AMERICAN PSYCHIATRIC ASSOCIATION

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June 25, 2018

Seema Verma, Administrator
Department of Health and Human Services
Attention: CMS-1694-P
P. O. Box 8011
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 Prospective Payment System. Our comments focus specifically on issues that impact the care of patients with mental health and substance use disorders (MH/SUDs), particularly the following priorities:

- Access to psychiatric services
- Inpatient PPS Quality Reporting
- CMMI RFI
- Program payment updates

Regulations Affecting Access to Psychiatric Services

Proposed Changes to Regulations Governing Satellite Facilities

The Centers for Medicare & Medicaid Services (CMS) proposes regulatory changes that would refine the responsibilities of satellite facilities, in much the same manner that the agency updated the hospital-within-a-hospital (HwH) in the 2018 rule. Last year, CMS concluded that HwHs (which are excluded from the inpatient prospective payment system and are co-located with IPPS hospitals) should be held to the separateness and control requirements. CMS made the HwH regulatory payment changes to reduce the potential for inappropriate patient shifting and hospitals behaving as illegal de facto units.

Since that time, the agency has seen such questionable behavior moderate among co-located IPPS-excluded hospitals. In this proposed rule, CMS considers making the same type of payment changes to satellite facilities that the agency views as like HwHs, and which are defined as "part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital."

The proposed rules specify that beginning in fiscal year 2018, satellite facilities would be defined similarly to HwHs. A satellite facility that is "part of an IPPS-excluded hospital that provides inpatient services in a building also used by an IPPS-excluded hospital, or in one or more entire buildings located on the same campus as buildings used by an IPPS-excluded hospital" would not be required to meet the defining criteria in §412.22(h)(2)(iii)(A)(1).

However, satellite facilities that are "part of an IPPS-excluded hospital which is in a building also used by an IPPS hospital, or in one or more entire buildings located on the same campus as buildings used by an IPPS hospital" would still be required to meet the criteria noted above.

In addition, CMS proposes, in parallel with its rulemaking on satellite facilities, to remove the definition restriction on IPPS-excluded hospitals that bars them from containing a psychiatric unit. This change would apply to cost reporting periods on or after October 1, 2019. APA thanks the agency for recognizing the benefit of expanding regulations that acknowledge the status of some co-located facilities and for considering the removal of this potential barrier to psychiatric care. **APA welcomes this proposal that would offer beneficiaries more access points to mental health services.**

Proposed Revisions Regarding Physician Certification and Recertification of Claims

Current Medicare regulations dictate that physicians indicate the specific location in the medical record where the medical necessity documentation can be found. It has been brought to the agency's attention that an overly technical interpretation of the current regulation has led to many unnecessary claim denials.

As a solution, CMS proposes to revise the regulation by moving one sentence, such that it would read,

> §424.11 General procedures.
>
> (b)Obtaining the certification and recertification statements. No specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form. Except as provided in paragraph (d) of this section for delayed certifications, there must be a separate signed statement for each certification or recertification. If that information is contained in other provider records, such as physicians' progress notes, it need not be repeated.
>
> (c)Required information. The succeeding sections of this subpart set forth specific information required for different types of services. ~~If that information is contained in other provider records, such as physicians' progress notes, it need not be repeated.~~ It will suffice for the statement to indicate where the information is to be found."

The agency's goal is to remove the need to repeat supporting statements that are readily found elsewhere in the certification or recertification, and describe the flexibility afforded to completion of the required statement of medical necessity. **APA agrees with CMS on this proposal to simplify the medical necessity documentation by removing a duplicative requirement that has added administrative burden to the physician's responsibilities.**

Quality Data Reporting Requirements for Specific Providers and Suppliers

APA appreciates the effort made by CMS's Hospital Inpatient (IQRP) and Long-Term Care Hospital Quality Reporting Program (LTCHQRP) administrators to align, where possible, with other CMS quality and value-based purchasing programs. Program process and procedure coordination among the different quality programs promote agency unity and emphasize that programmatic changes are made more deliberately, rather than uniquely to each individual program without standardized criteria. We appreciate 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.

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.** Of the two constructs that address social risk, stratifying social risk factors during measurement instead of eliminating them would provide a more detailed picture of the costs and quality administered among facilities. Considering CMS's examination into the public reporting of some IQRP and LTCHQRP quality and value-based purchasing program measures, stratified by patient dual eligibility, APA requests that attribution model specifications for each measure be included within the respective programs' measures technical specifications guides. When data is publicly reported and assigned to an individual clinician, service line, or facility, it is important to be clear about who is responsible for the reported outcomes and/or performance rates.

Like CMS, APA prioritizes improving health disparities for patients with mental and substance use disorders. We invite CMS to work with APA and other stakeholders to define the necessary steps to implementing quality measures that 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 IQRP

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 IQRP and LTCHQRP. 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 utilize 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.**

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 whose benefits justify the CMS administrative burden, even if it comes at a high cost to CMS but serves beneficiaries.

Proposed Removal and Retention of Measures for the FY 2020 Payment Determination and Subsequent Years

Of the measures proposed for use during the FY 2020 payment determination, APA requests a more precise definition of the phrase "potential clinically significant medication issues" cited in the quality measure, "Drug Regimen Review Conducted with Follow-Up for Identified Issues - Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)." Because of the unfortunate history of long-term care facilities' engagement in inappropriate prescribing of antipsychotic medications, we understand CMS's recently increased monitoring of the use of psychotropic medications. **However, APA is concerned that policies in other CMS programs hinder appropriate prescribing. The phrase warrants a more precise definition and should be included within the technical measure specifications update.**

Possible IPPS QR Program Measures and Measure Topics for Future Consideration

APA appreciates CMS's comprehensive review of the quality measures currently used in the IQRP and LTCHQRP. We recognize the efforts to remove quality measures that are duplicative in data element

collection or are used in one of the value-based purchasing programs of the IQRP. However, because of the high rates of medical comorbidity for patients with mental and substance use disorders, **APA strongly recommends the inclusion of a facility-level quality measure that addresses mental health.** Often, patients who are admitted to short- and long-term acute care hospitals receive outpatient mental health care for multiple mental and substance use disorders; examination and appropriate treatment of these disorders during their inpatient-physical hospital stay is likely to help improve their physical health outcomes.

When patients' injuries from suicide attempts result in treatment at short- and/or long-term care facilities, the physical consequences are addressed. However, the patients' mental and substance use disorders are sometimes left unaddressed. It is critical that these patients receive the appropriate behavioral health treatment (e.g., psychotropic medications or other therapeutic interventions) during their inpatient hospital stay. Treating the symptoms that contributed to the suicide attempt is important to reduce the likelihood of future attempts, like treating patients with diabetes with medication and education to prevent future diabetes emergencies.

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.

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