June 15, 2018 D R A F T

Ms. 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; Prospective Payment System Inpatient Psychiatric Facility***

Dear Ms. Verma:

On behalf of its member hospitals, the Michigan Health & Hospital Association (MHA) appreciates this opportunity to provide comments to the Centers for Medicare & Medicaid Services’ (CMS) regarding the fiscal year (FY) 2019 proposed rule to update the **Medicare Inpatient Psychiatric Facility (IPF**) prospective payment system (PPS). For the 50 IPFs in Michigan, this rule is expected to increase Medicare fee-for-service (FFS) payments by approximately $1 million, or 0.6 percent, in FY 2019. This minimal increase fails to cover the projected 5.2 percent increase in medical inflation, further threatening the financial viability of IPFs and patient access to the services they provide. Our key concerns regarding the FY 2019 proposed rule are below.

**Proposed Removal of Quality Measures**

The CMS proposes to remove eight measures from the IPF quality reporting (QR) program and notes that the agency is moving away from using chart-abstracted measures such as the Alcohol Use Screening (SUB-1), measure. The CMS also noted that IPFs routinely demonstrate high performance on this measure and are likely to continue providing this screening to patients without the measure in place. **The AMA agrees with this rationale and supports the removal of the SUB-1 measure.**

However, removing SUB-1 would not significantly reduce the burden for providers, as this information must be collected for completion of subsequent measures, Alcohol Use Brief Intervention Provided or Offered (SUB-2), and Alcohol Use Brief Intervention (SUB-2a). These measures were developed for use in general acute care settings where patients are typically 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 upon admission, and the information garnered from those screenings informs the appropriate course of treatment for each patient, including treatment for any substance abuse disorders. For patients with severe alcohol use problems, the “brief” intervention described in the measure specifications would be insufficient and inappropriate. **Therefore, the MHA urges the 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 (TOB-3/3a) Measures. Similarly to the rationale used in proposing to remove the SUB-1 measure, the CMS notes that IPF performance is uniformly high and unvarying on the TOB-1 measure. In regard to the TOB-3 and 3a measures, the 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 MHA 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 regarding where to obtain needed care and to facilitate quality improvement efforts by psychiatric facilities. It suggests 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. It also suggests that psychiatric facilities should focus their quality improvement efforts on this aspect of care rather than on improving treatment for the mental illness and substance abuse disorders that warranted the patients’ hospitalizations.

The MHA, along with the American Hospital Association, believe 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 behavioral health needs. **As a result, the MHA urges the CMS to remove TOB-2/2a in addition to the tobacco use measures currently proposed for removal.**

The CMS also proposes to remove the Hours of Physical Restraint Use (HBIPS-2) and Hours of Seclusion Use (HBIPS-3) measures. **The MHA is supportive of this removal but** **urge the CMS to continue monitoring the use of seclusion and restraint through the survey process to determine whether there are trends of increasing use of these interventions after the measures are removed.**

**Request for Information on Interoperability**

The CMS seeks input regarding whether the agency should promote interoperability by including electronic sharing of health information as a Medicare condition of participation for hospitals, skilled-nursing facilities, inpatient rehabilitation facilities, and other post-acute care settings including IPFs.

**Although the MHA is supportive of the CMS’ promoting interoperability, we object to the CMS requiring interoperability as a Medicare condition of participation since this would likely result in some hospitals and post-acute providers no longer being eligible to participate in the Medicare program and therefore would be ineligible for Medicare payments for services to Medicare beneficiaries, potentially resulting in facility closures. Hospital closures or exclusion from Medicare would reduce access to inpatient psychiatric services for patients. The MHA recommends that the CMS provide additional incentive payments to help ensure that hospitals and post-acute care facilities have the resources necessary for investing in technologies that promote interoperability.**

We believe that our recommended changes would result in a positive outcome for IPFs and the Medicare beneficiaries they serve. If you have any questions, please contact me at (517) 703-8608 or via email at [vkunz@mha.org](mailto:vkunz@mha.org).

Sincerely,

**Vickie R. Kunz**

**Senior Director, Health Finance**