitted between January 1, 2013 and August 15, 2013. As we referenced above, CMS could consider submission of the NOP as the requirement in which it determines whether a hospital is eligible to receive the market basket update for FY 2014.

Sampling of Patients to Populate Measures. We support all of CMS’s proposals regarding sampling for the IPFQR program. We feel providing data on all patients, not just Medicare patients, is important for this program. We also feel that the sampling requirements specified in TJC’s measure manual are appropriate.

Reconsideration. We support all of CMS’s proposals for reconsideration of IPFQR data. CMS proposes to give hospitals 30-days from the date identified on the payment determination notification letter to file a reconsideration.

Waiver for Extenuating Circumstances. We support all of CMS’s proposals for the waiver process when natural disasters occur. CMS proposes to allow IPFs to submit a request for a waiver of data submission when a natural disaster occurs. This would allow IPFs to receive the full market basket update, without submitting required data during a natural disaster.