American Hospital Association

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June 25, 2014

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

RE: CMS-1606-P, Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System-Update for Fiscal Year Beginning October 1, 2014 (FY 2015); Proposed Rule, May 6, 2014.

Dear Ms. Tavenner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including our more than 1,660 behavioral health care providers, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) inpatient psychiatric facility (IPF) prospective payment system (PPS) proposed rule for fiscal year (FY) 2015. Our comments focus on CMS's proposals for the IPF quality reporting (IPFQR) program.

The AHA believes that CMS's implementation of the IPFQR program was an important step forward for behavioral health care. We strongly agree that the public deserves reliable, accurate and important information on the quality of care provided in IPFs, and that IPFs benefit from the opportunity to use IPFQR data to benchmark and improve performance. CMS launched this program in October 2012 with six measures assessing aspects of IPF care. It now seeks to address a broader range of topics by proposing a total of six new measures for FYs 2016 and 2017. The proposed measures include the use of patient experience surveys and electronic health records (EHRs), tobacco cessation screening and treatment, and patient and health care personnel (HCP) influenza vaccination.

The AHA is disappointed, however, that most of the proposed measures – especially the patient experience survey and EHR use measures – provide limited insight on the quality of the behavioral health and substance abuse treatments and services at the center of IPF care. While we appreciate that there are few rigorous IPF-specific measures available to CMS, we believe that the public and providers deserve information far more relevant to the care provided in IPFs than will be generated by the proposed set of measures. Given the widely recognized importance of addressing behavioral health care needs, we would strongly support efforts to develop measures more relevant to IPF care in the future. Our detailed comments on each of CMS's proposals follow.

FY 2016 IPFQR MEASURE PROPOSALS

CMS proposes to add two structural "measures" to the FY 2016 IPFQR program – one assessing whether the IPF uses a patient experience survey, and another asking about the extent to which the IPF has implemented an EHR.

IPF ASSESSMENT OF PATIENT EXPERIENCE

CMS proposes to require IPFs to submit, as part of FY 2016 measure reporting, information about whether they routinely conduct patient experience surveys using a standardized tool, and which survey tool is used. CMS indicates that these data would be used to help inform future efforts to implement a single patient experience survey for all IPFs. CMS finalized this measure for *voluntary* submission in the FY 2014 inpatient PPS final rule; however, CMS now proposes to *require* IPFs to submit this information.

The AHA does not support the addition of this measure to the IPFQR. We fully support the notion that hospitals – all hospitals – should be seeking information from their patients about their experiences while being treated by the hospital. To that end, we support the use of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) as a nationally standardized survey that can provide useful information and performance benchmarks in general acute care hospitals. We also support the concept of having a well-tested, effective, nationally endorsed patient experience survey used in IPFs. Using such standardized patient experience surveys can give consumers important information on what to expect if they choose to use an IPF, and can give IPF leaders important information on what their patients are seeing or experiencing so they can focus improvement efforts on areas where performance could be improved.

We appreciate that the proposed measure is part of a longer-term effort by CMS to implement a standardized patient experience assessment tool for all IPFs, which the AHA strongly supports. **However, we are concerned that the use of this measure in the context of a quality reporting program would provide very limited insight to patients on the actual experience of care in IPFs. Moreover, while it requires relatively little effort for IPFs to report the measure, the results cannot be used to make care better in IPFs.** Similarly, asking a broad question about the use of EHRs does not provide meaningful, actionable information to patients or hospital leaders. These measures appear to be much more appropriate as survey questions that could be used for policy development efforts. Thus, **if CMS seeks to understand what survey tools for psychiatric patients exist and what proportion of IPFs use those tools and what proportion use EHRs, then the AHA would be pleased to work with the agency to ascertain this information. We believe these questions could be answered much more quickly through surveys than by inserting them into a measurement program and then waiting more than a year for the answers.**

Further, neither proposed measure is endorsed by the National Quality Forum (NQF), nor supported for use in the IPFQR program by the multi-stakeholder Measure Applications

Partnership (MAP). In fact, neither measure, as currently constructed, is truly a quality measure. With respect to the patient experience measure, we strongly believe that IPF patients should have the ability to provide feedback on their care experience. However, this measure does not directly assess the patient experience in IPFs; rather, it simply asks what survey instruments IPFs use. Given that there is not yet consensus on an assessment tool that accurately reports IPF patient experience, it is not clear how the public could use this measure to judge "good" versus "bad" performance. Moreover, we are concerned that the measure includes no specific definition of a "standardized tool" for assessing the patient experience. Thus, there would be little consistency to the results obtained by CMS.

Instead of implementing this measure, we strongly encourage CMS to continue its efforts to develop a standardized patient assessment survey for IPFs. We also recommend the agency solicit a broader range of information on patient experience surveys than the name of the survey instrument to inform future patient experience survey development efforts**.** When CMS sought to develop the HCAHPS survey, it had a call for survey instruments and questions, and got a fair number of useful responses from a variety of survey vendors. The agency used this information very effectively. However, we note that CMS did not start its work toward developing a patient experience survey by requiring everyone to name the survey vendor they were using at the time. Rather, the HCAHPS survey blended the best available questions and survey approaches from a variety of sources.

Further, we note that the experience survey for IPF patients has some special challenges. Some IPF patients have behavioral disorders that make it difficult for them to reliably report their experiences. Others may be extraordinarily sensitive to privacy issues. Thus, the survey may need to be conducted with input from family members and caregivers, and soliciting input from others may pose particular challenges in preserving privacy. **For these reasons, the agency should undertake a more in-depth study of IPFs** to identify not only which survey instruments are used, but also the potential costs and operational barriers of implementing a standardized patient experience survey. The AHA would be pleased to assist the agency with such an effort.

IPF USE OF EHRS

IPFs do not currently participate in CMS's EHR Incentive Program, and are not subject to the reporting or EHR certification requirements of that program. However, in the proposed rule, CMS states its belief that the use of EHRs by IPFs can help improve patient care, support information exchange during care transitions and potentially facilitate the use of electronically specified clinical quality measures (eCQMs). Moreover, CMS indicates that it, along with the Office of the National Coordinator for Health Information Technology (ONC), is considering how to expand EHR certification into behavioral health and other care settings (e.g., post-acute care) not currently participating in the EHR Incentive Program. Based on these developments, CMS proposes a structural measure intended to assess how IPFs currently use EHRs during care transitions. Specifically, IPFs would be asked to attest to whether they most commonly use one of three mechanisms to "exchange" health information during care transitions: 1) paper-based information exchange, 2) EHRs certified by ONC, or 3) EHRs not certified by ONC.

The AHA agrees that the use of EHRs has the potential to improve the quality of care in IPFs. However, CMS presents no evidence in the rule that the mere presence of an EHR leads to better care in IPFs, and acknowledges that health IT policy for IPFs is still under development. For these reasons, we do not support the inclusion of the measure in the IPFQR.

The purpose of the IPFQR is to provide the public with usable, meaningful information about the quality of care in IPFs. Yet, the public reporting of this measure would yield little usable information and could potentially lead to confusion. For example, CMS does not state how consumers would be expected to judge "good" versus "poor" performance on this measure. In the absence of an EHR certification program for IPFs, we believe it would be inappropriate to rate those IPFs using either paper-based information exchange or "non-certified" EHRs as somehow having poorer performance than those using a "certified" EHR. The inclusion of a measure that lacks any definition of "good" versus "poor" performance in a public reporting program simply leads to confusion.

The AHA believes that the information the measure seeks about how IPFs are using EHRs could help to inform health IT policy development efforts for IPFs. For this reason, we would be pleased to work with CMS on conducting a survey of IPFs to obtain this information. We also believe that such a survey could help CMS gather information on other issues relevant to the development of health IT policy for IPFs, such as interoperability and privacy regulations that limit the sharing of patient behavioral health information among providers.

FY 2017 MEASUREMENT PROPOSALS

HEALTH CARE PERSONNEL (HCP) INFLUENZA VACCINATION

CMS proposes to add the same HCP flu vaccination measure to the IPFQR that it uses in a number of other quality reporting programs. The measure assesses the percentage of HCPs working in a facility for at least one day during flu season (i.e., October through March) who have received the flu vaccine. Measure data would be reported using the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) beginning with the 2015-2016 flu season.

The AHA supports this proposal. In 2011, the AHA Board of Trustees adopted a formal policy that encourages hospital workers to receive influenza vaccinations, as it is a highly effective way of preventing the spread of the flu in health care facilities.

INFLUENZA VACCINATION (IMM-2)

CMS proposes to add the same chart-abstracted patient influenza vaccination measure to the IPFQR that is currently in the hospital inpatient quality reporting (IQR) program. The measure assesses the percentage of patients discharged during influenza season (i.e., October through March) screened for flu vaccine status and vaccinated, if indicated.

The AHA believes that IMM-2 is a promising addition to the IPFQR, and agrees that vaccination can keep patients healthier, and reduce the spread of influenza. However, we recommend that CMS pilot test the measure in IPFs before finalizing it for the program to ensure there are no negative unintended consequences of reporting it. It is not clear from the measure specifications currently posted to NQF's website, and the specifications reviewed by the NQF Population Health Committee in 2012, whether this measure has been tested in IPFs. Indeed, both sets of specifications suggest that the measure is specified for "Hospital/Acute Care Facility."[i] We agree that the measure has been adequately tested in medical/surgical acute care hospitals, and that it is reasonable for CMS to consider "importing" this measure to the IPFQR. However, it is important that measures be tested for the specific care settings in which they are used to ensure that they maintain their ability to accurately capture information.

We also urge CMS to use pilot testing to assess the potential for unintended consequences. For example, IPF patients have access to influenza vaccination in multiple settings prior to IPF admission, such as a primary care provider's office or acute care hospital. In other cases, patients simply may not know or forget their vaccination status. This creates the potential for patients being vaccinated more than is medically necessary. Additionally, the patient population for IPFs may present unique challenges both with obtaining an accurate vaccination history and for safely administering the vaccine. Many IPF patients have severe behavioral health disorders, and may have conditions that make them fearful or distrustful of health care providers. This may make obtaining an accurate vaccination history more difficult.

TOBACCO USE SCREENING (TOB-1) AND TOBACCO USE TREATMENT PROVIDED OR OFFERED (TOB-2/TOB-2A)

CMS proposes two related, chart-abstracted measures assessing whether IPFs screen patients for tobacco use status, and offer patients counseling and/or Food and Drug Administration (FDA)-approved nicotine replacement medication. TOB-1 assesses the proportion of patients screened within the first three days of admission for tobacco use (i.e., cigarettes, smokeless tobacco, pipe and cigar) within the previous 30 days. TOB-2/TOB-2a is a single measure reported as two rates. The overall rate (TOB-2) reflects the proportion of patients identified as tobacco users using the TOB-1 measure who **receive *or* refuse** counseling to quit, and **receive *or* refuse** FDA-approved tobacco cessation medications within the first three days following admission. The second rate (TOB-2a) is a subset of TOB-2 and assesses the proportion of tobacco use patients who ***actually receive*** medication and counseling.

CMS states that tobacco use is the single-largest contributor to disease in the country, and indicates that a tobacco screening measure would "encourage the uptake of tobacco cessation treatment and attendant benefits" for IPF patients. CMS originally intended to propose a different tobacco use measure; however, at the recommendation of the MAP, it instead proposes TOB-1 and TOB-2/TOB-2a. The AHA commends CMS for its responsiveness to the MAP's recommendations. We also strongly agree that tobacco use is an important public health issue, and that it deserves attention as a component of a patient's treatment plan.

However, we do not support the addition of TOB-1 and TOB-2/TOB-2a to the IPFQR. Instead, we recommend that CMS adopt one of the measures from the Hospital Based Inpatient Psychiatric Services measure set, HBIPS-1. This measure is already collected by most IPFs, captures much of the information on tobacco use that the agency seeks to collect with TOB-1 and TOB-2/TOB-2a, and facilitates a more holistic approach to addressing tobacco use. HBIPS-1 is an NQF-endorsed measure that requires IPFs to conduct a comprehensive screening of patients within three days of admission for a number of issues that would inform the course of their care in an IPF. Substance use – including the use of tobacco, alcohol and drugs – is included in this assessment, along with risk of violence to self or others, psychological trauma history and "patient strengths" (e.g., patient understanding of current medications). The majority of IPFs already collect this measure, as it is required for Joint Commission accreditation.

The collection of information on tobacco use using HBIPS-1 has a number of advantages over the use of TOB-1 and TOB-2/TOB-2a. **First, while we absolutely do not minimize the importance and benefit of screening and offering treatment for tobacco use, IPFs often manage multiple substance use and behavioral issues for a given patient. We believe that HBIPS-1 provides IPFs with the flexibility to offer tobacco treatment in a way that best meets the needs of their patients.** Without question, the use of tobacco threatens the long-term health of patients. However, to meet the needs of patients during hospitalization, IPFs may need to prioritize other treatment issues. For instance, it may take more than the three-day post-admission window allowed by the TOB-2 measures to stabilize a patient to the point where the care team can provide meaningful "counseling" about smoking cessation. Similarly, for a patient using multiple substances, the care team may deem it best to allow a patient to continue using tobacco while weaning the patient off of other substances that pose a more immediate health risk. The use of HBIPS-1 would ensure that IPFs obtain information about a patient's tobacco use. However, it also provides flexibility for the care team to offer counseling or medication at the IPF within a timeframe that suits the specific needs of the patient.

Another advantage of using the HBIPS-1 measure is that it allows for IPFs to collect data in a consistent fashion for all patients, rather than separately collecting and reporting data on tobacco use and treatment. Moreover, given that most IPFs collect HBIPS-1 to meet Joint Commission accreditation requirements, IPFs would not need to expend additional resources to collect and report it to CMS. Finally, we note that the HBIPS measures were specifically designed for and tested in IPFs. By contrast, the TOB measures were designed and tested for a general acute care hospital patient population.

DATA COLLECTION AND REPORTING REQUIREMENTS

MEASURE SPECIFICATIONS FOR FY 2017 PROPOSED MEASURES

CMS proposes that IMM-2, TOB-1 and TOB-2/TOB-2a be collected using the specifications in the *Specifications Manual for National Hospital Inpatient Quality Measures* that is maintained by The Joint Commission. CMS indicates it also would provide any additional information

needed to collect and submit the measures using *QualityNet*. **The AHA does not support the addition of TOB-1 and TOB-2/TOB-2a to the IPFQR program, and asks that CMS test IMM-2 in IPFs before finalizing it. However, if CMS finalizes the three proposed measures, then we would agree with CMS's proposed approach.**

SAMPLING DATA

For data submitted for the FY 2017 IPFQR program, CMS proposes to update its data submission requirements for program measures that permit the use of sampling. Specifically, CMS proposes that IPFs submit aggregate population and sample size counts for Medicare and non-Medicare discharges by age group, diagnostic group and quarter. CMS indicates that these data will help it better understand the completeness of measure data, as well as provide insight into the impact the measures in the program are having for particular patient populations. **The AHA supports this proposal.**

Additionally, while we do not support the adoption of TOB-1 and TOB-2/TOB-2a, and urge CMS to conduct further testing of IMM-2, we ask the agency to permit the use of sampling for these measures if they are finalized for the program. While the measure specifications permit the use of sampling to collect all three measures, CMS does not explicitly state in the rule whether the measures can be collected using sampling.

FUTURE MEASUREMENT TOPICS

CMS solicits comment on several measures and measurement topics it is considering for future years. The agency indicates that the following five measures are undergoing testing:

1. Suicide Risk Screening completed within one day of admission
2. Violence Risk Screening completed within one day of admission
3. Drug Use Screening completed within one day of admission
4. Alcohol Use Screening completed within one day of admission
5. Metabolic Screening

All five measures were included on the list of measures reviewed by the MAP in early 2014, and CMS indicates that it intends to propose one or more of them "in the near future." However, the MAP did not support any of them, suggesting that none of the five measures met the needs of the program.

The AHA agrees with the MAP's assessment of these measures, and is concerned that the first four measures are unnecessarily duplicative with HBIPS-1. As noted above, HBIPS-1 is collected by the majority of IPFs to meet Joint Commission accreditation requirements. HBIPS-1 measures require the same screenings as the first four measures above, but within *three* days of admission. The measure developers chose this timeframe, in consultation with experts from the field, because a patient condition upon admission to an IPF may not be stable enough to fully and accurately assess all of these elements within the first day of admission.

Thank you for the opportunity to comment. We look forward to continuing to work with you to ensure the program is focused on the highest priority issues. If you have additional questions, please contact me or Akin Demehin, senior associate director of policy, at (202) 626-2365 or ademehin@aha.org.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President
Public Policy Analysis & Development

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[i] For the current measure specifications, see the National Quality Forum's Quality Positioning System at http://www.qualityforum.org/QPS/1659. For the review of the measure by the NQF Population Health Committee, see http://www.qualityforum.org/Projects/nr/Population_Health_Prevention/Population_Health__Prevention_Endorsement_Maintenance_-_Phase_1.aspx#t=2&s=&p=