American Hospital Association

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

June 22, 2015

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

RE: Proposed Rule: CMS-1627-P, Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System – Update for Fiscal Year Beginning October 1, 2015 (FY 2016)

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the proposed rule from the Centers for Medicare & Medicaid Services (CMS) that would update the prospective payment system (PPS) rates for Medicare inpatient hospital services provided by inpatient psychiatric facilities (IPFs).

In this letter, we comment only on the proposals related to the IPF Quality Reporting (IPFQR) Program. While we support some of the rule's proposals, **we remain concerned that CMS continues to propose quality measures for the IPFQR Program that are not central to the treatment of the psychiatric disorders for which patients have been admitted.** We urge CMS to work with IPF stakeholders to identify evidence-based measures that more appropriately assess the type of care that patients predominantly need and receive in these settings. Further, we continue to be concerned that several of the proposed measures lack National Quality Forum (NQF) endorsement or have not been endorsed for, or tested in, psychiatric settings.

Our comments on specific proposals follow.

CHANGES RELATED TO THE FY 2017 PAYMENT DETERMINATION

We support CMS's proposal to remove HBIPS-4, Patients Discharged on Multiple Antipsychotic Medications. CMS proposes to remove HBIPS-4 from the IPFQR program because the measure is no longer endorsed by the NQF. We agree that measures that lose NQF-endorsed status should no longer be included in CMS quality reporting programs.

However, CMS will continue to require HBIPS-5, Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification. We understand that IPFs have experienced difficulty reporting this measure because they are not always able to obtain a thorough history about patients and, therefore, do not know if an adequate justification exists for the patient to be on more than one antipsychotic medication. For example, one justification is whether the medical record contains documentation of a history of three failed multiple trials of monotherapy. However, the IPF may be unable to connect with prior or current providers to obtain the patient's history related to monotherapy. Further, due to a lack of interoperability, efficient mechanisms do not exist to search for and identify a patient's prior providers and learn the prior medical history of monotherapy. In addition, sometimes IPFs learn that the patient's community caregiver wants the patient to be on multiple antipsychotic medications. Therefore, we ask CMS to work with the measure developer and other stakeholders to determine if additional exclusions should be incorporated into this measure.

CHANGES PROPOSED FOR THE FY 2018 PAYMENT DETERMINATION

We do not support the inclusion of TOB-3, Tobacco Use Treatment Provided or Offered at Discharge, and the subset measure, TOB-3a, Tobacco Use Treatment at Discharge (NQF #1656). TOB-3 identifies adult patients who are tobacco users and who are referred to or refuse evidence-based outpatient counseling and receive or refuse a prescription for Food and Drug Administration (FDA)-approved tobacco cessation medication at discharge. TOB-3a identifies those patients who are referred to counseling and receive a prescription at discharge, as well as those who are referred to counseling and have a reason for not receiving the prescription.

We agree that tobacco use is a serious public health problem and recognize the important population health goal of eliminating it. However, we do not believe that a tobacco treatment measure belongs in a program whose stated purpose is to provide information that can be used by patients and families in making informed choices about where to obtain needed care and to facilitate quality improvement efforts by psychiatric facilities. It suggests that consumers should make choices about where to seek hospital care for patients with significant mental illness symptoms based on whether the facility provides tobacco use treatment at discharge. It also suggests that psychiatric facilities should focus their quality improvement efforts on this aspect of care rather than on improving treatment for the mental illness and substance abuse disorders that warranted the patients' hospitalizations.

The AHA believes that IPFs should be evaluated on how well they treat the underlying diseases and diagnoses for which their patients are admitted. We believe the tobacco treatment measures in the IPFQR program would take time and resources away from caring for a

patient's more immediate needs and could be contraindicated where a practitioner believes the patient should focus on modifying a different behavior. A practitioner may decide, for example, that it is neither timely nor appropriate to try to affect a patient's tobacco use at discharge. Further, while the measure excludes patients who refused tobacco screening, it does not exclude patients who agreed to be screened but, for whatever reason, later decide they do not wish to focus on reducing their tobacco use. In such situations, it may be counterproductive to approach the patient again at discharge about reducing tobacco use.

We do not support the addition of SUB–2, Alcohol Use Brief Intervention Provided or Offered and SUB–2a Alcohol Use Brief Intervention (NQF #1663). SUB–2 evaluates whether patients 18 years of age and older who screen positive for unhealthy alcohol use receive or refuse a brief intervention during the hospital stay. SUB–2a evaluates the number of patients who receive the brief intervention.

These measures were developed for use in general acute care settings where patients are most commonly admitted for conditions other than substance abuse. This brief intervention for excess alcohol use may be useful as a therapy in addition to whatever treatment is provided for the trauma, disease or other need that warranted the acute care hospitalization. However, IPFs already conduct comprehensive patient screenings at admission, and the information garnered from those screenings informs the appropriate course of treatment for each patient, including treatment for any substance abuse disorders. For patients with severe alcohol use problems, the "brief" intervention described in the measure specifications would be insufficient and inappropriate. Therefore, we urge CMS not to finalize the measure for the IPF setting. We believe that the course of treatment for patients should be based upon what they need and not whether the course of treatment meets measure specifications.

We do not support the replacement of HBIPS-6 and HBIPS-7 with new transition of care measures. In the rule, CMS proposes to replace HBIPS-6 (NQF # 0557) and HBIPS-7 (NQF # 0558), which focus on developing a post discharge care plan and providing that plan to both patients and next level of care providers, with similar measures that CMS believes are more comprehensive. Specifically, CMS would add NQF #0647, which evaluates whether patients receive a post-discharge transition record that includes, at a minimum, 11 separate elements. In addition, CMS proposes to add NQF #0648, which captures whether the transition record is transmitted to the next care provider within 24 hours after discharge.

In April, we joined with several other stakeholders, including the National Association of Psychiatric Health Systems, The Joint Commission, the Federation of American Hospitals and the National Association of State Mental Health Programs Directors Research Institute in expressing our concern about replacing HBIPS-6 and HBIPS-7 with NQF #0647 and NQF #0648. The attached letter explains the many reasons we believe it would be shortsighted to switch these measures. Among our concerns:

1. The HBIPS measures were developed specifically for, and tested within, the psychiatric setting. **NQF #0647 and #0648 have not been tested in the psychiatric setting and do not appear to be NQF-approved for the psychiatric setting.**

2. The HBIPS measures were developed for use in psychiatric specialty facilities (those covered by the CMS requirements for the IPFQR program), and they focus on elements of specific importance in the care of psychiatric patients, known to be related to outcomes, and having historically lower rates of compliance. In contrast, #0647 and #0648 pertain to all patients who are discharged from a general hospital or observation unit, skilled nursing facility or rehabilitation facility. These measures contain elements that are not as relevant for psychiatric patients.

   For example, #0647 requires IPFs to create a record that includes a list of the studies pending at discharge, such as laboratory or radiological studies. In the rule, CMS states that about 40 percent of patients have studies pending at discharge, but the agency does not clarify whether 40 percent of *psychiatric* patients have studies pending at discharge. We believe the data provided refers to general acute care patients, and that the rate for psychiatric patients is much lower. The reference that CMS states for that statistic relate to two tertiary care academic hospitals. Under NQF #0647, the transition record also should include major procedures and tests performed during the inpatient stay and the results. We ask CMS to clarify whether it believes that psychiatric patients typically undergo major procedures and tests during an IPF stay and, if so, to identify the most common procedures and tests that occur for these patients.

3. There is an extensive database for the HBIPS measures that can be used for trending and further analysis. Changing the requirements at this time would make the existing data irrelevant to the IPFQR program, as well as hinder the quality initiatives that facilities have started to address their performance in the area of continuity of care.

4. The use of the HBIPS measures has promoted significant improvements in IPFs, and their continued use would help the field close the remaining performance gap.

5. Changing measures of the same domain of care without compelling reasons to do so has the potential to impede provider progress toward the goals of quality care and improved electronic tracking systems. **Further, in order to report NQF #0647, some IPFs and hospital-based units would be required to make modifications to their electronic health records (EHRs). This will mean these hospitals would need to undertake an expensive effort to collect data that may not always pertain to psychiatric patients**.

6. If CMS replaces the current HBIPS measures with the proposed measures, psychiatric hospitals would still need to report information on the HBIPS measures to The Joint Commission. Thus, they would report on two competing measures in the same dimension of care. There has been a long tradition of trying to align measure specifications between CMS and The Joint Commission as much as possible, while keeping the focus of the measures specific to the patient populations.

We do not support CMS's proposal to add an agency-developed measure evaluating whether IPFs screen patients for metabolic disorders. CMS proposes to adopt a screening

measure for metabolic disorders developed by the agency. The Screening for Metabolic Disorders measure is a chart-abstracted measure that calculates the percentage of patients discharged on antipsychotic medications for which a structured metabolic screening was performed. The screening has four elements that include body mass index, blood pressure, glucose or HbA1c and a lipid panel.

This measure has not been reviewed or endorsed by NQF. Further, there was no explanation in the rule as to why CMS did not take this measure through the NQF process. **CMS should not include this measure in the IPFQR program unless it has been NQF-endorsed specifically for the psychiatric setting.** Further, the technical expert panel (TEP) that CMS convened to evaluate this measure made several important recommendations as to how this measure should be amended, including recommendations to ensure the measure aligns more closely with clinical guidelines. At the very least, CMS should not include this measure unless the TEP's recommendations are incorporated.

Future Readmission Measure. CMS is developing a 30-day psychiatric readmission measure similar to the readmission measures in other quality reporting programs. **We urge CMS to ensure that any readmissions measures it proposes are adjusted for sociodemographic factors.** Further, we ask that the agency submit its proposed measure to NQF for review, and refrain from adopting a readmissions measure that has not been NQF-endorsed for the psychiatric setting. Moreover, readmission measures are risk-adjusted for some clinical factors using billing data, but we have concerns whether adequate information can be derived from claims data on psychiatric patients to appropriately adjust the measures. These measures need thorough review through the NQF process to determine if claims-based measures can be accurately risk-adjusted for mental health patients.

CHANGES TO REPORTING REQUIREMENTS

CMS proposes several changes to how IPFs report measures.

We support CMS's proposal to remove the current requirement to report measures by age group, and we support its proposal to require facilities to report data for chart-abstracted measures to the Web-Based Measures Tool on an aggregate basis by year, instead of by quarter.

We also support CMS's proposal to require non-measure data to be reported as an aggregate, yearly count instead of by quarter. Thus, CMS would have IPFs report aggregate populations counts for discharges as a single, yearly count, instead of by quarter.

In addition, we support CMS's proposal to allow a uniform sampling methodology for 10 of the measures. Specifically, CMS proposes to permit The Joint Commission/CMS Global Initial Patient Population sampling found in Section 2.9 (Global Initial Patient Population) of the Specifications Manual for inpatient hospitals.

Thank you for the opportunity to comment on this proposed rule. Please contact Evelyn Knolle, senior associate director, at eknolle@aha.org with any questions.

Sincerely,

/s/

Rick Pollack
Executive Vice President

Attachment

American Hospital Association

Federation of American Hospitals

The Joint Commission

National Association of Psychiatric Health Systems

NRI - National Association of State Mental Health Program Directors Research Institute

---

VIA EMAIL: Patrick.Conway@cms.hhs.gov

April 8, 2015

Patrick Conway, M.D.
Deputy Administrator for Innovation and Quality
CMS Chief Medical Officer
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Conway,

We are writing to express concerns from members of the psychiatric-provider community about two measures which were supported by the National Quality Forum (NQF) Measure Application Partnership (MAP) in January 2015 as measures under consideration (MUC) for inclusion in the Inpatient Psychiatric Facilities Quality Reporting program (IPF QR). The measures are 1) Transition Record with Specified Elements Received by Discharged Patients (NQF #0647); and 2) Timely Transmission of Transition Record (NQF #0648). The measure steward for both measures is the American Medical Association—Physician Consortium Performance Improvement (AMA-PCPI). Given their inclusion on the MUC list, the Centers for Medicare & Medicaid Services (CMS) could formally propose the measures for the IPF QR as soon as the upcoming fiscal year (FY) 2016 Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) proposed rule.

We absolutely agree with the importance of effective care transitions in providing high-quality behavioral health care. However, we are concerned that NQF #0647 and #0648 overlap with the continuity of care measures currently in use in the IPF QR and Joint Commission programs. As a result, the addition of NQF #0647 and #0648 in the IPF QR would not address an unmet programmatic need, and could disrupt important improvement efforts that use data from the care continuity measures already in the IPF QR program. We urge CMS not to include NQF #0647 and #0648 in the IPF QR at this time.

Two NQF-endorsed measures related to continuity of care (HBIPS-6 and HBIPS-7) have been required by CMS for inclusion in the IPF QR program since its inception in FY 2013. They were publicly reported by CMS for the first time in April 2014.

The core element of both the HBIPS and AMA-PCPI measures is the development and transmission of a post-discharge continuing care plan. Both outline specific components that must be included. Overlapping elements include: reason for hospitalization, principal discharge diagnosis, current medication, and plan for follow-up care (next level of care recommendations).

-continued-

We have attached a side-by-side comparison of the HBIPS and AMA-PCPI measures. As outlined below, we feel there are several compelling reasons why the HBIPS measures should be retained as the measures in the continuity of care domain and not replaced with the AMA-PCPI measures.

1. The HBIPS measures were developed with significant input from the psychiatric field and fully tested for validity and reliability in the psychiatric setting by both CMS and The Joint Commission (TJC). They are endorsed by NQF. They have been available from The Joint Commission, as a condition of accreditation for psychiatric hospitals, for seven years. Based on a commitment to the importance of continuity of care, hospitals using the measures have developed important strategies to improve care at the point of discharge.

2. Since the HBIPS measures were developed for use in psychiatric specialty facilities (those covered by the CMS requirements for the IPF QR program), they focus on elements of specific importance in the care of psychiatric patients, known to be related to outcomes, and having historically lower rates of compliance. An example of this is the rigorous communication of details pertaining to medication (including name of medication, dosage, and indication for use) and recommendations for continuing care based on an overview of the current hospitalization. In contrast, the AMA measures pertain to all patients who are discharged from a general hospital or observation unit, skilled nursing facility, or rehabilitation facility. The AMA-PCPI measures have never been tested in the psychiatric population and contain elements that do not apply to this population. Moreover, national comparative rates for the HBIPS measures are much more meaningful because all users are psychiatric inpatient specialty providers (rather than all hospitals, skilled nursing facilities, and rehabilitation hospitals). The value of the information to the public could be compromised.

3. Due to their widespread use, there is an extensive database in existence for the HBIPS measures that can be used for further analysis and refinement. Changing the requirement at this time would make the existing data irrelevant to the IPF QR program as well as hinder the quality initiatives that facilities have started to address their performance in the area of continuity of care.

4. The use of the HBIPS measures has promoted significant improvements in IPFs, and their continued use would help the field close the remaining performance gap. The HBIPS measures have been required of psychiatric hospitals accredited by The Joint Commission since 2011, although hospitals had the option of reporting the measures since October 2008. Within The Joint Commission reporting system, the overall performance of IPFs on HBIPS-7 began at 56% in the fourth quarter of 2008 with 155 facilities, improving to 85% in the second quarter of 2014 with 663 facilities. All units in general hospitals reimbursed under the IPF PPS system were added to the measure pool in October 2012. Overall compliance reported by CMS in April 2014 for HBIPS-7 was 62.7%. By comparison, one-third of these facilities also reported to The Joint Commission for the same time period and had a compliance rate of 87.8%. This translates to a compliance rate of only 44% for the two-thirds of psychiatric facilities that began using the measures based on the CMS requirement. In short, there remains significant additional room for improvement, and we believe the continued use of the HBIPS measure would help foster such improvement.

5. The inclusion of IPF PPS facilities in the CMS Quality Reporting initiatives is still very new. Facilities have been challenged to report to CMS a very significant number of measures with complex data specifications using local data systems that are not well-developed along the lines of certified EHRs. It has been a very steep learning curve. The quality of publicly reported data needs time to improve and stabilize. Changing measures of the same domain of care without compelling reasons to do so has the potential to impede provider progress toward the goals of quality care and improved electronic tracking systems (EHRs).

6. If CMS replaced the current HBIPS measures with the AMA measures, psychiatric hospitals would still need to report information on the same dimension of care in a different way to The Joint Commission. The use of such competing measures adds to reporting burden, creates

confusion and potential inaccuracy in interpreting performance results, and diffuses the valuable learning that is possible when large numbers of providers report data in exactly the same way. There has been a long tradition of trying to align measure specifications between CMS and The Joint Commission as much as possible while keeping the focus of the measures specific to the patient populations.

In summary, we fully support CMS's goal of improving care transitions in IPFs. However, the addition of NQF #0647 and #0648 to the IPF QR would not address an unmet programmatic need, and could disrupt important improvement efforts that use data from the care continuity measures already in the IPF QR program. We recommend that the IPF QR program continue to require IPFs to use HBIPS-6 and HBIPS-7 to assess important elements of transition of care at the point of discharge. We further recommend that the AMA transition measures not be adopted for use in the IPF QR program.

We appreciate the need to continually assess and improve measures in public quality reporting programs. We would be happy to work with CMS and the HBIPS measure steward (TJC) to identify and test refinements that would potentially strengthen HBIPS-6 and HBIPS-7.

If you have questions, please contact Kathleen McCann, R.N., Ph.D., at 202/393-6700, ext. 102, or Kathleen@naphs.org.

Sincerely,

Linda E. Fishman
Senior Vice President
Public Policy Analysis & Development
American Hospital Association
Email: lfishman@aha.org
www.aha.org

Jayne Hart Chambers
Senior Vice President Quality
Federation of American Hospitals
Email: JChambers@FAH.org
www.fah.org

David W. Baker, MD, MPH, FACP
Executive Vice President
Healthcare Quality Evaluation
The Joint Commission
Email: dbaker@jointcommission.org
www.jointcommission.org

Mark Covall
President and CEO
National Association of Psychiatric Health Systems
Email: mark@naphs.org
www.naphs.org

Timothy Knettler
Executive Director/CEO
NRI - **N**ational Association of State Mental Health Program Directors **R**esearch **I**nstitute
Email: Tim.Knettler@nri-inc.org
http://www.nri-inc.org/