National Association of Psychiatric Health Systems

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SUBMITTED VIA www.regulations.gov

June 25, 2012

RE: **CMS–1588–P: Proposed Rule** – "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; **Quality Reporting Requirements for Specific Providers** and for Ambulatory Surgical Centers"

NOTE: Our comments focus on new requirements for quality reporting by **inpatient psychiatric facilities (IPFs)** that are participating in Medicare.

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 445–G
Washington, DC 20201

Dear Ms. Tavenner,

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 titled "Medicare Program: Hospital Inpatient Prospective Payment Systems….; Quality Reporting Requirements for Specific Providers…." as published in the May 11, 2012, *Federal Register*.

We are specifically commenting on **new requirements for quality reporting by inpatient psychiatric facilities (IPFs)** that are participating in Medicare.

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 700 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 partial hospitalization services, outpatient services, residential treatment, and inpatient care.

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COMMENTS

We support CMS' selection of Hospital-Based Inpatient Psychiatric Services (HBIPS) measures to meet the requirements of the *Affordable Care Act's* mandate that both psychiatric hospitals and psychiatric units begin reporting inpatient quality measures. The ACA requires that, as of rate year 2014 (starting October 1, 2013), all facilities (freestanding psychiatric hospitals and the psychiatric units of general hospitals) reimbursed under the inpatient psychiatric facility prospective payment system (IPF PPS) must report data on measures to CMS for the purpose of public reporting, payment updates, and pilot pay-for-performance programs.

The measures are six of the seven Hospital-Based Inpatient Psychiatric Services (HBIPS) core measures, which are already required of psychiatric hospitals by The Joint Commission (and available for use by psychiatric units to meet ORYX reporting requirements):

- HBIPS-2 Hours of physical restraint use (patient safety);
- HBIPS-3 Hours of seclusion use (patient safety);
- HBIPS-4 Patients discharged on multiple antipsychotic medications (clinical care/efficiency/cost reduction);
- HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification (clinical care/efficiency/cost reduction);
- HBIPS-6 Post discharge continuing care plan created (care coordination); and
- HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge (care coordination).

We believe that they are appropriate measures for a number of reasons.

The measures came to be tested and nationally used as the result of a multi-year, collaborative, evidence-based public/private partnership. The original Hospital-Based Inpatient Psychiatric Services (HBIPS) project grew from a historic public-private partnership among the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD), and the NASMHPD Research Institute, Inc. (NRI) in collaboration with the American Psychiatric Association (APA). The partnership approached The Joint Commission (TJC) and asked to begin the process of developing core measures for inpatient psychiatry.

At its inception, the project gathered input from 24 diverse stakeholder organizations (including consumers, researchers, employers, providers, and other content experts) as a foundation for the measure development process.

Psychiatric core measure development at The Joint Commission continues to be overseen by a Technical Advisory Panel (TAP), made up of clinicians, researchers, and technical experts, all informed by the practical experience of the providers who must collect and use the data. By selecting measures that have the buy-in of major professional societies as well as consumers and other stakeholders, CMS is selecting a set of measures that will be meaningful to the field.

We note that measure 2 and 3, 4 and 5, and 6 and 7 are paired measures and no effort should be made to delete components of the pairs. Public reporting should include both elements of each pair for accuracy.

Each of these measures is approved by the National Quality Forum (NQF).
HBIPS measures on restraint and seclusion, psychotropic medication, and continuity of care were endorsed by the National Quality Forum (NQF) in May 2010. The measures were also recommended by the Measurement Application Partnership (MAP) for inclusion in the Inpatient Psychiatric Facility Quality Reporting (IPFQR) program. In its proposed rule outlining selection of the CMS quality measures, CMS noted that "we generally prefer to adopt NQF-endorsed measures in our reporting programs, with some exceptions as provided by law." Revisions to the measures, based on clinical evidence and measurement advances, are reviewed and implemented on a regular schedule through the measure maintenance process at NQF.

The measures CMS has selected – already in use by many in the field – would be expanded to all psychiatric hospitals and psychiatric units reimbursed under the Medicare Inpatient Psychiatric Facility Prospective Payment System (IPF PPS). Duplication of effort will be minimized by CMS' selection of measures that are already reported to a major accrediting agency. Opportunities for national benchmarking and widespread performance improvement would be maximized.

Beginning October 1, 2008, both freestanding psychiatric hospitals and psychiatric units in general hospitals were permitted to select the HBIPS measure set to help them meet Joint Commission ORYX (a program of performance measurement required by The Joint Commission as a condition of accreditation) performance measurement reporting requirements.

Beginning January 1, 2010, freestanding psychiatric hospitals were required to report HBIPS data to The Joint Commission on a quarterly basis. For general hospitals with psychiatric units, HBIPS is an additional set of core measures that can be selected. It is not mandatory for general hospitals to select the HBIPS measure set, but approximately 25% of hospitals reporting HBIPS data are general hospital units. The Joint Commission notes that significant value can be derived from use of this measure set, and hospitals are encouraged to adopt it.

We applaud CMS for helping the field to focus on collecting, reporting, and fully analyzing measures that the field itself has identified as important for improving quality of care.

The CMS measures will provide public data for behavioral health – keeping behavioral health on par with the rest of medicine.
Other payment systems have required quality reporting to CMS for many years. The ACA extends this requirement to IPF PPS-reimbursed systems.

The CMS measures will support overall national goals for improved health care.
As CMS noted in the proposed rule, "In implementing the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program, our overarching objective is to support the HHS National Quality Strategy's three-part aim of better health care for individuals, better health for populations, and lower costs for health care."

We agree with CMS that "implementation of the IPFQR Program will help achieve the three-part aim by creating transparency around the quality of care at IPFs to support patient decision-making and quality improvement. Over time, the IPFQR Program will help align the goals for quality measurement and improvement at IPFs with those of other providers in the health system."

Every effort must be made to address "the need to balance breadth with minimizing burden" in quality reporting.
As CMS noted in the proposed rule, "given the availability of well-validated measures and the need to balance breadth with minimizing burden, the measures should address as fully as possible the six domains of measurement that arise from the six priorities of the National Quality Strategy (NQS)." We note that the HBIPS measures, unlike the diagnostic-specific measures used in the inpatient prospective patient payment system (IPPS), apply to all patients of all ages, without regard to diagnosis. While we think this creates significant advantages for benchmarking and public reporting, it also makes it necessary to review every record (with sampling permitted for some, but not all measures, in facilities with very high volume). We support the proposal to report aggregate data rather than patient-level data for FY14 and subsequent years.

We believe the six measures CMS has selected do a good job of focusing on key NQS priorities, including clinical care, safety, efficiency and cost reduction, and care coordination.

While the measures address "breadth," we believe more can be done to "minimize burden."
Although in use by many providers since 2008, the initial use of the six CMS-selected measures requires significant investment of resources.

The field was first notified of CMS' interest in these measures in the proposed rule issued May 11, 2012. Many facilities that do not follow proposed rules do not fully know of the proposed requirement. The final rule will only be required to give organizations 60 days notice before implementation. Given the current proposed timeline, facilities will only have 60 days to implement the measures in order to begin collecting data as of October 1, 2012. Based on our experience with many facilities' implementation process, this is not sufficient time to put the systems in place to adequately monitor compliance with the measures and to be prepared to publicly report the data.

There must be adequate time for providers to implement the data-collection and reporting systems, particularly because failure to do so will affect payment.
As stated in the proposed rule, CMS expects to tie quality reporting to payment. The ACA requires that, for rate year 2014 (RY14) and each subsequent rate year, the Secretary of Health and Human Services "shall reduce any annual update to a standard federal rate for discharges occurring during such rate year by 2.0 percentage points for any inpatient

psychiatric hospital or psychiatric unit that does not comply with quality data submission requirements with respect to an applicable rate year." To determine payment for RY14 (starting October 1, 2013), CMS is proposing that IPFs report on the proposed measures for discharges between October 1, 2012, to December 31, 2012, (Q4 of CY12) and January 1, 2013, to March 31, 2013, (Q1 of CY13). The proposed data-submission timeframe would be July 1, 2013, to August 15, 2013. This is a much tighter timeframe than has historically been given for implementation and reporting of a new measure set within the Hospital IQR program.

We note CMS' call for new quality measures for future years. CMS should strive to keep the number of measures manageable.
While we recognize the importance of continuing to develop a comprehensive set of quality measures to be used for informed decision-making and quality improvement, we urge CMS to proceed cautiously and not add measures too quickly. The field has begun to demonstrate that the HBIPS measures have great potential for improving quality. The measures need to be used to their maximum potential without providers being unduly distracted with a multitude of diverse measurement-reporting requirements. We have seen in other payment systems that reporting becomes the goal rather than thoughtful attention to understanding the data that is being developed and the implementation of multi-faceted strategies to improve care.

We also urge CMS to not publicly display data until it is fully satisfied that the data is reliable and valid. The current rule calls for public display of data submitted under the IPFQR program beginning the first quarter of the calendar year following the respective payment determination year. Public display of data for FY14 would follow the 30-day preview period of September 20, 2013, to October 19, 2013. Because of the very short period many facilities will have had to begin to collect data, we request that 1) the fact of reporting data to CMS be sufficient for the full annual update to the standard federal rate for FY14 and 2) that actual data be made public only after adequate data analysis is completed by CMS. We are unable to comment on CMS's request for feedback on proposed procedural requirements for the FY14 payment determination because the required forms have not yet been posted to the QualityNet Web site.

We ask CMS to make its requirements for IPF PPS reporting consistent with Joint Commission requirements. As measure stewards for the HBIPS measures, The Joint Commission is responsible for maintaining and updating the measure *Specification Manual*. In questions related to proposed populations, sampling, case thresholds, and other technical aspects, we think it is very important to maintain consistency across Joint Commission-approved and CMS-approved measures. Without that, we begin to lose the power for benchmarking and quality improvement that exists across the two programs.

We support CMS's proposed waivers from quality-reporting requirements. We appreciate CMS's attention to the realities that there are occasions when providers are unable to submit required quality data due to extraordinary circumstance that are not within their control. We ask that the provision for the granting of waivers that shield IPFs from incurring payment reductions because of unavoidable circumstances be retained in the final rule.

We urge CMS to encourage Congress to fund extension of EHR incentives to behavioral health.
As noted in the proposed rule, CMS will "continue to work with standard-setting organizations and other entities to explore processes through which EHRs could speed the collection of data and minimize the resources necessary for quality reporting."

Behavioral health providers are excluded from current federal efforts to provide incentives for the adoption of information technology. In February 2009, President Obama signed the *American Recovery and Reinvestment Act of 2009*, which included about $20 billion for spending on health information technology. As part of this spending proposal, hospitals would receive incentive payments to encourage adoption of electronic health records. This legislation specifically *excluded* psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals. Psychiatric hospitals have the same needs as other hospitals for federal support to help implement health information technology and electronic medical records. Legislation has been introduced in the Senate (and House introduction is anticipated) to extend health information technology (IT) incentives to behavioral health.

We urge CMS to help the behavioral health community receive comparable incentives for IT adoption. The ultimate goal of widespread adoption of health information technology – to save American lives through improved coordination of care – is particularly relevant to persons with mental and addictive disorders. Health IT will enable behavioral health and substance abuse providers to effectively coordinate care across mental health and substance abuse service systems, primary care entities, and specialty medicine.

Psychiatric hospitals and residential treatment centers are critical parts of the overall healthcare delivery system, and these organizations have made great strides in beginning to implement health IT to help improve the delivery of behavioral health care and to better coordinate with overall health care. Also, these facilities treat a high proportion of Medicare and Medicaid patients. Much more needs to be done, and financial support by the federal government will be critical to ensuring that these providers will be able to take the next step in fully implementing health IT along with other hospitals and healthcare providers.

We would urge CMS to support funding for these behavioral healthcare providers this year.

RECOMMENDATIONS

In summary, the National Association of Psychiatric Health Systems recommends the following:

1. **CMS needs to use its full discretion in setting the timeframe for the initial submission of data.** Whatever is decided must be in time for the 2014 rate year so facilities do not run the risk of not getting the full federal update. We ask that CMS review all strategies and timetables available to it for giving facilities the maximum amount of time before they are required to submit data for RY14.

2. **In the future, CMS should strive to keep the number of measures manageable.** We know from our experience the value of these measures in demonstrating quality and bringing about clinical change. Adding additional measures next year may divert

attention from deriving full value of these measures. CMS should not add layers of complexity by adding more measures, which could be too much for providers to adequately analyze and use. We believe it is most important to encourage a focus on making meaningful changes that will improve patient care.

3. **We also urge CMS to not publicly display data until it is fully satisfied that the data is reliable and valid.**

4. **We ask CMS to make its requirements for IPF PPS reporting consistent with The Joint Commission requirements.**

5. **We urge CMS to encourage Congress to fund extension of EHR/HIT incentives to behavioral health**.

CONCLUSION

Thank you for the opportunity to provide feedback.

If you have any questions, please contact me or NAPHS Director of Quality and Regulatory Affairs Kathleen McCann, R.N., Ph.D., at 202/393-6700.

Sincerely,

/s/

Mark Covall
President/CEO