NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS
ADVOCATING FOR BEHAVIORAL HEALTH
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January 4, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-3317-P: "Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies" (42 CFR Parts 482, 484, and 485)

Dear Acting Administrator Slavitt,

As an association representing behavioral healthcare provider organizations and professionals, the National Association of Psychiatric Health Systems (NAPHS) appreciates the opportunity to provide comments on the proposed rule (CMS-3317-P) titled "Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies" as published in the November 3, 2015, *Federal Register*.

ABOUT NAPHS

Founded in 1933, NAPHS advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Our members are behavioral healthcare provider organizations, including more than 800 psychiatric hospitals, addiction treatment facilities, general hospital psychiatric and addiction treatment units, residential treatment centers, youth services organizations, outpatient networks, and other providers of care. Our members deliver all levels of care, including inpatient hospital treatment, residential treatment, partial hospitalization, and outpatient services.

COMMENTS SPECIFIC TO PSYCHIATRIC AND SUBSTANCE ABUSE TREATMENT

We note the particular emphasis in the proposed rule on the need for increased focus on psychiatric and behavioral health patients, including patients with substance abuse disorders. Discharge planning is very important to the care of patients in psychiatric hospitals. We have taken this responsibility seriously as an industry in several ways.

At §482.60 the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation: Special Provisions Applying to Psychiatric Hospitals require a multidisciplinary discharge summary be developed for ALL patients that includes a) recapitulation of the patient's hospitalization, b) recommendations for services concerning follow-up or aftercare (to include arrangements for services in the community, specific appointments, living arrangements, financial needs and plans, medication, and involvement of

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family and significant others); and c) summary of the patient's condition on discharge including recommendations for aftercare. Areas surveyed include whether the patient was involved in the aftercare planning process; access to related documents by patient, family, community treatment source and other appropriate sources; involvement of the interdisciplinary team; and evidence of contact with the post-hospital treatment entity regarding recommendations. These requirements have been in place since the mid-1960s.

The psychiatric hospital field also developed the first set of Hospital Based Inpatient Psychiatric Services (HBIPS) core measures. This set includes specific continuity of care measures that require that a documented continuity of care plan is developed and sent to the next level of care in a timely way. These measures have been a Joint Commission requirement for accreditation since 2010 and demonstrate a compliance rate of 92% (plan developed) and 86% (plan transmitted) among accredited facilities.

The same HBIPS measures were adopted by CMS as part of the initial set of measures used for the Inpatient Psychiatric Facility Quality Reporting System (IPF QR) payment and public reporting requirement as mandated by the *Affordable Care Act* (ACA). For fiscal year 2016, CMS decided to remove the continuity of care measures referenced above and replace them with two AMA-developed measures: Transition Record Received by Discharged Patients and Timely Transmission of Transition Record. Data collection for these measures will begin for all inpatient units reimbursed under the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) as of July 1, 2016.

Experience with these reporting requirements has helped us learn a great deal about the challenges psychiatric patients, their families and caregivers, and providers face in developing and implementing effective discharge plans.

REQUIREMENTS OF THE CONDITION OF PARTICIPATION

We note the emphasis in the proposed rule on the importance of having a thorough understanding of available community services that impact the discharge planning process, and the importance of teamwork among healthcare facilities, patients, their families, and relevant community organizations. **While it is clearly a responsibility of the professionals in psychiatric facilities to be thoroughly knowledgeable about the resources that do exist in their communities, we must acknowledge that these resources are often woefully inadequate for the continuing care of psychiatric patients**. More than three-quarters of counties in the United States have a serious shortage of mental health professionals, a problem particularly acute in rural and low-income areas[1]. Intensive intermediate and outpatient programs with documented, publicly available quality ratings that are the appropriate level of care for persons leaving the hospital are often very difficult to find. Skilled nursing and in-home services are not typically provided to psychiatric patients as they are to patients with non-behavioral health diagnoses.

Hospitals providing specialized psychiatric services frequently draw their patients from distant communities because of the uneven distribution of psychiatric resources, including lack of psychiatric beds in many communities**. Being aware of resources and coordinating ongoing care in these distant communities has special challenges.** This challenge is compounded with the proposed rule's focus on the hospital's consideration of the availability of and access to non-healthcare services for patients, including such things as transportation, meal and household services, and housing. While this is clearly of value, it is not necessarily achievable given the current resources.

The proposed Condition of Participation includes several lists of requirements (such as the discharge planning policies and procedures, considerations in evaluating a patient's discharge needs, information sent during the transfer of patients to another facility, discharge instructions, information sent to the practitioner responsible for follow-up care) that are clearly labeled MUST include. Failure to include some

[1] Thomas, K.C., Ellis, A.R., Konrad, T.R., Holzer, C.E., & Morrissey, J.P. (2009). County-level estimates of mental health professional shortage in the United States. Psychiatric Services (Washington, D.C.), 60(10), 1323-1328.

element of these lists could potentially be seen as a deficiency during the survey process**. We strongly recommend that facilities be given more flexibility to determine, through internal decision-making and policy development, which elements are deemed to be essential based on the assessed needs of their patients.**

We support the importance given throughout the proposed rule to the inclusion of the patient and family in decision-making. **We note, for the record, the challenges behavioral health providers sometimes face in including families and others because of patient choice and confidentiality laws.** We support patients always being included to the maximum of their ability in decision-making, and families and others also being included to the maximum extent possible. From our experience with other discharge measures, we are also aware that patients do not always give permission for information to be shared with others including the next level of care provider. We fully respect a patient's right to make that decision. How would this be assessed in the survey process?

We support, in concept, the proposed rule's emphasis on the patient's goals and treatment preferences. **Our concern is how compliance with a patient's treatment preferences will be assessed in the survey process.** It is not always possible, for reasons beyond the control of the patient or the facility (such as availability, location, cost/coverage, clinical appropriateness), to develop a discharge plan that fully complies with a patient's preferences. For some patients, their clear preference, despite great effort on the part of the provider, is to not seek post-hospital treatment. Will documented efforts to work with the patient to address preferences and find solutions, when possible, constitute compliance?

We support the concept that quality post-acute providers contribute more to successful outcomes than those of lesser quality. We have major concerns about the requirements in the proposed rule regarding the responsibility of the discharging facility as evidenced by the phrases, "The hospital must assist the patients, their families, …in selecting a post-acute care provider by using and sharing data that includes…data on quality measures and data on resource use measures. The hospital must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences." There are limitations to the data that is available and the accuracy of the data. Data on outpatient providers, including community mental health centers, is not systematically reported. This requirement appears to raise legal and ethical questions that are far beyond the scope of the proposed regulations. The burden to the provider in preparing this information in the highly individualized way outlined in the proposed conditions would potentially be very great**. We recommend that CMS give more attention to developing this requirement, including pilot testing, before including it in the Conditions of Participation and to deliberately engaging the field in developing the measures it intends to stipulate in response to the requirements of the *IMPACT Act*.**

We note the proposed new requirement that the hospital must establish a post-discharge follow up process. This requirement states, "we note the importance of ensuring that hospitals follow-up, post-discharge, with their most vulnerable patients, including those with behavioral health conditions." While we acknowledge that for certain patients, with their permission, some kind of post-discharge contact may be helpful, the evidence is still being developed on how best to do this. **We <u>oppose</u> any requirements that mandate post-discharge contact with all patients.** This is of particular concern since the proposed rule equates vulnerable patients with patients with behavioral health conditions—implying that all behavioral health patients would require post-discharge follow-up. Facilities should be permitted to develop policies and procedures through which they identify criteria for patients for whom follow-up contact may be particularly necessary. The investment of resources relative to the clinical benefit must be part of this criteria.

The proposed rule asks for comment on a potential requirement that providers use the Prescription Drug Monitoring Programs (PDMP) for both review of a patient's risk of non-medical use of controlled substances as well in the medication reconciliation process. The proposed rule clearly outlines the legal, policy, and technical challenges that would be involved if this were made a requirement**. The PDMPs serve an important purpose in states and their use should remain focused on patients for whom providers have a specific concern.** Requiring their use for all patients would overwhelm current

systems and make it impossible for them to focus on the true at-risk groups they are intended to serve. **We strongly oppose including this requirement.**

The proposed rule stipulates that CMS would expect that the appropriate medical staff member would discuss the patient's post-acute care goals and treatment preferences with the patient, the patient's family, or their care/giver support persons (or both) and subsequently document goals and treatment preferences in the medical record. **While the medical staff member has responsibility for the development of the appropriate discharge plan as part of his or her overall responsibility for the patient, we recommend that the facility be given the flexibility to designate an appropriate staff member to conduct this kind of discussion with the patient.** Members of the nursing and social service staffs have skills that make them well-qualified to address these complex issues and provide information. This process works best when it is coordinated and integrated into the work flow of the interdisciplinary team and not compartmentalized into requirements that are within the scope of practice of various disciplines.

Because of the scope and complexity of this proposed Condition of Participation, **we recommend it be implemented over a 12-month period from the time of its finalization.**

Thank you for your consideration of our comments. We look forward to working with CMS and the Department of Health and Human Services to ensure that Medicare and Medicaid beneficiaries continue to have access to high-quality hospital services, including psychiatric hospital services, that help them smoothly make appropriate transitions to the next level of care.

Sincerely,

/s/

Mark Covall
President/CEO