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The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Verma:

The American Psychiatric Association (APA), the national medical specialty society representing over 37,800 psychiatric physicians and their patients, strongly urges the Centers for Medicare & Medicaid Services (CMS) not to adopt the Psychoses/Related Conditions episode-based cost measure for inclusion in the Merit-based Incentive Payment System (MIPS). We share the concerns expressed by the National Quality Forum (NQF) in their recommendation of “Do Not Support.” As currently constructed, the measure could have a significant negative impact on the provision of mental health services to the most vulnerable segment of our patient population. This measure, as likely others, raises important questions related to appropriate follow-up window for an episode of care and adjustment for clinical complexities and social determinants of health that perpetuate disparities. Together, we believe we will be more strongly positioned to refine quality measures for persons with psychiatric disorders and to improve our methods to transparently and consistently monitor the quality of care for our most vulnerable citizens.

Implementation of the measure would be particularly problematic given the unique complexities of the transition from inpatient psychiatric hospitalization to outpatient mental health care. Successful transitions from inpatient care to the community often demand navigating a complex, fragmented health care system. In its December 2017 report, *The Way Forward: Federal Action for a System That Works for All People Living with SMI and SED and Their Families*, the Interdepartmental Serious Mental Illness Coordinating Committee included recommendations for providing “a comprehensive continuum of care for people with SMI and SED.” National recommendations for comprehensive continuum of care have yet to be established.

In addition, the challenges to transition from inpatient to outpatient care are often accentuated for persons suffering chronic, psychotic disorders. Influential patient-level factors include lack of primary supports, absence of an ongoing relationship with an outpatient provider prior to admission, clinical comorbidity (i.e., co-occurring substance use disorders, atherosclerotic cardiovascular disease), and disproportionately high negative social determinants of health (i.e., poverty, unemployment, housing and food insecurity, stigma). At the system level, this vulnerable population faces greater barriers that have a well-established negative impact on the cost and availability of care ---inadequate insurance coverage, a fragmented system of care, and lack of access to specialty care. This transition is further complicated by the maldistribution of outpatient mental health services that often hinders the patient’s ability to receive timely follow-up treatment.

To hold inpatient psychiatrists responsible for access to and timely follow-up outpatient care for persons with psychotic disorders is not appropriate. Inpatient psychiatrists cannot be held accountable for addressing acute and chronic clinical needs of their patient in an environment where support for patients leaving the hospital is often inadequate. The acceptable scope of responsibility for the hospital physician is the development of an appropriate discharge plan with recommendations that are communicated in a timely way to the designated outpatient provider.

While inpatient psychiatrists do their best to treat patients in a way that will prevent rehospitalization, there is no recognition in the proposed measure that the inpatient psychiatrist rarely serves as the provider for follow-up outpatient care. Traditional case management services often do not adequately meet the needs of individuals with severe mental illnesses who are transitioning from inpatient to outpatient care. Additional work, including consideration as to how accountability for this interaction can best be attributed and measured needs to be done to build on what we know now and identify best practices that can be effectively implemented. More research needs to be done to identify the components necessary to increase successful transitions and begin to make a meaningful impact on the cost of care.^{1 23}

While the development process put in place by CMS and Acumen, LLP to define the measure set has been collaborative, the lack of relevant key stakeholders (i.e., social worker, psychiatric nurse, care managers,) to represent the individuals who play a significant role in the transition process may have contributed to the measure's failure to account for the complexities of post-hospitalization follow-up. There is also a lack of evidence supporting the scientific acceptability for the measure in the field testing. No preliminary findings using existing publicly available data sources to support the reliability or validity of this measure are reported, a requirement when applying for NQF endorsement.

We support CMS's vision to implement measures for which adherence drives improvement in care. However, this measure falls short. It would be premature for CMS to move forward with the implementation of the Psychosis/Related Conditions measure given the lack of adequate stakeholder input, insufficient evidence of scientific acceptability, and the lack of support from NQF.

We urge CMS to postpone implementation, and we welcome the opportunity to partner in future research or demonstration projects that would allow for sufficient testing and further refinement of this and other quality measures related to mental health. We will reach out to the appropriate CMS staff to have further discussions.

If you have any questions, please contact Becky Yowell, Director, Reimbursement Policy, at byowell@psych.org or 202-683-8298.

Sincerely,



Saul M. Levin, M.D., M.P.A.
CEO and Medical Director

¹ Gaynes BN, Brown C, Lux LJ, et al. Management Strategies To Reduce Psychiatric Readmissions [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2015 May. (Technical Briefs, No. 21.)

² Care Transition Interventions to Reduce Psychiatric Re-Hospitalizations. Alexandria (VA): National Association of State Mental Health Program Directors; 2015 September.

³ Smith TE, Abraham M, Bolotnikova N, et al. Psychiatric Services 2017 68:1, 92-95