American Hospital Association

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

June 25, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

RE: CMS-1690-P, Medicare Program; FY 2019 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2018 (FY 2019)

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including our nearly 1,600 psychiatric and substance use disorder provider members, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2019 proposed rule for the inpatient psychiatric facilities (IPF) prospective payment system (PPS) and quality reporting updates. We support CMS's commitment to its Meaningful Measures initiative, but believe additional measures can be removed. We also urge caution and continued oversight as CMS develops additional quality measures for the IPF setting.

IPF QUALITY REPORTING PROGRAM (IPFQR)

Proposed New Measure Removal Factor for Previously Adopted IPFQR Measures. In previous rulemaking CMS finalized factors to determine whether a measure should be removed from a QRP on a case-by-case basis. In addition to these seven previously finalized measure removal criteria, CMS proposes to add an eighth factor: "the costs associated with a measure outweigh the benefit of its continued use in the program." CMS defines "costs" as those affecting providers and clinicians as well as the costs to the agency associated with program oversight. The agency also reiterates that the measure removal evaluation process would continue to be done on a case-by-case basis, and measures that are considered burdensome or "costly" might be retained in the QRP if the benefit to beneficiaries justifies the reporting burden. **The AHA supports the long overdue addition of this measure removal factor.**

Proposed Removal of Influenza Vaccination Coverage Among Healthcare Personnel Measure. CMS proposes to remove this measure, which is reported via the National Healthcare Safety Network (NHSN) system. While this system is used by various health care facilities and providers to monitor infections and other patient safety issues, it is used by IPFs only for the reporting of this measure. Due to the significant cost, time and resource burdens associated with complying with NHSN requirements for a single measure, CMS believes the measure should be removed. The AHA agrees with the importance of health care workers receiving influenza vaccination, and compliance with this measure already is high. As a result, the cost of its continued use outweighs the value of retaining it in the program. **The AHA agrees that this measure is unduly burdensome and appreciates CMS's proposal to remove it from the IPFQR.**

Proposed Removal of Alcohol Use Screening (SUB-1) Measure. CMS notes that it is moving away from using chart-abstracted measures like the SUB-1 measure; in addition, CMS has noted that IPFs routinely demonstrate high performance on this measure and are likely to continue to provide this screening without the measure in place. **The AHA agrees with this rationale and supports the removal of the SUB-1 measure.**

However, removing SUB-1 would not reduce significantly the burden for providers, as this information must be collected in order to complete the subsequent measures, SUB-2, Alcohol Use Brief Intervention Provided or Offered, and SUB-2a, Alcohol Use Brief Intervention. These measures were developed for use in general acute care settings where patients are most commonly admitted for conditions other than substance abuse. This brief intervention for excess alcohol use may be useful as a therapy in addition to whatever treatment is provided for the trauma, disease or other need that warranted the acute care hospitalization. However, IPFs already conduct comprehensive patient screenings at admission, and the information garnered from those screenings informs the appropriate course of treatment for each patient, including treatment for any substance use disorders. For patients with severe alcohol use problems, the "brief" intervention described in the measure specifications would be insufficient and inappropriate. **Therefore, we urge CMS to remove SUB-2 and 2a in addition to SUB-1, as performance is "topped out" and the measures do not meaningfully contribute to improved patient outcomes in the IPF setting.**

Proposed Removal of Tobacco Use Screening (TOB-1) and Tobacco Use Treatment Provided or Offered and Discharge/Tobacco Use Treatment at Discharge (3/3a) Measures. Similar to the rationale used in proposing to remove the SUB-1 measure, CMS notes that IPF performance is uniformly high and unvarying on the TOB-1 measure. In regard to the TOB-3 and 3a measures, CMS reports that the same data reported for these measures is captured in the required transition record received by discharged patients, rendering the measures duplicative. **The AHA agrees with this rationale and supports the removal of the TOB-1, 3 and 3a measures.**

However, as with the SUB-1 measure, TOB-1 must be collected in order to complete the subsequent measures, Tobacco Use Treatment Provided or Offered/Tobacco Use Treatment (TOB-2/2a). We agree that tobacco use is a serious public health problem and recognize the important population health goal of eliminating it. However, we do not believe that a tobacco

treatment measure belongs in a program whose stated purpose is to provide information that can be used by patients and families in making informed choices about where to obtain needed care and to facilitate quality improvement efforts by psychiatric facilities. It seems misguided that consumers should make choices about where to seek hospital care for patients with significant mental illness symptoms based on whether the facility provides tobacco use treatment at discharge. Having to report and track performance on a measure so peripherally related to behavioral health also diverts attention away from improving treatment for the mental illness and substance use disorders that warranted the patients' hospitalizations.

The AHA believes that IPFs should be evaluated on how well they treat the underlying diseases and diagnoses for which their patients are admitted. We believe the tobacco treatment measures in the IPFQR program would take time and resources away from caring for a patient's more immediate needs and could be contraindicated where a practitioner believes the patient should focus on modifying a different behavior. **The AHA urges CMS to remove TOB-2/2a in addition to the tobacco use measures currently proposed for removal.**

Proposed Removal of Hours of Physical Restraint Use and Hours of Seclusion Use (HBIPS-2 and 3) Measures. CMS proposes to remove these two patient safety measures because they are topped out. In addition, the agency notes that these measures "have only been one element of the coordinated approach to minimizing the use of physical restraint and seclusion," and are secondary to the CMS survey and certification process for monitoring and assessing the appropriateness of the interventions.

The AHA agrees that continued monitoring of the use of seclusion and restraint by surveyors will continue to protect against patient harm related to inappropriate use of seclusion and restraint, and thus supports the removal of these measures. However, after hearing concerns from our members, we urge CMS to closely monitor trends from these surveys to ensure that removing these measures does not inadvertently result in an increase in the inappropriate use of these interventions.

Proposed Removal of Use of an Electronic Health Record (EHR) and Assessment of Patient Experience of Care Measures. CMS proposes to remove these structural measures that assess whether an IPF uses EHR technology and administers a patient experience of care survey, respectively. These measures only evaluate whether the items exist, not the quality or improved patient outcomes associated with the items. In addition, CMS has found that performance on the measure among IPFs has remained static across multiple program years, and thus the measures should be removed as they no longer produce meaningful data for providers, patients or CMS. **The AHA supports the removal of these structural measures, and urges CMS to decline to adopt additional structural measures in the future.**

Possible IPFQR Program Measures and Measure Topics for Future Consideration. CMS is considering the development of process and outcomes measures related to treatment and management of depression. Specifically, the agency is considering the future development and adoption of a process measure that assesses administration of a standardized depression instrument, like the Patient Health Questionnaire (PHQ)-9, at admission and discharge for

patients admitted with depression. While the AHA agrees that there are few current measures that meet the Meaningful Measure area of Prevention, Treatment, and Management of Mental Health, we do not believe that a standardized depression assessment instrument like the PHQ-9 would meaningfully fill this gap in the inpatient psychiatric setting. Unlike in the general acute-care space, the practice of depression assessment is so ingrained in the work of psychiatric providers that such a measure would be immediately topped-out and be eligible for removal based on CMS's removal criteria. We understand that a patient-reported outcome measure related to treatment and management of depression would require consistent administration of a standardized assessment instrument, but we do not believe that adding a measure regarding the use of such a tool (and subsequently removing it just a few years later) is the most efficient and least burdensome manner of determining whether the tool is used. We encourage CMS to evaluate other approaches to glean how inpatient psychiatric providers are assessing depression.

Regarding the request for comments on other possible new measures or new measure topics, we believe any new measures should be central to the treatment of the psychiatric disorders for which patients have been admitted. If CMS removes the eight measures as proposed, those measures that would remain in the IPFQR do not relate specifically to psychiatric care or the particular safety needs of patients in this space. Many of the measures were actually developed for use in general acute care settings, and, with the exception of the HBIPS measures, were not tested within the psychiatric setting. In addition, we strongly believe that CMS should only propose measures for adoption in the IPFQR that have been endorsed by the National Quality Forum specifically for the psychiatric setting.

Thank you for the opportunity to comment on this proposed rule. Please contact me if you have questions or feel free to have a member of your team contact Caitlin Gillooley, associate director of policy, at (202) 626-2267 or cgillooley@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development