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ADVOCATING FOR BEHAVIORAL HEALTH
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June 24, 2013

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

RE: CMS-1599-P: "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation"
(42 CFR Parts 412, 482, 485, and 489)

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 (CMS-1599-P) titled "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation" as published in the May 10, 2013, *Federal Register*.

We are specifically providing comments on the proposed **Quality Reporting Requirements** section of the proposed rule.

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

COMMENTS

NAPHS is a founding partner in a collaborative effort with the National Association of State Mental Health Program Directors (NASMHPD) and the NASMHPD Research Institute, Inc. (NRI), the American Psychiatric Association (APA), and The Joint Commission (TJC) to develop the Hospital-Based Inpatient Psychiatric Services (HBIPS) core measures. These have been widely used by the field since they were piloted in 2008. They have been required for Joint Commission accreditation for freestanding psychiatric hospitals (both public and private) since 2010. Eighty-six units in general hospitals also voluntarily report HBIPS data.

NAPHS has also been actively involved in helping the psychiatric hospital field implement the provisions of Section 1886(s)(4)(C) of the *Social Security Act* relative to the collection and submission of quality data for services reimbursed through the inpatient psychiatric facility prospective payment system (IPF PPS).

HBIPS 2-7 have been adopted by the Centers for Medicare & Medicaid Services (CMS) for payment purposes, and all psychiatric facilities (both freestanding hospitals and units in general hospitals) reimbursed through the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) began collecting data on these measures as of October 1, 2012. We continue to support the value of all facilities reimbursed under prospective payment using the same measures. This helps CMS develop a comprehensive, yet targeted and focused, database for purposes of quality analysis and public reporting.

We understand the challenges of working with the complex measures (HBIPS 2-7) that were adopted in the FY 2013 IPPS/LTCH PPS Final Rule. We appreciate CMS's recognition of the importance of allowing IPFs an additional year to "ramp up recordkeeping and improve quality of care on existing measures" before removing, replacing, or adding any new measures. From our extensive experience helping our members use the HBIPS measures, we know they require very significant clinical and administrative resources, especially in the initiation phase. The CMS focus on using the data developed through these measures to improve the quality and efficiency of care is extremely important. The field has demonstrated over time that these measures have direct applicability to quality and can be used to positively impact the patient care experience. We strongly support the decision to not add any new measures to the IPFQR Program for the FY 2015 payment determination.

PROPOSED NEW QUALITY MEASURES FOR THE FY 2016 PAYMENT DETERMINATION

We would like to comment on the three new measures proposed for the FY 2016 payment determination. As background for these comments, we note that HBIPS 1 (Admission Screening for Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths) was recommended for endorsement at the June 5, 2013, meeting of the NQF Behavioral Health Steering Committee meeting. Freestanding psychiatric hospitals (approximately 530) have been required to use HBIPS 1 for accreditation purposes since 2010. We recommend use of HBIPS 1 to meet some of the quality measurement priorities CMS has identified.

The first of the specific measures being proposed is:

1) **SUB-1: Alcohol Use Screening: The number of patients age 18 years or older who were screened for alcohol use using a validated screening questionnaire for unhealthy alcohol use during their inpatient stay.**

NAPHS recognizes the importance of identifying patients in our care who use alcohol in unhealthy ways. However, we think SUB-1 is a very limited measure relative to the needs of hospitalized psychiatric patients. While it requires screening for unhealthy alcohol use with a validated questionnaire of all hospitalized patients above the age of 18, SUB-1 does not include patients who are using/abusing other substances and does not stipulate what period of use/abuse is being assessed (current, last year, lifetime, etc.). It does not include patients under the age of 18 and it does not report the data stratified by age. It does not specify when during the hospitalization the screening is to be completed, whether or not the data is also to be requested from collateral sources such as family or previous caregivers, nor does it specify the clinical credentials of the persons permitted to complete the screening.

RECOMMENDATION:

We propose that CMS use HBIPS 1 in place of SUB-1. HBIPS 1 contains a requirement for all psychoactive substance use screening in addition to alcohol use screening. This screen is done within the first three days of admission on all patients (no excluded populations) and covers the last 12 months of each patient's life. Freestanding psychiatric hospitals and many units in general hospitals have been using this measure since 2010 after recognizing this as a measurement gap in the affected population. It is required to be done by a qualified psychiatric practitioner.

2) **SUB-4: Alcohol and Drug Use: Assessing Status after Discharge: The number of discharged patients who are contacted between 7 and 30 days following hospital discharge in order to collect post-discharge follow-up information regarding their alcohol or drug use status.**

SUB-4 was **no**t recommended for endorsement by the NQF Behavioral Health Steering Committee at its meeting in June 2013. NAPHS has a number of concerns about the structure and implementation of the measure. It is unclear how the data could be used for performance improvement. The measure requires follow up, not only of patients who screened positive for unhealthy alcohol use, but also patients who

received a diagnosis of drug use disorder during their hospital stay. It is very unclear what the purpose of the follow-up is. The patient is asked (between 7 and 30 days after hospital discharge) about their alcohol or drug use status. We are concerned that appropriate confidentiality protections are not in place for contacting patients once they leave the jurisdiction of the hospital. We are concerned about the potential liability a hospital may face in discovering information (e.g., a patient is seriously misusing alcohol or drugs) during a post- discharge phone call when they no longer have a formal treatment relationship with the patient. How does the wide variation (7-30 days) in call time affect the results? What relationship are we measuring between screening (alcohol abuse) and diagnosing (drug disorder) and post-discharge status? How can the results of the follow-up call be recorded in a closed record? How can this be recognized as a publicly reported measure of hospital quality?

The requirement for follow-up after discharge would impose a very significant data-collection burden on hospitals with no clinical justification. At least 3 attempts to reach the patient are required. Persons discharged from psychiatric care are often very difficult to follow because of the psychosocial challenges and chaotic life circumstances they face. They are understandably reluctant to share sensitive clinical data with persons they do not know via a phone call (especially addictive disorder data which, in some cases, involves illegal possession and use). Mail-in results from this patient population do not have scientifically acceptable return rates.

There is no clinical benefit to the patient in collecting the information. Patients are no longer under the jurisdiction of the hospital after they are discharged. Staff placing the calls would not be prepared to answer patient's clinical questions, should they arise, or provide them with individualized information (such as to which outpatient provider the patient was referred, what was the purpose of the referral, etc.)

There is currently no staff member in psychiatric hospitals performing this function so it would require hiring additional staff (again, with serious concerns about the clinical value the data could possibly have). Larger hospitals could easily be placing many hundreds of calls per month. The measure is calculated on the number of patients who are contacted, not the number of patients who are not drinking. Improvement is noted as an increase in the rate of patients who are contacted, not on any clinical factors. We do not feel this measure is not consistent with the CMS goal of weighing the relevance and utility of measures compared to the burden on IPFs of submitting data.

We think the requirements of HBIPS 6 and 7 (currently required in the IPF Quality Reporting Program) related to continuity of care (the discharge plan is developed and transmitted to the next level of care) accomplish the goal of both referring the patient to an outpatient provider and assuring the provider receives the discharge plan and recommendations in a timely way. We think this is the appropriate scope of responsibility the hospital can and should assume.

RECOMMENDATION:

NAPHS recommends not adopting SUB-4 for the IPF QR reporting system. We note that in the proposed rule CMS proposes the addition of three new chart-abstracted measures (including SUB-4). SUB-4 is clearly not a chart abstracted measure.

3) Follow-Up After Hospitalization for Mental Illness (FUH) (NQF #0567)

NAPHS supports the importance of continuity of care for patients diagnosed with psychiatric illnesses, but we have significant concerns about the applicability of this measure to inpatient psychiatric patients. We note that the eligible population for the measure specifies insurance product lines including commercial, Medicare, and Medicaid. It includes references to "members" and allows for no gaps in "enrollment." The proposed rule states that the measure is specified by the steward for either collection through chart abstraction or calculation using claims/administrative data, with CMS considering using claims/administrative data for measure calculation.

Given that patients cared for in IPF PPS facilities have many payer sources (or no payment), it is difficult to understand how facilities (or CMS) could obtain the data needed to report this measure. We cannot access data from health plans. Nor can we obtain it from Medicare (with some exceptions) or Medicaid. While we take responsibility for identifying the next level of care at the time of discharge and getting important information to the next provider through other CMS-required measures (HBIPS 6-7), we have no way of actually knowing if the patient kept a first appointment. While a health plan can answer that question fairly easily by reviewing its internal data (as is specified in the FUH measure), it is impossible for a hospital to do

the same. There would be no place on the chart to find this data since it involves an event that happens 7-30 days after the patient has been discharged and occurs when the chart is closed.

RECOMMENDATION:

We do not recommend FUH (NQF #0567) for inclusion in the IPF QR program. This measure was developed and specified for a very different use than is being suggested in the proposed rule. For the reasons outlined in our response to SUB-4, calling patients a month after they are discharged to determine if they have kept an appointment is not feasible. The information required to report this measure is not available to hospitals through chart review or claims/administrative data. Again we note that in the proposed rule CMS proposes the addition of three new chart-abstracted measures (including FUH). FUH is not a chart abstracted measure.

PROPOSED REQUEST FOR VOLUNTARY INFORMATION--IPF ASSESSMENT OF PATIENT EXPERIENCE OF CARE

We acknowledge that there is no formal measure of patient and family engagement and experience of care in the current IPF QR program. We appreciate your identification of the collection, reporting, and compatibility issues raised as we move forward and the need for planning over time. We are aware of several experience-of-care tools currently in use which could be examined and used to inform the field of the strengths and weaknesses of the various instruments. The proposed rule suggests a voluntary polling of the field to determine what survey people are currently using.

RECOMMENDATION:

NAPHS would be willing to partner with other interested parties to gather data from the field that CMS could use to begin conceptualizing the issues related to measurement of psychiatric patient engagement and experience-of-care. Our membership is broadly representative of providers of inpatient psychiatric services reimbursed under the IPF PPS in both freestanding facilities and units in general hospitals. This form of data collection could be more effective and efficient than if CMS developed a voluntary reporting measure. In gathering data from the field, we would seek to find out the name and description of the instrument, the domains of measurement, and providers' experience with the measure. We can then address with CMS, if necessary, the field's needs for future measure development in order to address this priority of the Health and Human Services National Quality Strategy (NQS).

REQUEST FOR RECOMMENDATIONS FOR NEW QUALITY MEASURES FOR FUTURE YEARS

NAPHS appreciates the opportunity to offer suggestions for new quality measures for future years, consistent with the NQS strategy. The first specific domains you highlight are treatment and quality of care for geriatric patients and other adults, adolescents, and children. We wish to point out that the current measures in use (HBIPS 2-7) and the measure recently recommended for NQF endorsement (HBIPS 1) are all stratified by age group. It is possible to analyze the data from any of the measures relative to the specific populations you identify. All the measures are used for **all** patients in IPF PPS-reimbursed facilities, regardless of diagnosis. Consequently, data is being collected and reported on virtually every patient (with some use of statistically appropriate sampling) treated in these facilities. In comparison to disease-specific measures, the HBIPS measures are universally applied.

Screening for suicide and violence is also identified by CMS as an area of measurement interest through the Technical Expert Panel convened to advise CMS on further IPF QR measure development. HBIPS-1 contains a requirement for screening for suicide and violence as part of its set of required assessments. HBIPS1 was recently recommended for NQF endorsement and has been in use by Joint Commission-accredited organizations since 2010. Participants have found this area of screening to be critically important. Potential for violence to self and others remains very high among the hospitalized psychiatric population, and professional knowledge and skills in assessment is critical to maintaining a safe therapeutic environment.

Relative to readmissions, we direct you to a publication recently released by The Moran Company, *Medicare Psychiatric Patients & Readmissions in the Inpatient Psychiatric Facility Prospective Payment System.* NAPHS engaged The Moran Company to assess, for the first time, the discrete issues raised by admission and readmission patterns for inpatient psychiatric facilities (IPFs) paid under Medicare IPF PPS (which includes freestanding psychiatric IPFs and hospital-based psychiatric distinct part units). All previous studies of psychiatric readmission had focused on discharges from and readmissions to short-term acute

care hospitals (IPFs). The Moran Company study identifies characteristics of the beneficiaries (including disability status, age, and primary diagnosis) as well as rates of readmissions by time intervals and average length of stay. This analysis pinpoints the high rates of disability, chronic psychiatric diagnosis, and low income which have all been previously identified as risk factors for readmission across various payment systems. We would be happy to talk further with you regarding the findings of this study.

RECOMMENDATIONS:

As CMS continues to expand its portfolio of measures applicable to IPF QR facilities, NAPHS recommends that CMS review the paper authored by Don Moran titled *Medicare Psychiatric Patients & Readmissions in the Inpatient Psychiatric Facility Prospective Payment System.* This is the first analysis of the characteristics and readmission patters of patients reimbursed under the IPF PPS system. The study highlights very important readmission issues specific to this population which must be taken into consideration when constructing readmission measures. We would be happy to talk with you further about the study.

We recommend that CMS use HBIPS 1 to its greatest potential in addressing domains of interest such as substance abuse and risk assessment (suicide and violence). These are areas recommended by the Technical Expert Panel convened to advise CMS on future measurement development and are consistent with the National Quality Strategy (NQS). HBIPS 1 also assesses trauma, an area well-documented in the literature as a high co-morbidity within the psychiatric inpatient population. It assesses patients strengths, foundational data on which to base recovery-oriented treatment. Use of the HBIPS set of measures maintains alignment of numerator and denominator definitions, sampling requirements, and operational definitions and avoids the conflicts introduced in attempting to measure and report data on similar domains through the use of measures that are not aligned.

PROPOSED PUBLIC DISPLAY REQUIREMENTS FOR THE FY 2014 PAYMENT DETERMINATION

We support the CMS proposal to align the IPF reporting and display periods with that of the Hospital IQR program (April of each calendar year). We agree that it will give IPFs the opportunity to review the data that is to be made public prior to its being made so.

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 beneficiaries continue to have access to high-quality Medicare services.

Sincerely,

/s/

Mark Covall
President/CEO