30 June 2014

Marilyn Tavenner
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:


The American Psychiatric Association (APA), a professional society representing 35,000 psychiatric physicians who practice throughout the United States, is grateful for an opportunity to submit comments in response to the Department of Health and Human Services’ Proposed Rule on Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System - Update for the Fiscal Year Beginning October 1, 2014 (FY 2015) (Vol. 79, Federal Register No. 87, 26040, May 6, 2014). In particular, APA is pleased to offer our comments on the proposed changes to the Inpatient Psychiatric Facilities Quality Reporting Program (IPFQRP) contained within the proposed rule.

APA has been a longtime supporter of the IPFQRP and has worked with HHS and the Centers for Medicare and Medicaid Services (CMS) since its inception to ensure that the program is administered well and that inpatient psychiatric facilities are able to report on the quality measures to the best of their ability. In the current proposed rule, CMS is announcing that they are adding a number of new measures, many of which are not endorsed by the NQF or have not been tested for psychiatric facilities. We do have concerns the rate at which CMS is adding new measures could negatively impact participation in the IPFQRP and that the measures that CMS is proposing to add may not be the most appropriate measures to accurately evaluate quality in these facilities. Since the IPFQRP is publicly reported and because there are financial incentives involved, APA wants to ensure that the measures used are a good indicator of the quality of care provided and that there are safeguards in place to make sure that the data will be presented properly to the public.
We would like to offer our specific comments on the proposed measures below:

**ASSESSMENT OF PATIENT EXPERIENCE OF CARE**

APA agrees with CMS that the improvement of care for patients, families and caregivers is at the core of the Medicare quality programs and we agree that patient-reported experience can often reflect the care provided. However; this is not always the case, depending on the setting. Unfortunately, the patients who receive care at many psychiatric facilities may not be seeking care of their own volition and, depending on their condition, may receive care at vastly different types of psychiatric inpatient facilities. Therefore, the self-reported “patient experience” could differ greatly between care settings and be wildly subjective. For example, APA feels that it could be unfair to compare the patient experience surveys from a high security forensic psychiatric unit to that of a low risk, private unit. Those patients who receive care in a psychiatric facility also may not have a choice as to where they receive care, which makes the public reporting of such data of limited value. APA has serious concerns that the public reporting of this measure will not accurately reflect the level and quality of care provided in certain facilities and may unfairly prejudice patients who rely on this information when choosing a healthcare setting.

**USE OF ELECTRONIC HEALTH RECORD**

CMS is also proposing including a measure regarding the extent of the IPF’s use of electronic health records in the IPQFR program. APA similarly has serious concerns about this measure and would object to its inclusion if it were tied to payment and publicly reported. Many mental health and psychiatric facilities are poorly funded and have minimal electronic health records.

This would already put these facilities at a disadvantage when reporting to what extent they are using an HER. While we recognize that CMS is trying to ascertain the degree to which facilities are using and are able to use electronic records, we do not think this is an appropriate point at which to tie this measure to payment. Further, APA has concerns that the effort to report on the use of an electronic health records will divert attention away from physicians’ and staffs’ core duties which may negatively impact patient care.

As CMS states in the proposed rule, this measure is not endorsed by the NQF and 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.” APA does not believe that this measure adds value to the quality reporting program and would urge CMS not to move forward with its inclusion.

**INFLUENZA IMMUNIZATION (IMM-2) (NQF #1659) AND INFLUENZA VACCINATION COVERAGE AMONG HEALTHCARE PERSONNEL (NQF #0431)**

APA understands that influenza immunization is a priority for HHS and CMS as it can dramatically reduce the spread of the flu to highly vulnerable populations and we support efforts to encourage and measure immunized healthcare workers. However, APA does not agree that this measure necessarily belongs in the IPQFR program since there is no demonstrable impact on the delivery of mental health care. APA cautions CMS against including measures simply to increase the volume of measures.
TOBACCO USE SCREENING (TOB-1)(NQF #1651), TOBACCO USE TREATMENT PROVIDED OR OFFERED (TOB-2), AND TOBACCO USE TREATMENT (TOB-2a)(NQF #1654)

Given the prevalence of tobacco use among persons with mental illness and the detrimental effects of tobacco use on overall health, APA is in full agreement that clinicians should provide tobacco use screening and offer treatment. CMS has proposed measures which are NQF endorsed, which we support, but we do have concerns that they have not been tested in the psychiatric population. In the future, APA would urge CMS to use measures which are both NQF endorsed and developed for and tested in the psychiatric arena. We also note that tobacco use is included within HBIPS-1 which APA has endorsed in the past. APA strongly believes that this is a useful measure which will increase quality care and supports CMS's inclusion of a tobacco screening measure, but asks that CMS look into harmonizing this with the HBIPS-1 measure.

AGGREGATE POPULATION COUNTS FOR MEDICARE AND NON-MEDICARE DISCHARGES

CMS has proposed that, beginning in FY2017, IPFs report on the aggregate population counts for Medicare and non-Medicare discharges including demographic information. APA objects to the inclusion of this data as a part of the IPQRF. This information may be of use to CMS, however; we believe this is measurement for measurement’s sake and will not contribute to the quality of care at IPFs. If CMS needs to collect such data, there are alternative mechanisms which are not and should not be tied to the quality reporting program.

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.

We join with NAPHS in supporting this exception.

FUTURE MEASURES UNDERGOING TESTING

CMS is proposing adding more measures in the future which are currently undergoing testing to “achieve better health care and improved health for Medicare beneficiaries who obtain inpatient psychiatric services through the widespread dissemination and use of quality information.”

The measures currently being tested and proposed 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

APA has serious concerns as to how these measures will meet the stated goals CMS has proposed in this rule. The first four measures listed above are all embedded in the Hospital-Based Inpatient Psychiatric Services (HBIPS) measures which are NQF-endorsed, required by the Joint Commission and have been in widespread use since 2008.
The main difference between the measures that CMS is testing as compared to the HBIPS measures is that HBIPS asks that these screenings be done within three days of admission while CMS will require it be done within one day of admission. When the HBIPS measures were developed, there was much discussion concerning the screening timeframe and the developers settled on three days as the most clinically important timeframe. Indeed, most of the time, these screenings do occur within 24 hours of admission, but requiring this for quality reporting does not improve the quality of care. APA objects to this change as we do not believe that shortening this will improve health or health care for Medicare patients. We urge CMS to consider using HBIPS measures as already required for the Joint Commission and harmonizing with existing measures sets.

The fifth and final measure undergoing testing is a metabolic screening. APA fully supports the use of a metabolic screening measure as we are aware of clinical importance of managing metabolic syndromes in psychiatric patients. However, since we do not know what the measure specifications are at this time, we cannot comment on the utility of the measure or its impact on patient care. We strongly support the idea of IPF physicians being able to care for and report on patient health from a holistic basis, but we would be cautious about the burden placed on physicians and ask that CMS keep that in mind when developing the measurement specifications. We look forward to commenting on the specific measure when it is released.

**30-DAY PSYCHIATRIC RE-ADMISSION**

CMS is also proposing adding a measure concerning psychiatric readmissions within 30 days, including those not for psychiatric diagnoses. APA objects to this measure as developed. There are a myriad of reasons why a patient could be readmitted and the measure does not adjust for any kind of risk-analysis. Consumers will not gain any useful information from this measure as to why the patients were readmitted and the readmissions may have no reflection on the quality of care provided at the IPF. APA strongly urges CMS to reevaluate the inclusion of this measure.

Thank you for the opportunity to submit comments on the IPF PPS and the IPQFR and we hope that you take our comments under consideration. We encourage you to contact APA’s Department of Government Relations at (703) 907-7800 should you have any questions.

Sincerely,

[Signature]

Saul Levin, MD  
CEO and Medical Director