AMERICAN PSYCHIATRIC ASSOCIATION

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June 25, 2018

Seema Verma, Administrator
Centers for Medicare and Medicaid services
Department of Health and Human Services
Attention: CMS-1690-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Administrator Verma:

The American Psychiatric Association (APA), the national medical specialty society representing over 37,800 psychiatric physicians and their patients, would like to take the opportunity to comment on the 2019 proposed rule for the Medicare Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2018 (FY 2019). Our comments focus specifically on issues that affect the care of patients with mental health and substance use disorders (MH/SUDs), particularly the following priorities:

- Inpatient Psychiatric Facilities Quality Reporting Program (IPFQR)
- CMMI Request for Information (RFI)
- Program payment updates

Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers And Suppliers

APA appreciates the effort made by CMS's Inpatient Psychiatric Facility Quality Reporting Program administrators to align, where possible, with other CMS quality programs. APA appreciates and support alignment in the areas of best practices when accounting for social risk, applying the Meaningful Measures framework in support of the Patients Over Paperwork Initiative, and standardizing the criteria for measurement removal, addition, and retention.

Accounting for Social Risk Factors

APA supports CMS's efforts to show the implications and potential methods for applying social risk-adjustment strategies to quality measures when assessing the quality of care administered within a facility. The clouded initial findings of the two-year NQF SES Trial demonstrated that measures with a "conceptual basis for adjustment generally did not demonstrate an empirical relationship" between social risk factors and the outcomes measured. We look forward to learning the results of NQF's SES Trial extended project period so that we may better understand how socio-economic (SES) disparities can be separated from health care quality disparities.

As stated in the proposed rule, CMS's examination of the benefits and implications of risk adjustment and stratification on value-based purchasing programs is undetermined. However, APA supports the concept of using measures as tools for hospitals to identify gaps in their respective patients' outcomes. Stratifying risk factors during measurement instead of eliminating them would provide a more detailed picture of the costs and quality administered among facilities. Because neither social risks nor differences among IPFs are being considered, APA cautions against comparing outcomes rates among patient groups treated in dissimilar facilities. To accurately compare facilities' performance as part of a value-based purchasing program, all three components of value-based care (outcomes, costs, and quality) should be examined.

Inpatient psychiatric facilities differ in several ways. Examples include case mix, bed volume, and special patient populations (e.g., geriatric or diagnostic-specific). Of the potential differences among facilities, those treating patients suffering with severe behavioral issues and/or high acuity have the greatest potential to demonstrate misleading participation rates in value-based purchasing programs. **APA recommends that CMS examine differences between locked inpatient, and voluntary unlocked psychiatric facilities, when accounting for risk.** Often patients in locked inpatient-facilities have more acute needs (including severe behavioral issues), requiring more resources to achieve minimal outcomes. However, when locked inpatient facilities with more acute patients spend more money to meet those minimal positive outcomes, their quality and value scores appear lower than those of unlocked inpatient facilities treating less acute patients—where less money is required to achieve a greater number of positive outcomes. **APA invites CMS to work with us and other stakeholders to define the necessary steps to implementing quality measures that would reduce disparities among patient groups within and across hospitals.**

Improving Patient Outcomes and Reducing Burden Through Meaningful Measures

APA appreciates the efforts of Congress and CMS to reduce the burden of CMS quality reporting in the different quality programs. APA supports the development and implementation of quality measures that close gaps in mental health and substance use disorders care and reduce variation in practice. Measurement should integrate evidence-based practice and help facilitate achieving optimal outcomes that are jointly identified by patients, psychiatrists, and other health care providers. We agree that the application of the Meaningful Measures framework criteria would demonstrate to CMS decision makers and measure users the value of the implemented quality measures. This would be most useful in meeting the goals set forth in the CMS Quality Strategy. We welcome the benefits of reduced burden at the hospital level of quality measurement.

Proposed Removal and Retention of Quality Measures in the IPFQRP

APA supports the seven factors CMS employs across its Medicare programs when determining whether to propose a measure for retention or removal, but questions the process involved with factor one, or "topped-out" measures. While APA understands the concept behind removing topped-out measures, we are unclear of the life cycle finalized for a topped-out measure within the IPFQRP. When quality measures in the CMS QPP Merit-based Incentive Payment System (MIPS) are designated as topped-out, they navigate through a four-year cycle. This provides measure users with the opportunity to use the topped-out measures until they are removed, but also allows the administrators to observe whether the measures reliably maintain increased performance rates with little variation. If the measure performance rates decrease, demonstrating room for clinician improvement, the measure would lose its topped-out designation and be subject to the four-year cycle again. **APA recommends that CMS provide clarity of**

the mechanisms/timelines that assist in determining a measure is "topped out" and officially removed from the Program.

CMS should develop a plan that mitigates the potential for facilities to regress when measures are removed due to meeting the "topped-out" criteria. Examples from specialties other than mental health suggest that reduced attention to measures is associated with decreases in performance and with worse outcomes.[1,2] A substantial portion of the burden associated with performance measures used in digital environment relates to the building, testing, and integration of such measures into the electronic record and the workflow. Eliminating measures that are beginning to function well and have beneficial effects for patients are counterproductive.

APA is pleased that CMS has proposed an eighth factor to its measure removal and retention criteria. Factor eight, if finalized, would support the removal of quality measures that have costs (including financial and burden) that outweigh their total quality improvement benefits. **However, we caution CMS and recommend that the measures that are considered for factor eight removal be reviewed and determined for removal or retention based on the measures' true ability to elicit program-wide quality improvement; it should not be based solely on the associated costs.** Since measures would be reviewed on a case-by-case basis, APA recommends that CMS continue to implement a measure, even if it comes at a high cost to CMS but serves beneficiaries, such that the benefits justify the CMS administrative burden.

APA is concerned about the proposed removal of the two Hospital-Based Inpatient Psychiatric Services (HBIPS) measures— HBIPS-2: Hours of Physical Restraint Use (NQF #0640) and HBIPS-3: Hours of Seclusion Use (NQF #0641)—without proposing better specified measures in their place. Although we are pleased to learn that the topped-out measure criteria are the impetus for this removal (as it connotes IPFs demonstrate high performance rates without room for improvement). As stated previously, we are interested in learning about the mechanisms/timeline used to make this determination. Given our support for including risk factor strategies into the measures used by the program, we recommend that future measures developed to replace or update HBIPS-2 and -3 are specified in a way that measures and compares true facility performance rates.

APA supports the monitoring of seclusion and restraint processes during the Medicare Hospital Conditions of Participation (COP) on-site survey. However, **we caution CMS to assume that the COP on-site surveyors' examination into whether IPFs maintain processes to reduce seclusion and restraints is synonymous with measuring whether reductions occurred.** Further, it is our understanding that CMS surveyors may have had little experience with working in an IPF. We are concerned with their ability to properly monitor for the *appropriate or inappropriate* use of seclusion and restraints during Medicare Hospital COP on-site surveys. **APA recommends that CMS (and organizations with deemed status to carry out the surveys, like The Joint Commission) regularly provide education to the surveyors that includes a true understanding of what to expect when visiting locked and unlocked IPFs. APA invites CMS to work with APA and other stakeholders to examine potential components of an ongoing educational initiative for surveyors.**

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[1] Shelton et al., *Journal of General Internal Medicine*. 2015;30(8):1133-1139.
[2] Schriger et al., *JAMA*. 1997;278(19):1585-1590.

APA supports the proposed removal of TOB-1: Tobacco Use Screening (NQF #1651). We agree with CMS that this measure is implemented to a degree that leaves little room for IPFs to improve, but again we request more detail about the topped-out criteria. TOB-1, as specified, states that screening must occur "within the first day of admission." This is problematic because of the poorly defined denominator exclusion that states, "Patients who are cognitively impaired." Without a more detailed definition, it is unclear whether this is applicable to *temporary* cognitive impairment that is often a symptom of the treated acute condition but is not part of the diagnosis. For instance, patients in an IPF may behave in a bizarre, disorganized, psychotic, catatonic, or agitated state, and might be diagnosed with schizophrenia. This state might exceed the time permitted in the denominator. Although the facility could screen later during the patient stay, after the *temporary* cognitive impairment has improved the facility would still "fail" the measure and appear to demonstrate poor care when this has not been the case.

APA does not support the proposed removal of TOB-3/a: Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge (NQF #1656). Our concern with the potential removal of TOB-3/a, which has only been included within the IPQRP since 2016, is that evidence strongly demonstrates that tobacco use rates in individuals with mental or substance use disorders persist at higher rates than in the general population. APA also has concerns, as previously described, related to the specifications of the other tobacco use measures.

Rates of tobacco use in patients with mental and substance use disorders are two to three times higher than those in the general population.[3,4] This group consumes at least a third of the tobacco sold in the United States; it is unsurprising that tobacco accounts for a staggering 50% of deaths in individuals with serious mental illness and kills more substance users than their primary substance.[5,6,7] Tobacco use is also associated with threats to mental and substance use disorder recovery, and to community integration.[8,9,10,11] For these reasons, APA supports the continued implementation of TOB-3/a. As

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[3] Lasser K, Boyd JW, Woolhandler S, Himmelstein DU, McCormick D, Bor DH. Smoking and mental illness: a population-based prevalence study. *JAMA*. 2000;284(20):2606-2610.

[4] Centers for Disease Control and Prevention. Vital signs: current cigarette smoking among adults aged ≥18 years with mental illness — United States, 2009–2011. *MMWR*. 2013;62:1-7.

[5] Callaghan RC, Veldhuizen S, Jeysingh T, et al. Patterns of tobacco-related mortality among individuals diagnosed with schizophrenia, bipolar disorder, or depression. *J Psychiatr Res*. 2013;48:102-110.

[6] Hurt RD, Offord KP, Croghan IT, Gomez-Dahl L, Kottke TE, Morse RM, Melton LJ III. Mortality following inpatient addictions treatment. Role of tobacco use in a community-based cohort. *JAMA*. 1996; 275(14)1097-103.

[7] Veldhuizen S, Callaghan RC. Cause-specific mortality among people previously hospitalized with opioid-related conditions: a retrospective cohort study. *Ann Epidemiol.* 2014;8:620.

[8] Taylor G, McNeill A, Girling A, et al. Change in mental health after smoking cessation: systematic review and meta-analysis. *BMJ*. 2014;13:348.

[9] Prochaska JJ, Delucchi K, Hall SM. A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery. *J Consult Clin Psychol*. 2004;72:1144-1156.

[10] Weinberger AH, Platt J, Esan H, Galea S, Erlich D, Goodwin RD. Cigarette smoking is associated with increased risk of substance use disorder relapse: a nationally representative, prospective longitudinal investigation. *J Clin Psychiatry.* 2017;78(2):e152-e160.

[11] Jasek JP, Williams JM, Mandel-Ricci J, Johns M. Trends in smoking among adults with serious psychological distress during comprehensive tobacco control in New York City, 2003-2012. *Tob Control*. 2015;6:622-623. doi: 10.1136/tobaccocontrol-2014-052024. Epub 2014 Dec 30.

currently specified, TOB-3/a does not require a screening for tobacco use within a certain period after admission or before discharge. This is preferable to the TOB-1 measure specification. By removing the TOB-1 imposed "screening within one day of admission," IPF staff can stabilize the most acute symptoms and restore any temporary cognitive impairments that are related to the mental or substance use disorder but are not included as part of the official diagnosis.

The proposed rule emphasizes that the TOB-3/a chart-abstracted data is duplicative of the quality measure "Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (NQF #0647)." However, this quality measure could not be located when visiting the National Quality Forum measure finder (www.qualityforum.org). This causes concern because it has either lost its NQF endorsement or was inaccurately assigned one. With TOB-3/a maintaining a confirmed NQF endorsement, APA trusts that it has successfully navigated through the scientifically rigorous NQF endorsement process, while the unconfirmed transition measure leaves APA questioning the quality (including feasibility, usability, validity, and reliability) of the test data. APA also found limitations to the transition measure, as it is not truly duplicative of TOB-3/a. The transition measure captures only half of the TOB-3/a numerator, "… received or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication at discharge." While the transition measure would capture FDA-approved cessation medications prescribed, it would not address the evidence-based outpatient counseling shown to increase the likelihood for individuals to quit tobacco use.

Proposed Measure Set for the FY 2020 Payment Determination and Subsequent Years

APA supports the measures proposed for the fiscal year 2020 and subsequent years' payment determination, given the confirmation that the tobacco use screening measure and the alcohol use screening measure were previously included in the IPFQRP. The measures that obligated clinicians to screen for the respective substance use within the first day of admission are not required before using SUB-2/a *Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention* (NQF #1663) and TOB-2/a *Tobacco Use Treatment Provided or Offered and Tobacco Use Treatment* (NQF # 1654). In the past, APA disagreed with CMS when the agency included the rushed screening measures and then linked them to the TOB-2 and SUB-2 measures. Because TOB-2 and SUB-2 are no longer linked to those screening measures, APA is comfortable supporting their inclusion in the program. **APA agrees that using the proposed measures is beneficial to improving overall patient outcomes.**

Possible IPFQR Program Measures and Measure Topics for Future Consideration

APA is pleased with the measurement-based care (MBC) concept under consideration by CMS. While MBC is a process that has been slowly adopted by psychiatrists, it is becoming more commonly required in quality programs and facilities where psychiatrists practice. As an example, the Joint Commission recently announced a new requirement that all program participants must regularly use standardized screening and patient reported outcome tools. Because the potential for the regular implementation of standardized assessment tools to track and broadly define patients' outcomes (clinical or functional), **APA strongly supports CMS's investigation. The investigation into the future development and potential adoption should consist of 1) a process measure that assesses the administration of a standardized assessment instrument at admission and discharge, and 2) a patient-reported outcome measure which assesses change in patient-reported function between admission and discharge.** APA recommends that CMS examine additional standardized assessment tools to reduce the prescriptive nature of the quality measure and promote clinician choice, as this concept is continuously refined.

Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety

Promoting Interoperability

APA acknowledges the success of the Health Information Technology for Economic and Clinical Health (HITECH) Act and the original Meaningful Use program in incentivizing the adoption of electronic health record (EHR) systems into practice, especially among hospitals. APA also appreciates CMS's commitment to reducing administrative burdens associated with EHR adoption and utilization with respect to the MIPS program and supports CMS's commitment to do so for inpatient and critical access hospitals through this IPPS proposed rule.

As APA has detailed extensively in previous letters, the focus on true interoperability—rather than on arbitrary, measure reporting thresholds with respect to EHR use—should remain the cornerstone of the Medicare EHR Incentive Program. **As such, APA appreciates the current proposed rule's emphasis on using EHRs to promote interoperability, as well as the overall reduction of mandatory reporting thresholds, both of which represent progress toward implementing the aims of the Office of the National Coordinator for Health Information Technology (ONC) MyHealthEData initiative.**

First, APA supports the performance-based approach to determining hospitals' scores on Promoting Interoperability. While questions remain about the direct correspondence of these activities with improved patient outcomes, the proposed scoring methodology would allow for psychiatrists employed by eligible hospitals to pick and choose among measures that best meets their strengths with a focus on health-data exchange, patients' access to their records, and open APIs to facilitate the movement of patient data across systems. Many certified EHR technology (CEHRT) systems used by psychiatrists in inpatient and critical access hospital (CAH) settings do not directly mirror psychiatric care workflows; offering psychiatrists some degree of leniency in selecting from among measures most germane to them is appreciated.

Second, APA appreciates the efforts of CMS in this proposed rule to reduce administrative burdens within the EHR Incentive Program that have been time-consuming or otherwise not truly aligned with the meaningful use of EHR systems in general. The removal of patient-driven measures (e.g., Patient Specific Education; Patient Generated Health Data; Secure Messaging; View, Download, Transmit) is especially appreciated, given the amount of administrative burden endured by clinicians in adopting these activities into workflows and subsequently tracking successful incidences of their use. Additionally, successful reporting on these measures is based on whether patients engage with their own record, something beyond the control of clinicians. These measures are especially challenging to many psychiatrists who work with patient populations whose diagnoses make it extremely difficult to engage regularly and meaningfully with the EHR in the interest of their own care coordination. APA recommends that these changes also be applied to eligible clinicians in the forthcoming Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) proposed rule.

Finally, some psychiatrists within eligible hospitals and CAHs may find the remaining or renamed/re-envisioned measures (e.g., Supporting Electronic Referral Loops by Sending Health Information; Provide Patients Electronic Access to their Health Information) challenging due to the unique nature of psychiatric workflows. APA appreciates the proposed rule's elimination of many of the arbitrary thresholds and administrative burdens associated with these types of reporting activities required under the current

reporting program; however, the attaining the minimum 50 points required as a performance score under these revised Promoting Interoperability measures might still prove challenging for many psychiatrists practicing in hospitals due to the unique nature of psychiatric workflows.

Transition to sole use of 2015 CEHRT

In the current proposal, CMS states that it will require inpatient hospitals to use 2015 Edition CEHRT by the 2019 reporting year. This is based on the confirmation that "at least 66 percent of eligible clinicians and 90 percent of eligible hospitals and CAHs have 2015 Edition available based on previous EHR Incentive Programs attestation data" and that the trend for projecting 2015 Edition readiness "is based on the major developers who have a major share of the market." APA understands the drive toward 2015 CEHRT to maximize the potential for interoperability between systems and that including 2014 CEHRT results in a number of drawbacks due to retro-adaptations. **APA recommends that CMS allow the use of 2014 CEHRT for the foreseeable future.**

With respect to the CEHRT program overall, psychiatrists still struggle to adopt CEHRT into their practices for multiple reasons, compared to other care providers. Regardless of CEHRT Edition, it is in the interest of Medicare to promote greater engagement of independent and small group psychiatrist eligible clinicians with larger hospital systems and limiting the type of EHR system that can support said engagement precludes these efforts. The MyHealthEData initiative's focus on interoperability and this proposed rule's use of APIs to connect patients and providers may eventually bridge this gap; unfortunately, the business case for smaller, psychiatry-focused EHR vendors to adopt CEHRT simply does not exist, often because many solo and small group providers have opted out of Medicare due to increasing demands of reporting requirements. While many larger vendors certified to the 2015 Edition can and do support psychiatry, there is often an added cost in adapting the software to fit psychiatric workflows, including integrating relevant electronic clinical quality measures into the platform. These providers must also then bear the cost of hiring administrative support staff to help adhere to the quality reporting programs.

APA therefore recommends that CMS continue to allow 2014 Edition CEHRT for the foreseeable future so that those psychiatrists who are using this technology for the quality reporting programs may continue to do so—especially for solo and small group providers who wish to connect into eligible hospitals to "close the referral loop."

New Opioid Measures: Query of Prescription Drug Monitoring Program (PDMP); Verify Opioid Treatment Agreement

APA appreciates CMS's efforts in addressing the opioid epidemic. While the addition of two new measures under the e-prescribing objective may prove helpful in this endeavor, APA has some questions regarding their implementation.

Query of PDMP: First, APA supports the Query of PDMP measure as a tool to address opioid abuse and diversion. However, as the proposed rule acknowledges, "PDMP integration is not currently in widespread use for CEHRT, and many eligible hospitals and CAHs may require additional time and workflow changes at the point of care before they can meet this measure without experiencing significant burden." APA notes some specific burdens: the significant amount of time required to query PDMPs due to additional time spent logging into systems, entering patient data for querying purposes, and the two-factor authentication. Better integration of PDMPs into CEHRT would help to mitigate these issues and

APA is supportive of CMS or the ONC in developing standards around resolving this issue provided the CMS accepts feedback on proposed standards during additional rulemaking.

While opioid treatment agreements have demonstrated some benefit to patients and providers, APA urges caution in the widespread adoption of this measure into the Promoting Interoperability framework. A lack of consensus on how an opioid treatment agreement is defined, the potential for the introduction of mistrust into the therapeutic alliance, and the potential for providers to discontinue treating patients due to systemic errors in the technology related to integrating this measure broadly into a patchwork of EHR systems may result in more negative than positive outcomes.

Proposed Update of the Federal Per Diem Base Rate and Electroconvulsive Therapy Payment Per Treatment

Electroconvulsive therapy (ECT) claims from an inpatient psychiatric facility (IPF) must show a valid International Classification of Diseases procedure code (ICD-10-PCS). For 2019, CMS proposes to maintain the same coding from 2018. The preliminary update to ICD-10-PCS did not result in any changes to the ECT codes. The current codes are:

- GZB0 Unilateral-Single Seizure
- GZB1 Unilateral-Multiple Seizure
- GZB2 Bilateral-Single Seizure
- GZB3 Bilateral-Multiple Seizure
- GZB4 Other Electroconvulsive Therapy

As proposed, the per-treatment payment for ECT would increase, from $332.08 (FY 2018) to $336.67 (FY 2019). Similarly, the federal per-diem base rate for IPF would increase from $771.35 (FY 2018) to $782.01 (FY 2019). For IPFs that fail to meet the IPFQR requirements, the ECT per treatment payment would be $330.02, in FY 2019. **APA welcomes the proposal to maintain the ICD-10-PCS codes for ECT, and the increase to the reimbursement rates.**

Proposed Update to MS-DRG Assignment

For FY 2019, the agency does not propose changes to the IPF Medicare Severity Diagnosis Related Groups (MS-DRG) adjustment factors and it proposes to maintain the existing IPF MS-DRG adjustment factors. CMS proposes to continue the existing payment adjustment for psychiatric diagnoses that fit in any one of the existing 17 IPF MS-DRGs. Psychiatric principal diagnoses that do not fit in one of the 17 designated MS-DRGs would still receive the federal per diem base rate and all other applicable adjustments; however, the payment would not include the MS-DRG adjustment. **APA welcomes the proposed consistency from 2018 to 2019.**

Proposed Update to the Outlier Fixed Dollar Loss Threshold Amount

CMS, using its regression analysis and payment simulations, proposes to update the outlier payment threshold amounts to $12,935.00, to maintain the two-percent outlier policy. The calculations are based on the latest available data (the December 2017 update of FY 2017 IPF claims) and rate increases. CMS states that this "strikes an appropriate balance between protecting IPFs from extraordinarily costly cases while ensuring the adequacy of the federal per diem base rate for all other cases that are not outlier cases." It is critical for IPFs to receive reimbursement that allows them to accept the most costly cases. **APA appreciates the agency's concern with keeping the outlier threshold current.**

Conclusion

Thank you for your review and consideration of these comments. If you have any questions or would like to discuss any of these comments, please contact Debra Lansey, M.P.A., APA Associate Director for Payment Policy, at DLansey@psych.org or (202) 609-7123.

Sincerely,

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