MEDPAC Medicare Payment Advisory Commission

425 Eye Street, NW • Suite 701
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Jon B. Christianson, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

June 2, 2014

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

RE: File Code CMS-1606-P

Dear Ms. Tavenner:

The Medicare Payment Advisory Commission (MedPAC) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System—Update for Fiscal Year Beginning October 1, 2014 (FY 2015); Proposed Rule. We appreciate your staff's continuous efforts to administer and improve the Medicare payment system for inpatient psychiatric facilities (IPFs), particularly given the competing demands on the agency.

This rule proposes a payment update for IPFs in FY2015 and details a number of additional proposals. We focus our comments on CMS's proposed new quality measures for the IPF quality reporting program (IPFQR).

Proposed quality measures for the FY 2016 and 2017 payment determination and subsequent years

CMS is required in fiscal year 2014 and each subsequent year to reduce the annual market basket update by 2 percentage points for any inpatient psychiatric facility (IPF) that fails to successfully report on a specified set of quality measures. Eight quality measures have been previously adopted for the IPF Quality Reporting (IPFQR) program:

- Hours of physical restraint use;
- Hours of seclusion use;
- Patients discharged on multiple antipsychotic medications
- Patients discharged on multiple antipsychotic medications with appropriate justification;
- Alcohol use screening;
- Follow-up after hospitalization for mental illness;

- Post-discharge continuing care plan created; and
- Post-discharge continuing care plan transmitted to the next level of care provider.

The May 6, 2014 rule proposes to add six new measures to the IPFQR. Two measures are proposed for FY 2016 and would require only an annual attestation by the provider: whether the facility conducts some type of assessment of patient experience of care and uses an electronic health record. Four more measures are proposed for FY 2017: influenza immunization of patients; influenza vaccination among healthcare personnel; tobacco use screening of patients; and tobacco use treatment offered and provided for patients identified as tobacco users. These four measures would be collected via chart abstraction and would be reported in aggregate for all specified patients, regardless of payer. CMS also indicates in the proposed rule that it is testing six additional measures for future inclusion in the IPFQR program: screening for suicide risk, violence risk, drug use, and alcohol use; and metabolic screening. In addition, the agency reports that it is planning to develop a 30-day psychiatric readmission measure and a standardized survey of patient experience of care tailored for use in the psychiatric setting.

Comments

As noted in our June 25, 2013 comment letter to CMS on the acute and long-term care hospital prospective payment systems and the IPFQR, the Commission is concerned about the steadily increasing number of clinical process measures required for providers under Medicare's QR programs, in part because such measures require providers to devote substantial resources to clinical record data abstraction. The Commission is concerned that the benefits of measuring providers' adherence to these processes might be outweighed by the costs of implementing the measures, and might deflect providers' attention and resources from more productive quality improvement activities.

We appreciate the agency's efforts in this year's proposed rule to review and report on evidence demonstrating that tobacco users hospitalized with psychiatric illnesses can successfully overcome their tobacco dependence and that such intervention can, in the long run, improve health outcomes. However, we are concerned that CMS is proposing additional process measures rather than outcome measures that policy makers and patients can use to evaluate differences in the care IPFs furnish and the outcomes their patients achieve. For example, requiring IPFs to report if they use some type of patient experience survey will not provide Medicare with any information about IPF patients' actual current experiences of care or changes over time. In addition, an improved rate of influenza immunization is a desirable goal for the public health system, but CMS has not made clear how measuring rates of immunization in a short-term inpatient psychiatric setting will appreciably improve outcomes for Medicare beneficiaries and other patients hospitalized with serious mental illnesses.

In considering future measures for the IRFQR, CMS should critically evaluate the extent to which potential measures will contribute to meaningful differences in the health outcomes achieved by IPF patients. Further, CMS should take care not to burden providers with too many measures. The Commission is mindful that Medicare is one of many payers that may be requiring providers to collect data for quality reporting.

As we noted in our June 25, 2013 comment letter, the Commission believes that measuring patient outcomes such as readmissions can have a greater impact on provider behavior than process measures. We therefore support CMS's efforts to develop a readmission measure for IPFs and encourage the agency to include it in the IPFQR as soon as possible. As with any quality measure, a readmissions measure should be constructed so that policy makers and patients can use it to evaluate differences in the care IPFs furnish and the outcomes their patients achieve. Therefore, an IPF readmissions measure should focus on readmissions that are clinically related to the index admission and potentially preventable by the IPF. We are concerned that CMS' proposal goes far beyond this principle, and may detract from IPFs' mission of providing high-quality psychiatric care for their patients.

In addition to focusing on readmissions that are clinically related to the index admission and potentially preventable by the IPF, the readmissions measure should be risk-adjusted to account for differences across patients in the likelihood of readmission. Currently, CMS does not collect patient assessment data for IPF patients, so the agency lacks important information necessary for adequate risk adjustment. To adequately adjust quality measures for differences in patient risk—and to make other needed improvements to the IPF payment system—CMS may need to collect additional information about patients.

Conclusion

MedPAC appreciates your consideration of these policy issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on IPFs, and we look forward to continuing this relationship.

If you have any questions regarding our comments, please do not hesitate to contact Mark Miller, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Glenn M. Hackbarth, J.D.
Chairman

GMH/dkk