MEDPAC Medicare Payment Advisory Commission

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May 27, 2015

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

RE: File Code CMS-1627-P

Dear Mr. Slavitt:

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, 2015 (FY 2016); Proposed Rule, Federal Register 80, no. 84, 25012-25065 (May 1, 2015). 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 fiscal year (FY) 2016 and details a number of additional proposals. We focus our comments on CMS's proposed new quality measures for the IPF quality reporting program (IPFQRP).

Proposed quality measures for the FY 2018 payment determination and subsequent years

CMS is required in FY 2014 and each subsequent year to reduce the annual market basket update by 2 percentage points for any IPF that fails to successfully report on a specified set of quality measures. Fourteen quality measures have been previously adopted for the IPFQRP:

- 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;
- Tobacco use screening;
- Tobacco use treatment offered and provided;
- Influenza immunization of patients;
- Influenza vaccination among health care personnel;

- Assessment of patient experience of care;
- Use of electronic health record;
- 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.

In the May 1, 2015 rule, CMS proposes to add three new measures to the IPFQRP:

- Tobacco use treatment provided or offered at discharge, with subset measure tobacco use treatment at discharge;
- Alcohol use brief intervention provided or offered, with subset measure alcohol use brief intervention; and
- Screening for metabolic disorders.

In addition, CMS proposes to remove one measure from the IPFQRP—patients discharged on multiple antipsychotic medications—because the National Quality Foundation does not endorse it and because another measure (patients discharged on multiple antipsychotic medications with appropriate justification) sufficiently includes the information. CMS also proposes to replace two measures—post-discharge continuing care plan created and post-discharge continuing care plan transmitted to the next level of care provider—with new measures that the agency believes are more specific, effective, and robust.

Comments

The Commission has urged CMS to move toward the use of outcome measures in Medicare's QRPs. Outcomes are more meaningful to patients, and focusing on outcomes rather than process measures can have a greater impact on provider behavior. Nevertheless, we are mindful that mental health care, especially for the seriously mentally ill, has certain qualities that distinguish it from other types of medical care, and that these qualities may necessitate a greater reliance on process measures, at least in the near term. As noted by the Institute of Medicine, care for the seriously mentally ill is characterized by low adherence to established clinical practice guidelines, as well as "…more frequent coercion of patients into treatment;…a less-developed infrastructure for measuring and improving quality of care; [and] the need for a greater number of linkages among the multiple clinicians, organizations, and systems providing care to patients…."[1] Thus, IPF processes of care—such as hours of physical restraint and seclusion use, frequency of patients discharged on multiple antipsychotic medications with appropriate justification, provision of transition records to discharged patients, timely transmission of transition records to follow-up health care professionals, and follow-up after hospitalization—can be important indicators of the quality of care in this setting.

However, the Commission urges CMS not to burden providers with too many measures. For several years, we have voiced our concern about the steadily increasing number of clinical process

[1] National Research Council, Institute of Medicine. *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series.* Washington, DC: The National Academies Press, 2006.

measures required for providers under Medicare's QRPs, in part because such measures require providers to devote substantial resources to clinical record data abstraction. CMS must ensure that the benefits of measuring providers' adherence to these processes are not outweighed by the costs of implementing the measures, and does not deflect providers' attention and resources from more productive quality improvement activities. For example, as we noted in our comment letter on the FY 2015 proposed rule for IPFs, it is not 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 IPFQRP, CMS should critically evaluate the extent to which potential measures will contribute to meaningful differences in the health outcomes achieved by IPF patients. We support CMS's efforts to develop a readmission measure for IPFs. 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.

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 clinical differences across patients that affect the likelihood of readmission. Currently, CMS does not collect patient assessment data for IPF patients, so the agency lacks important clinical information necessary for adequate risk adjustment. To adequately adjust quality measures for differences in patient health status—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,

Francis J. Crosson, M.D.
Chairman

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