NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS
ADVOCATING FOR BEHAVIORAL HEALTH
900 17th Street, NW, Suite 420, Washington, DC 20006-2507 | Ph 202/393-6700 | Fx 202/783-6041 | naphs@naphs.org | www.naphs.org

SUBMITTED VIA www.regulations.gov

June 24, 2014

RE: **CMS–1606–P: Proposed Rule** – "Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System—Update for Fiscal Year Beginning October 1, 2014 (FY2015)"

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services (CMS)
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; Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS)—Update for Fiscal Year Beginning October 1, 2014 (FY2015)" as published in the May 6, 2014, *Federal Register*.

We are specifically commenting on 1) the **inpatient psychiatric prospective payment system (IPF PPS) update for FY15** and 2) **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.

COMMENTS: IPF PPS UPDATE FOR FY15

We appreciate the opportunity to respond to the preliminary findings of the CMS work to determine the potential merit of an IPF-Specific Market Basket. Since promulgation of the May 2006 IPF PPS final rule, IPF PPS facility payments have been updated using a FY 2002-based market basket (hospital input price index) reflecting the operating and capital cost structures for inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and inpatient psychiatric facilities paid under the IPF PPS system. Since 2009

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CMS has expressed interest in exploring the possibility of creating a stand-alone or IPF-specific market basket that reflects the cost structures of only IPF providers.

We note the significant work CMS has done in the development of a potential IPF-specific market basket. However, without more information, NAPHS is unable to comment on whether a stand-along market basket would improve payment accuracy in the IPF PPS. We agree that further analysis is required at this time before conclusions can be drawn from the research. We support your continuing this work, and we would be pleased to provide information that might be helpful.

COMMENTS: IPF QUALITY REPORTING PROGRAM (IPFQR)

As you know, NAPHS has long been committed to performance measurement – working with CMS, accrediting agencies, the public and private sectors, consumers, and other stakeholders – to develop and support the ongoing use of inpatient psychiatric performance measures. Our association was one of the original organizations that invested more than 10 years in development of the Hospital Based Inpatient Psychiatric Services (HBIPS) measures that were the among the first CMS performance measures in the IPFQR program. We are pleased that these measures remain a foundation of the IPFQR program.

We applaud CMS for helping the field to focus on collecting, reporting, and analyzing measures that are tested and valid for improving the quality of psychiatric care. We support the CMS IPFQR program, which articulates overall national goals for improved health care. The CMS IPFQR is an opportunity to 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 *Affordable Care Act* (ACA) extended this requirement to IPF PPS-reimbursed systems.

We agree with CMS' intent as stated in the proposed rule that "We seek to collect data in a manner that balances the need for information related to the full spectrum of quality performance and the need to minimize the burden of data collection and reporting."

Through our representation on the CMS Technical Expert Panel as well as through these opportunities to publicly comment, we are committed to continuing to provide perspective from the field on new measures under consideration.

The NAPHS Quality Committee has identified a set of principles by which the association views performance measurement efforts. We believe that all performance measurement and outcomes data-collection efforts must:

1. be for the purpose of improving the effectiveness and efficiency of patient care;

2. focus on indicators that provide the most useful clinical and operational data possible;

3. focus on indicators that support actionable steps that fall within the scope of responsibility and accountability of the organization being measured;

4. provide value in the data generated that is in proportion to the intensity of the data-collection effort. Allocation of limited resources needs to be directed to the collection of the most clinically significant and actionable data – with attention to operational and technical data extraction, feasibility, and burden.

5. have the potential for being used to measurably improve the processes, outcomes, efficiency, and patient experiences of the care being delivered.

Using these criteria as a lens through which to assess proposed IPFQR Program measures for future years, we offer the following comments.

PROPOSED ADDITIONS TO THE FY2016 PAYMENT DETERMINATION AND SUBSEQUENT YEARS:

Measure: "Assessment of Patient Experience of Care"

In this measure, CMS is asking IPFs to attest to the following questions:

- Do you administer a detailed assessment of patient experience of care using a standardized collection protocol and a structured instrument?
- If you do use such a measure, what is its name?

While we support CMS's general intent to move toward standardized experience of care assessments (as in the medical/surgical setting), we have concerns about the process that is proposed. We do not think an attestation measure (not specified and not endorsed by NQF) – **yet tied to payment** – is the most effective way to proceed.

Through discussion with our member organizations, we are aware that hospitals are widely using some type of assessment of the patient experience of care. Some are using highly structured evaluations (e.g., through groups such as Press Ganey). Others have adopted a variety of existing tools or developed their own tools to meet the needs of their patient populations, with a variety of questions and protocols in place. NAPHS generally agrees with the six domains CMS has outlined for clients' evaluation of their inpatient care—outcome, dignity, rights, treatment, environment, and empowerment as reasonable places to start.

CMS could not find an NQF-endorsed measure that asks the attestation questions listed above. Because the measure has not gone through a development process, it does not include definitions of terms such as detailed, standardized, and structured. Perhaps what CMS really wants to know is what is being used by the field, how is it structured, what are potential cross-cutting questions, what domains are assessed, how are the needs of special populations addressed (e.g., involuntarily committed patients, children and youth, older adults, longer/shorter lengths of stays, medically co-morbid patients). Other important information could be related to the protocol for data collection. Are instruments used at the point of discharge, what length of instrument is most effective for the inpatient psychiatric population, what levels of literacy and understanding need to be accommodated, who are the experts in this field? We welcome CMS's leadership in this effort.

We are aware of the development process that was used for the HCAHPS tool. It involved a partnership with various agencies, consultation with providers and consumers, literature review, psychometric analysis, stakeholder input, and pilot testing. There were multiple opportunities for public comment. We hope the work to develop a tool for use in psychiatric inpatient facilities will follow a similar path. The field needs to come together to use its collective experience to develop clinically sound and actionable tools that can be used to improve the quality of care for patients and families.

Recommendation:

The proposed measure is an attestation measure only – and is not a quality of care measure. As such, we believe it should not be part of a requirement that affects payment and that is publicly reported. We offer to work closely with you to assist in developing a tool for inpatient psychiatric facilities through a process similar to that used for the HCAHPS tool.

Measure: "Use of an Electronic Health Record"

CMS is proposing to require that facilities report the degree of their use of electronic health records (EHRs) for exchange of health information by answering one of the following:

- The facility most commonly used paper documents or other forms of information exchange (i.e., email) NOT involving transfer of health information using EHR technology at times of transition of care.
- The facility most commonly exchanged health information using non-certified EHR technology (not certified under the ONC HIT Certification Program) at times of transition of care.

- The facility most commonly exchanged health information using certified EHR technology at times of transition of care.

While the industry is making progress in the adoption of EHR technology for IPF facilities, there is not sufficient empirical evidence presented in the proposed rule to support a conclusion that the use of currently available EHR technology platforms facilitates the delivery of meaningfully better quality of care. Progress is complicated by the present lack of interoperability and communication among and between the various behavioral health and physical health EHR products. Privacy laws and regulations that limit the sharing of personal health information of patients treated for psychiatric and substance use conditions present unique challenges in the design of EHRs. Based on these limitations, we believe that public reporting of the level of adoption of electronic health records **would not** provide meaningful and useful information for consumers and others. It is more likely to confuse rather than inform the public in making decisions about the quality of care in IPFs.

The use of EHRs measure is not endorsed by the National Quality Forum (NQF). CMS states its preference for using NQF-endorsed measures. The NQF MAP did not support the measure in its 2013 consideration of it because it "does not adequately address any current needs of the program." We understand that CMS can use measures that are not endorsed by NQF when no measure exists, but we do not think this is an appropriate circumstance to invoke the justification to use a non-endorsed measure. If CMS is interested in assessing the degree of adoption of EHRs among IPF PPS providers, there are data collection methods that can do this without mandating the use of the measure for payment and public reporting purposes. We would be happy to work with our industry partners and CMS to gather this information outside of the IPFQR program.

Recommendation:

The proposed measure is an attestation measure only – and is not a quality of care measure. We do not think this measure should be used in the IPFQR program, nor should the data (including an individual provider's answer to the question) be publicly reported or tied to payment. We recommend that CMS work with the industry to find other ways to develop data on the current use of EHRs for IPF-facilities for the collection, use, and transmission of medical information.

PROPOSED NEW QUALITY MEASURES:

In the proposed rule, CMS states, "We seek to collect data in a manner that balances the need for information related to the full spectrum of quality performance and the need to minimize the burden of data collection and reporting. We have focused on measures that have high impact and support CMS and HHS priorities for improved quality and efficiency of care provided by IPFs." We use this overarching statement as the basis for our comments on the immunization and tobacco use proposed measures. **While we recognize there are public health values in these measures, we see them as more appropriately placed in the outpatient physical health setting and not as priorities for measuring the quality of psychiatric care delivered during an acute inpatient psychiatric hospitalization**. We are aware that countless things could be measured during hospitalization, but our focus needs to remain on what is essential for quality and public reporting within the context of an episode of acute psychiatric stabilization.

Measures: "Influenza Immunization (IMM-2) and Influenza Vaccination Coverage Among Healthcare Personnel"

Please see our comment above. We support the value of influenza vaccinations for both patients and staff as public health initiatives and know our providers are included in the requirements of state and regulatory agencies regarding influenza immunization. We do not think this is a priority measurement area for the IPFQR program. We note there is no empirically demonstrated direct, or indirect, relationship between these measures and the delivery of quality behavioral health care in the IPF setting. Adding these measures to the IPFQR Program contributes to the proliferation of measures and the diversion of attention away from

measures specific to behavioral health. Based on the NAPHS principles stated above, we recommend focusing on indicators that provide the most useful clinical and operational data possible.

Recommendation:

NAPHS recommends that the immunization measures **not** be included in the IPF QR program. In the event these measures are retained, before further action is taken, we strongly recommend that they first be tested in the IPF setting to ensure that the specifications (which have been designed for acute care facilities) are appropriate for this setting and address any unintended consequences. A key concern would be that the IPF patient population might be vaccinated more than medically necessary.

Measures: "Tobacco Use Screening (TOB-1), Tobacco Use Treatment Provided or Offered (TOB-2), and Tobacco Use Treatment (TOB-2a)"

Behavioral healthcare treatment organizations routinely screen for tobacco use in their evaluation of patients as part of substance use screening. We are very aware that persons with mental illness and substance use disorders represent a disproportionately high percentage of tobacco users. Hospitalization presents an important opportunity to assess and address tobacco use treatment needs on an individualized basis as part of an overall substance use treatment plan. Working with patients to develop the tools to deal with their various addictions is a very important, individualized, and routine part of care.

We believe these proposed measures – requiring detailed chart-abstracted data collection on all patients – are not the right measures to assess the overall quality of IPFs. The TOB measures apply to persons 18 and over. Tobacco use is a serious problem for patients under 18, and it is important to include them in screening.

The TOB measures were not developed for and were not tested in the psychiatric population. They are population measures intended for use with patients in general acute care hospitals. They are not in widespread use. Even though they were voluntarily offered for general hospital use through The Joint Commission accreditation process, relatively few facilities have chosen to use them. **As constructed, we do not think the measures are actionable in a way that will lead to the improvement of the quality of psychiatric care in an IPF.** Clinical integration of all dimensions of a patient's substance use (including tobacco) is an important part of psychiatric and substance use treatment.

Recommendation:

NAPHS suggests the TOB measures, as suggested for use in the IPFQR program, do not provide information that distinguishes quality psychiatric care and should not be required for public reporting and payment. If they are chosen for use, screening for tobacco use could be included in HBIPS-1 (substance use screening) through the measure harmonization process established by NQF.

Measure: Aggregate Population Counts for Medicare & Non-Medicare Discharges

CMS is proposing that IPFs – beginning with reporting for the FY17 payment determination – submit to CMS aggregate population counts for Medicare and non-Medicare discharges by age group, diagnostic group, and quarter, and sample size counts for measures for which sampling is performed.

We believe this is an inefficient use of the quality reporting program. **If CMS needs to refine its data collection for better analysis, the information needs to be collected in some other way**. We are not aware of a like requirement in other payment systems that link directly to public reporting and payment. CMS has provided only minimal tools to assist IPFs to report data—basically a spreadsheet. Adding what CMS terms "procedural requirements" does not contribute to the assessment of quality of care provided in IPFs nor to consumer's ability to evaluate care.

Recommendation:

CMS should identify ways outside the IPFQR program (eliminating a tie to public reporting and payment) to collect the data it needs to assess the accuracy and completeness of measure data.

Measure: Extraordinary Circumstance Exception
CMS is proposing an Extraordinary Circumstance Exception that would allow CMS to grant a waiver or extension to IPFs if it determines that a systemic problem with one of its data collection systems directly affects the ability of the IPFs to submit data.

Recommendation:

We support this exception.

FUTURE MEASURES (UNDERGOING TESTING):

CMS has said that "Through future rulemaking, we intend to propose new measures that will help us **achieve better health care and improved health** for Medicare beneficiaries who obtain inpatient psychiatric services through the widespread dissemination and use of quality information." We support this goal.

Measures: Five Screening Measures
We question how the proposed measures meet the goals highlighted in the above statement. The measures are:

1. Suicide Risk Screening completed within one day of admission
2. Violence Risk Screening completed within one day of admission
3. Drug Use Screening completed within one day of admission
4. Alcohol Use Screening completed within one day of admission
5. Metabolic Screening

Regarding Screening Measures (1-4 Above)

NAPHS recognizes the importance of screening for suicide and violence risk as well as drug and alcohol use (measures 1-4 above). We successfully advocated for the inclusion of these screens in NQF-endorsed HBIPS-1. We think the additional areas included in HBIPS-1 (trauma and strengths) are also important areas of screening for all patients. This integrated, comprehensive set of screens provides a clinical picture of the patient that any one screen by itself does not provide. The field is so committed to the clinical importance of the multi-dimensional screens required in HBIPS-1 that it set the requirement that **all** screens must be completed in order for the measure to be successfully met. Disaggregating this measure into separate measures introduces the potential for weakening the screening process. The HBIPS measures are required measures in the Joint Commission accreditation process, are NQF endorsed, and have been in widespread use since 2008

We are not aware of the measure specifications being used by CMS in the testing of the measures listed above but we note, on face value, there is one critical difference between the current HBIPS measures and the proposed CMS measures. **HBIPS measures require virtually the same screenings but within three days of admission. There were important reasons why developers of the HBIPS measures chose, and continue to endorse, a three day timeframe rather than one day.** The field begins screening for suicide and violence risk as well as drug and alcohol use immediately upon a patient's admission. These areas all have immediate impact on a patient's individualized treatment plan. It is important to note this is not a static, one time screen but, in fact, is the beginning of continuous assessments of these elements and symptoms throughout the acute care stay up to the moment of discharge. Clinicians are constantly collecting information based on what patients can tell us verbally, observation of non-verbal behavior, and supporting information from family and others. HBIPS developers felt it was more clinically valuable and

actionable to extend the time for facilities to complete **all** required elements of the measure rather than deeming the measure not met after 24 hours. After extensive discussion and testing, the requirement was set at 3 days rather than 1 day. We can provide more information if that would be useful.

It is critical that CMS engage in a measure harmonization process with the National Quality Forum (and with The Joint Commission as the steward for the HBIPS measures) to arrive at one set of screening measures. Asking facilities to report virtually the same information in two different ways for TJC and CMS would be inconsistent with the goals of all major measurement initiatives.

Recommendation:

HBIPS-1 should be substituted for screening measures 1-4. Screening measures 1-4 are contained within the NQF-endorsed HBIPS-1 measure. HBIPS-1 has been in widespread use in IPFs since 2008.

Regarding Metabolic Screening Measure (5 Above)

The metabolic screening measure is not a part of the HBIPS set of measures.

We do not know the specifications CMS is proposing in its testing of this measure. While we recognize the important clinical issue that metabolic syndrome presents for patients on antipsychotic medications, we suggest the use of anthropomorphic measures (such as BMI, weight, height, waist circumference, blood pressure) as the required measure. If the results of these screens raise concern to the level that, based on medical necessity criteria, further testing (such as lipids and blood sugar) are necessary, it should be provided outside the basic screening measure.

Management of metabolic syndrome is a long-term challenge for patients and providers. It can be best monitored and treated in the outpatient setting. Risk-benefit decisions must constantly be made regarding the value of medication even in the face of certain risks. Patient's ability to manage medication adherence as well as diet, exercise, etc. varies during the course of both crisis and long-term treatment. Which parts of this multi-faceted challenge are appropriate to address during an acute stabilizing hospitalization is a complex medical judgment best made on a highly individualized patient-centered basis. We support measures that are actionable within the scope of the provider being measured. It is important to achieve the right balance should this measure move forward.

Recommendation:

If the metabolic screening measure moves forward for further testing in the IPFQR program, the specifications should be limited to anthropomorphic screening.

Measure: 30-Day Psychiatric Readmission

There are specific issues that need to be identified in constructing a readmission measure for psychiatric facilities. Providers are dealing with both acute and chronic treatment issues in an environment where support for patients leaving the hospital is often inadequate. The reasons patients come back to psychiatric hospitals are different from why they return to medical-surgical settings.

As stated in the proposed rule, CMS envisions a readmission measure that would encompass all 30-day readmissions for discharges from IPFs, including readmissions for non-psychiatric diagnoses. This proposal raises several questions and issues:

- Would the measure include only Medicare patients (CMS has access to the database that could track this) or all IPF admissions? Providers do not have access to the databases required to report or track readmissions across all payers.

- There may be no relationship between a psychiatric hospital admission and a subsequent med/surg admission within 30 days (e.g., for an acute surgical condition). Yet consumers will only

know that there were certain numbers of "readmissions." This is not meaningful or actionable information.

- There are no published studies on the current readmission rate for IPFs. Reported rates are from the IPPS data.

- There is no risk-adjustment proposed (for example, for urban/rural, forensic/non-forensic, voluntary/involuntary, socio-economic status). This is an area where risk adjustment is critical in order to avoid misinforming the public through reporting that cannot be adequately understood, benchmarked, or interpreted.

- This is not an NQF-endorsed measure.

Recommendation:

CMS should address the points raised above (population included and provider access to the data, reasons for use of all cause data, present rates of IPF PPS readmissions, risk adjustment, and NQF endorsement) before considering a 30-day readmission measure.

We would like to make two additional recommendations relative to the IPF QR program:

We ask that efforts be made to make the display of the publicly reported data more accessible to users—especially the public for which it is intended. The current format makes it difficult to interpret the information.

To the extent possible, we ask that more time be given to the field before data collection on new measures is required. The rate year begins October 1 (with the final rule published 30 days before October 1). New measures must be implemented for patients admitted on or after January 1 of the new fiscal year (3-4 months' time). During that time, new measures must be adopted into clinical processes (including such things as development of policies and procedures, staff education, and quality monitoring). Measures must also be embedded into the documentation work flow (including such things as programming changes to electronic records, development of documentation tools and methods, and data abstraction approaches). These processes all take time in order to assure complete and accurate data is available for abstraction from the included records. Data from all quarters of the fiscal year (Q1, Q2, Q3, and Q4) is included in the data that is reported once annually (between July 1 and August 15 each year). Facilities collect data from January to December of each year, which they then report in July of the following year. We understand there are challenges for CMS and its contractors as well as for providers in setting a workable schedule, but we would like to explore possible modifications to the current schedule in the interest of producing data that truly reflects the practice of each organization.

FOCUS MUST BE ON QUALITY (SUMMARY OF KEY ISSUES)

In reviewing our comments on specific measures, there are recurring themes throughout. As CMS finalizes IPFQR measures, we urge CMS to consider the following:

- **The focus should be on the quality of inpatient psychiatric services.**

- **Limited resources should be directed** to the collection of the most clinically significant and actionable data relative to the provision of psychiatric services – with attention to operational and technical data extraction, feasibility, and burden.

- **Providers have to be given enough time to understand the measures and implement data-collection systems**. The time between promulgation of the CMS final rule each year and facility data collection is currently too tight. Facilities need enough time to embed the measures in clinical processes and develop methods for data collection.

- **Publicly reported data needs to help the consumer make choices on the *psychiatric* care provider they may need.** Measures of immunization status and tobacco use – while of interest – are not meaningful in this context. Data needs to be presented in a way that is usable for consumers.

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