MISSOURI HOSPITAL ASSOCIATION

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Marilyn B. Tavenner, R.N.
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201-0007

RE: CMS-1606-P, Medicare Program: Inpatient Psychiatric Facilities Prospective Payment System

Dear Ms. Tavenner:

INPATIENT PSYCHIATRIC FACILITY QUALITY REPORTING PROGRAM (IPFQR)

Proposed Measures

CMS proposes two new structural measures for the FY 2016 IPFQR program. One of the measures requires inpatient psychiatric facilities to provide information on whether they conduct assessments of patient experience. While assessing patient experience of the care in the outpatient setting has been shown to be beneficial, its use in the inpatient setting has been limited to internal evaluation of care provided. The population served in inpatient psychiatric units is often admitted not by choice but involuntarily or because of family pressure. A recent Moran Study[1] also found that 80 percent of psychiatric discharges from IPFs had a primary diagnosis of either schizophrenia or episodic mood disorders (including depression), diagnoses that may impact the reliability of their assessment of the care provided. The measure also is not endorsed by the National Quality Forum or the Measure Applications Partnership.

The second measure proposes to assess how IPFs currently use electronic health records. Currently IPFs are excluded from the Medicare EHR Incentive Program. We would support the inclusion of this structural measure if CMS and the Office of the National Coordinator for Health Information Technology plan is to expand the EHR Incentive Program to include IPFs.

CMS proposes four new measures that are NQF-endorsed for the FY 2017 IPFQR program: Influenza Vaccination (IMM-2), Healthcare Personnel (HCP) Influenza Vaccination Tobacco Use Screening (TOB-1) and Tobacco Use Treatment Provided or Offered (TOB-2/TOB-2a).

MHA supports the proposed new influenza measures for FY 2017 IPFQR program to align with similar measures collected across multiple types of acute and post-acute care settings. We do not support inclusion of the tobacco use and treatment measures TOB-1 and TOB-2/TOB-2a for several reasons. These proposed new measures require labor-intensive manual chart abstraction, sampling is not permitted under the proposal and there is no data validation of this aggregately submitted data. Without sampling, hospitals will invest valuable resources abstracting data for public reporting and possible future payment penalty that is not validated for accuracy.

Future Measurement Topics

CMS is considering five measures for future inclusion in the IPFQR program related to suicide and violence risk, drug and alcohol use and metabolic screening. While most inpatient providers currently assess for risk of suicide and violence and screen for drug use, we urge CMS not to include these measures in the IPFQR program until the MAP endorses these measures to ensure that they are relevant, will drive improvement and provide patients with useful information.

CMS also states that it intends to develop an all-cause, all-condition 30-day readmission measure for discharges from IPFs. A readmission measure may not be a true assessment of the quality of inpatient psychiatric care. The National Association of Psychiatric Health System has released a 2013 study performed by The Moran Company that examined readmission patterns within IPFs paid under the IPF prospective payment system.[1]

The Moran Company study, which looks at 2010 Medicare fee-for-service claims data, found that the majority of Medicare beneficiaries treated in IPFs exhibit characteristics that the available literature associates as risk factors for hospital readmissions — including chronic psychiatric diagnoses, disability and low income. The majority qualify for Medicare due to a disability and are dually-eligible for both Medicare and Medicaid. Eighty percent of psychiatric discharges from IPFs had a primary diagnosis of either schizophrenia or episodic mood disorders (including depression), both of which are considered chronic psychiatric conditions and potential risk factors for readmission. The study found 15 percent of all psychiatric discharges from IPFs were readmissions that occurred within 30 days. Only 5.4 percent of all psychiatric discharges from IPFs were readmissions that occurred within seven days. The study also found that for readmitted patients that had received partial hospitalization program services, the time to readmission for these Medicare beneficiaries was 131 days versus 59 days for those who did not participate in this program between admissions.

Adults with severe mental illness also have higher rates of chronic general medical conditions, such as hypertension, HIV/AIDS and diabetes which increase the risk of readmission but are not central to the care provided in IPFs.[2] While quality measures and care pathways aimed at improving medical care for heart attacks, heart failure and pneumonia have been in place for more than a decade, psychiatric measures and care pathways for treating chronic psychiatric diseases are in their early stages of development. Thus, unlike readmissions for conditions such as heart failure, heart attacks or pneumonia in the acute care hospital, a readmission to IPF care may not indicate anything meaningful about the quality and extent of care provided during an initial stay.

Sincerely,

Daniel Landon
Senior Vice President of Governmental Relations

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[1]The Moran Company May 2013 study, *Medicare Psychiatric Patients & Readmissions in the Inpatient Psychiatric Facility Prospective Payment System* accessed online June 9, 2014 https://www.naphs.org/resourcemanager/handlerresource.aspx?id=408.
[2] Horvitz-Lennon M., et al. From silos to bridges: Meeting the general health care needs of adults with severe mental illnesses. *Health Affairs* 25, no. 3 (2006): 659-669.