June 23, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2333-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Proposed Rule: Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System - Update for Fiscal Year Beginning October 1, 2015 (FY 2016) (CMS-1627-P)

I am writing to you on behalf of the American Psychiatric Association (APA), the national medical society representing over 36,000 physicians specializing in psychiatry, to provide comments to the proposed rule regarding the update to the Center for Medicare and Medicaid Services’ (CMS) Inpatient Psychiatric Facilities (IPF) Prospective Payment System (PPS) for the fiscal year 2016. As you know, APA members provide services to Medicare beneficiaries in all settings affected by the proposed rule. Our comments specifically focus on the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program, and we appreciate CMS taking our comments under consideration.

APA agrees with CMS that the program must improve the quality of inpatient care while also providing beneficiaries information enabling them to choose quality healthcare. Therefore, all of the proposed measures must be consistent with the CMS goals of maintaining a set of measures that balance the need for information with the need to minimize burden of data collection and reporting. As the IPFQR program grows, it has become increasingly difficult for physicians to successfully report across healthcare settings. The expectation has become that reporting in this program utilizes a broadly used electronic health record (EHR) system that is unable to consider the specific measures for psychiatric inpatient needs. However, many of the psychiatric facilities under the IPF PPS are not stand-alone psychiatric hospital systems, and this presents a problem for those psychiatric units within a larger system. Larger systems may not develop EHR programs that include the measures necessary for reporting in the IPFQR or, if the system does include the psych specific measures, it can complicate reporting in other programs for physicians in other specialties. For example, either a measure is not included in the EHR at all and then the psychiatric clinicians are unable to report on them, or the expectation is that an obstetrician use the same interface a psychiatrist would use and then become responsible for reporting on psychiatric measures. This represents a significant problem for physicians who are not in stand-
alone psychiatric facilities - and APA urges CMS to consider the needs of all those who are reporting in the IPFQR as the program continues to grow.

**HBIPS-4: Patients Discharged on Multiple Antipsychotic Medications**

APA agrees with CMS’s removal of HBIPS-4: Patients Discharged on Multiple Antipsychotic Medications and feels that the continued use of a measure for the sake of documentation does not lead to improved care and instead only increases the burden on physicians. We also agree that by maintaining the use of HBIPS-5: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification, the ability to detail the quality of care for those receiving multiple antipsychotics is still being considered. Therefore, **APA supports CMS’s proposal to remove HBIPS-4 and we urge CMS to finalize this proposed change.**

**SUB 1: Alcohol Use Screening (NQF #1661) and SUB 2 and 2A: Alcohol Use Brief Intervention Provided or Offered Alcohol Use Brief Intervention (NQF #1663)**

CMS has proposed adding two substance use disorder measures; SUB-1: Alcohol Use Screening (NQF #1661) and SUB-2 and 2A: Alcohol Use Brief Intervention Provided or Offered Alcohol Use Brief Intervention (NQF #1663). Given that alcohol withdrawal can complicate psychiatric care and screening for this condition is important for safety, APA supports the utilization of SUB-1. However, we have concerns with the utilization of the brief intervention measure (SUB-2 and 2A) and do not agree that this measure is appropriate for inpatient settings. These measures have been shown to have a modest effect in primary care and emergency room settings because the patient may not know they have an alcohol problem, in those settings, providers often do not assess or discuss the problem, but inpatient psychiatry is very different. If a psychiatric inpatient has an alcohol problem, they will likely need real treatment for alcohol, medication, counseling, etc. The patient is not receiving the care they need if they are simply given a brief intervention in a psychiatric setting, and APA does not believe these measures should be added to the IPFQR. **APA recommends that CMS finalize the proposed change to add SUB-1 to the IPFQR, but to reconsider adding the SUB-2 and 2A measures.**

**TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and TOB-3a Tobacco Use Treatment at Discharge (NQF #1656)**

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. **Therefore, APA supports the addition of the tobacco cessation measures TOB-3 and TOB-3(a).**

**HBIPS-6: Post discharge continuing care plan created (NQF #557) and HBIPS-7: Post discharge continuing care plan transmitted to next level of care provider upon discharge (NQF #558)**

The APA supports the continued use of a transition-to-care measure, but has concerns over replacing HBIPS 6: Post discharge continuing care plan created (NQF #557) and HBIPS 7: Post discharge continuing care plan transmitted to next level of care provider upon discharge (NQF #558), with the
recommendation to replace with Transition Record with Specified Elements Received by Discharged Patients (NQF #0647); and Timely Transmission of Transition Record (NQF #0648). APA recognizes the advantages to harmonizing and standardizing the processes in a psychiatric setting with what happens in non-psychiatric settings, and we want instructions for patients and other providers to be increasingly transmitted electronically. Patients should receive instructions using standardized education, this information should be transmitted as a part of their personal health record, and this should be available to whatever databases they use with their apps or other health repositories. This kind of standardization and harmonization will help synchronize diverse areas in healthcare and provide more quality care.

However, we have some concerns over the use of the newer measures which CMS has proposed for replacing the earlier measures. The older measures were developed with significant input from the psychiatric field and fully tested for validity and reliability in the psychiatric setting by both CMS and The Joint Commission (TJC). These measures focus on elements of specific importance in the care of psychiatric patients and are endorsed by NQF. APA is concerned that if the Transition Record with Specified Elements Received by Discharged Patients (NQF #0647); and Timely Transmission of Transition Record (NQF #0648) measures are for inpatients on a psychiatric unit, the phrase “surrogate decision maker” is problematic. In this kind of setting, it is unclear if this person is a conservator or who designates the surrogate. Further, what if the adult inpatient does not want or does not have a person they feel fits this role? Does this measure also assume that if a doctor is identified as the surrogate decision maker, that doctor must be available around the clock? This does not seem practical for an adult with serious mental illness who may be referred for follow-up care at a community mental health clinic (CMHC) and may not be assigned a psychiatrist until after his/her intake at the CMHC. In addition, the timely transition measure assumes that a CMHC has the capacity to receive this form, which it may not. If the terms of the measure are met, but the facility is overloaded or unable to provide the care necessary, the measure will not serve CMS’s goals of providing higher quality care to Medicare beneficiaries. APA has serious concerns that these measures may not be appropriate for the IPFQR and, given that there are already measures in place, we strongly urge CMS to refrain from replacing HBIPS-6 and HBIPS-7 with these measures until there is more clarity surrounding the use of these measures in a psychiatric setting.

Screening for Metabolic Disorders
APA agrees with CMS that the addition of the Screening for Metabolic Disorders measure can be highly beneficial to this patient population. People with serious mental illness die at a very high rate from cardiovascular illness, whether they are on a second generation antipsychotic or not. For example, people with schizophrenia are identified in American Diabetes Association (ADA) guidelines as being high risk, regardless of their medication regimen. We concur that individuals with mental illness should be screened for metabolic disorders and have their medical issues more closely managed within psychiatric facilities. However, APA needs to further examine the specifications of the proposed measure before we can officially support the use of the measure considered for addition to the
program. We ask that CMS publish the full measure specifications for stakeholder feedback before finalizing any measure additions to the IPFQR.

Thank you for the opportunity to submit comments on the IPF PPS and the IPQFR and we appreciate your review and consideration. If you have any questions, please contact Samantha Shugarman, Deputy Director, Office of Quality Improvement and Psychiatric Services, at 703-907-8667 if you have any questions.

Sincerely,

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