NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS
ADVOCATING FOR BEHAVIORAL HEALTH
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January 28, 2013

George Isham, M.D., and Elizabeth McGlynn, Ph.D.
Co-chairs, Measure Application Partnership
c/o National Quality Forum
1030 15th Street, NW, Suite 800
Washington, DC 20005

RE: Measure Applications Partnership Pre-Rulemaking Draft Report

Dear Drs. Isham and McGlynn,

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 Measure Applications Partnership (MAP) 2013 pre-rulemaking report.

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 600 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.

We recognize the very important role the Measurement Applications Partnership (MAP) plays in reviewing, selecting, and recommending measures for federal reporting and payment programs.

Our comments will specifically address the measures considered for the Inpatient Psychiatric Facilities Quality Reporting Program (IPF QRP). Inpatient psychiatric hospitals and psychiatric units reimbursed through the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) are required, for the first time in fiscal year 2013, to report six quality measures to CMS or receive a 2.0 percentage-point reduction in their annual market basket update in 2014. The field is in the process of implementing this reporting process, and the first data will be transmitted to CMS in July 2013. The measures cover all admissions to the affected facilities and are not diagnostic-specific, requiring individual review of each patient record. Reporting data on the six mandated measures is highly challenging and requires a very significant commitment of resources on the part of the facilities for whom these measures are new.

MAP input on IPH QRP measures includes a measure of **follow-up after hospitalization for mental illness** (0576). The discharge follow-up measure is specifically designed to be used with a managed care company that has “members.” The ability of such an organization to provide discharge referral and to track follow-up to those services through its database is totally different from the ability of the universe of facilities reimbursed under IPF PPS to follow its patients post-discharge. While HBIPS measures 6 and 7 address continuity of care for psychiatric patients, IPF PPS facilities do not have a database that would allow them to track whether a patient has arrived for an outpatient visit. The burden of calling individual

(and often difficult-to-reach) consumers would be very significant and perhaps not a true measure of whether the patient arrived for treatment or not. (For example, the patient may not be able to be contacted by phone, but did keep the appointment.) The measure also raises significant confidentiality issues. It is not an appropriate measure to be considered for recommendation to the Centers for Medicare & Medicaid Services (CMS) for quality or payment purposes for all psychiatric hospitals and units.

A second measure under consideration is a measure of **consumer evaluation of inpatient behavioral healthcare services** (0726). While we acknowledge that this NQF-endorsed measure is a valuable step in developing a consumer evaluation tool, we think it has too many items for general use and that it has not been formally tested in non-state hospital settings. There has not been discussion of the tool within the larger psychiatric hospital community. It has not been normed for non-governmental hospitals and is not imbedded in the current vendor systems. It is not ready for consideration for quality or payment purposes for all psychiatric hospitals and units.

We continue to be concerned about the evolution of the two other measures**, alcohol use screening** (M2753) and **assessment of status after discharge** (M2754). They were "supported in direction" by the MAP but are not NQF-endorsed. Should they achieve NQF endorsement, the measures should be reconsidered by the MAP before being recommended to CMS.

We suggest that each measure that is recommended to CMS for payment purposes be publicly reported for at least one year before being considered for inclusion in a pay-for-reporting program. In addition, the MAP should clarify and re-evaluate the categories and terms it uses for decision-making (particularly the term "support direction").

We strongly urge CMS to provide a list of the measures under consideration earlier than December 1 of each year. MAP members are called upon to review literally hundreds of measures in approximately a two-week time frame. In addition to being highly disruptive of the committee's time, it also makes it impossible for MAP members to fully consider all measures under consideration and to seek appropriate consultation from the field.

Thank you very much for considering our comments. We look forward to working with NQF and the MAP on these very important issues.

Sincerely,

/s/

Kathleen McCann, R.N., Ph.D.
Director of Quality and Regulatory Affairs