

**SUBMITTED VIA [www.regulations.gov](http://www.regulations.gov)**

June 13, 2017

Ms. Seema Verma, Administrator  
Centers for Medicare and Medicaid Services (CMS)  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Room 445-G  
Washington, DC 20201

RE: **CMS-1677-P: Proposed Rule** – “Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; **Quality Reporting Requirements for Specific Providers**; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices” (RIN 0938-AS98)

Dear Ms. Verma,

As an association representing behavioral healthcare provider organizations and professionals, the National Association of Psychiatric Health Systems (NAPHS) appreciates the opportunity to provide comments on the proposed rule titled “Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; **Quality Reporting Requirements for Specific Providers**; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices” as published in the April 28, 2017, *Federal Register*.

We are focusing our comments on **quality reporting by inpatient psychiatric facilities (IPFs)** that are participating in the IPF Quality Reporting (IPFQR) Program.

Recommendations on other aspects of the proposed rule and further discussion of our comments may be found below.

Founded in 1933, the National Association of Psychiatric Health Systems (NAPHS) advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Our members are behavioral healthcare provider organizations that own or manage more than 800 specialty psychiatric hospitals, general hospital psychiatric and addiction treatment units and behavioral healthcare divisions, residential treatment facilities, youth services organizations, and extensive outpatient networks. Our members deliver all levels of care, including partial hospitalization services, outpatient services, residential treatment, and inpatient care.

**COMMENTS: IPF QUALITY REPORTING PROGRAM (IPFQR)**

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NAPHS has long been committed to quality measurement – working with the Centers for Medicare and Medicaid Services (CMS), accrediting agencies, public and private sectors, consumers, and other stakeholders – to develop and support the ongoing use of inpatient psychiatric performance measures. Our association was one of the original organizations that invested more than 10 years in development of the Hospital-Based Inpatient Psychiatric Services (HBIPS) measures that were among the first CMS performance measures in the IPFQR program (based on testing by CMS). We are pleased that some of these measures remain a part of the IPFQR program.

We support the CMS IPFQR program, which articulates overall national goals for improved health care. The CMS IPFQR is an opportunity to provide public data for behavioral health – keeping behavioral health on par with the rest of medicine.

We agree with CMS's objective in selecting quality measures to balance the need for information on the full spectrum of care delivery and the need to minimize the burden of data collection and reporting. We support CMS's goal to focus on “measures that evaluate critical processes of care that have significant impact on patient outcomes and support CMS and HHS priorities for improved quality and efficiency of care provided in IPFs.”

Through representation on the CMS Technical Expert Panels as well as through opportunities to publicly comment, we are committed to continuing to provide perspective from the field on new measures under consideration as well as the measure set currently in use.

### **Topics for Future Measurement Development**

In response to a CMS call in the proposed rule for topics for future consideration, we suggest that CMS develop a standardized patient perception of care measure that is specific to the psychiatric hospital setting.

Another topic for future consideration is safety planning with patients who have suicidal ideation. A very high percentage of patients are admitted to psychiatric hospitals because they cannot keep themselves safe in the community or at other levels of care. Reasons for hospitalization can include suicidal ideation and/or impulsive self-destructive actions. Suicidal ideas and behaviors are a significant clinical issue that lends itself to clinical interventions that providers can take.

Suicide is a national public health crisis. The literature documents that the first two weeks after hospitalization are a high-risk period for patients who have suicidal ideation. A critical process of care is assisting patients manage current and future suicidal ideation. A measure could be developed to look at how hospitals help patients develop a plan for dealing with suicidal ideation—both during hospitalization and after discharge. There is a significant body of literature that could guide this development. This type of measure could also address family and caregiver engagement, which is an area CMS has identified as an area not currently sufficiently covered by IPFQR program measures. Safety planning is a good proxy for patient-centered involvement and could be linked to discharge planning and readiness. We would prioritize this as an area for measure development.

We recommend that population screening measures (such as the SUB, TOB) be eliminated from the measure set so the set can more sensitively represent the quality of psychiatric specialty care delivered in psychiatric facilities. We are very aware of the challenges the facilities represented in the IPFQR program face in balancing the need for delivering critical inpatient care while partnering with patients and families as they prepare for post-hospital care. The mental healthcare system is challenged by access to care and workforce issues. We need to coordinate with reimbursement systems, regulatory requirements, and professionals to strengthen a system that is responsible for provision of high quality, efficient, and consumer-centered care. NAPHS is committed to working diligently with all partners to develop the measures that will guide this work.

### **Measures Currently in Use**

### Substance Abuse and Tobacco Measures

We acknowledge that many of the patients we treat abuse alcohol and other substances. However, the Alcohol and Other Drug Use Disorder (SUB) measures included in the set were developed for broad population screening and do not adequately produce the kind of alcohol and substance use data that is required as the basis for treatment of persons with serious disorders. The modalities (such as brief intervention for alcohol use) have not been tested with patients demonstrating the high levels of alcohol and substance abuse that would justify treatment in inpatient facilities.

We are also aware of the high levels of comorbidity of tobacco use in the patients cared for in inpatient facilities. As a field, we take this very seriously and create individualized approaches to helping patients who use nicotine. We know that some percentage of patients are at a point of readiness to quit at the time of inpatient treatment (patients are generally tobacco-free during their hospitalization because of regulatory requirements). The measures require that treatment is provided (or offered) to all patients during their inpatient stay and at discharge. We continue to look for substantive data to support the usefulness of the interventions required of the Tobacco Use Treatment (TOB) measures for all patients who are seriously psychiatrically impaired, during a very brief, stabilizing hospitalization. We are required to use very limited resources in ways that are not demonstrated to be effective. There is significant burden to both patients and staff both in the application of the measures and the data recording and retrieval processes. We question whether this information distinguishes high and low performers among providers of psychiatric inpatient services or if the information is helpful in informing the public about the quality of the psychiatric care.

The level of concern about the lack of data to support the use of these measures in the IPFQR program is demonstrated in the NQF Measures Application Partnership (MAP) recommendation to delete both the SUB and TOB measures from the IPFQR set. In its recommendations (Maximizing the Value of Measurement: MAP 2017 Guidance, Final Report March 15, 2017), NQF noted the “importance of addressing both substance abuse and tobacco cessation but recommended that CMS prioritize measures that will better address the quality of mental health care.” We support the NQF recommendation and ask that the measures be deleted.

### Metabolic Screening

The Screening for Metabolic Disorders measure is in place for the 2019 and subsequent payment determination years. Hospitals are currently collecting data on the measure so data can be submitted for an entire year beginning 2018. The measure has not been submitted to NQF for endorsement. The measure was developed by the CMS contractor (HSAG) and went directly into the IPFQR program. We recommend the metabolic screening measure be submitted to NQF since it would provide feedback from the technical experts appointed by NQF and could address some of the concerns that continue to exist about the measure as currently specified (such as patient refusal of required blood work not being an exclusion). CMS and the field highly value NQF endorsement of measures required for payment and public reporting.

### Follow-up After Hospitalization for Mental Illness (FUH)

Despite providers’ commitment to helping patients make the best possible transition to outpatient care, the lack of psychiatric specialty outpatient resources is widely reported through formal statistics and the public press. In many markets, it is virtually impossible to arrange for an outpatient mental health specialty appointment within 30 days. In the face of these challenges, providers work with patients to help them understand the importance of follow-up care post-hospitalization. They make significant efforts to identify appropriate providers and to arrange timely specialty appointments. Patient preferences in the Medicare population do not always include specialist care. Often patients prefer to return for their psychiatric follow-up care to a trusted relationship they have with their established primary care provider. This approach can be consistent with the trend in all healthcare to provide integrated care.

We note that the National Quality Forum, in their MAP 2017 Guidance (March 15, 2017) recommended that the Follow-Up After Hospitalization for Mental Illness (FUH) be removed from the list of measures for federal programs until it is re-specified for acute care and submitted for NQF endorsement. Discussion

within the MAP noted that FUH, while it had NQF endorsement, was designed as a health plan measure in which the plan held significant responsibility for an adequate network of providers to assure follow-up for members post discharge. We support the re-specification of the measure. As part of the specification process, both these factors (availability of timely outpatient care and patient preference) should be explored.

#### Transition Record with Specified Elements Received by Discharged Patients/Timely Transmission of Transition Record

We continue to have concerns about the complexity of the transition measures and whether they are appropriate for the psychiatric setting. The efforts of the industry (including NAPHS, the American Hospital Association, the Federation of American Hospitals, NRI, Inc., and the American Psychiatric Association) to share concerns with CMS about these measures from the time they were originally proposed has had no effect. The transition measures replaced NQF-endorsed HBIPS discharge measures that were created for and in widespread use for many years in inpatient psychiatric facilities. CMS has made substantial changes in specifications in the transition measures since the measures received NQF-endorsement for use in other settings. Even though the measures are NQF-endorsed, they have not been designed for or tested in psychiatric settings. The transition measures now include the requirement for a psychiatric advanced directive (PAD). The PAD is a legal document, and many authorities in the field hold that it should not be executed when a patient is in crisis.

Eleven elements from the Transition Record are required to be given to patients at the time of discharge. The information is complex and does not prioritize the most important, individualized, or time-sensitive elements.

We also hear that the outpatient organizations receiving the data from the discharge planning measure are, in many instances, not willing to receive so much information and/or make it clear that they do not find the many elements required to be sent information that is clinically useful. Efforts to transmit the data electronically are not effective. Even if a hospital has an electronic record, receiving facilities are rarely interoperable. Transmission involves faxing protected information to facilities that cannot assure its confidentiality when sent to meet the 24-hour requirement (evenings, weekends, etc.). The 24-hour requirement for data transmission has not proven to improve the quality of care since it sometimes limits the information available for transmission and the receiving facility does not typically need the information in that timeframe.

CMS and its contractor have presented several webinars, created an extensive frequently asked questions document ([http://www.qualityreportingcenter.com/wp-content/uploads/2017/05/IPF\\_FAQs\\_20170511\\_vFINAL508.pdf](http://www.qualityreportingcenter.com/wp-content/uploads/2017/05/IPF_FAQs_20170511_vFINAL508.pdf)), and developed paper tools to support the implementation of the transition-of-care measures. Yet the field continues to really struggle with the implementation of the measures based on their complexity, perceived lack of appropriateness to the specialty area, and concerns about specific elements. We again ask CMS to consider the clinical value of this measure when weighed against its very significant burden. Organizations that fail to include any of the many elements of the measures are determined to “fail” the measures. The HBIPS Discharge measures continue to be NQF-endorsed, and we recommend that they be re-instated as an option for organizations.

#### **Evaluation of the Measure Set**

The measure set, having been in use for several years, has not been evaluated by CMS to assess whether it meets the objective of balancing the need for information on the full spectrum of care delivered and the need to minimize the burden of data collection and reporting. We recommend that this be done before more measures are added to the set. The focus needs to be on the areas that are actionable by providers and that demonstrate quality of psychiatric care, rather than being weighted toward population screening and post-discharge issues. While we acknowledge the value of choosing measures that align with other programs, measures that do not contribute to the demonstration of the value of psychiatric specialty care should not be adopted.

We note that CMS continues to be limited in its ability to receive data from facilities reimbursed through the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS). Data can only be reported once a year, and the reporting mechanism continues to be much less automated than other payment programs. This requires facilities to begin to collect data (to have a full 12 months of data as required) that will not be reported to CMS for approximately 15 months from initial collection. The data is not publicly reported for several months after that. The time lag in reporting makes the data less actionable and potentially less reflective of current practice.

### **Burden**

NAPHS fully supports the goal of CMS to balance the need for information with the burden of data collection and reporting. The NAPHS Quality Committee has identified a set of principles which we believe are consistent with the CMS goal and by which the association views performance measurement efforts. We believe that all performance measurement and outcomes data-collection efforts must:

1. be for improving the effectiveness and efficiency of patient care;
2. focus on indicators that provide the most useful clinical and operational data possible;
3. focus on indicators that support actionable steps that fall within the scope of responsibility and accountability of the organization being measured;
4. provide value in the data generated that is in proportion to the intensity of the data-collection effort. Allocation of limited resources needs to be directed to the collection of the most clinically significant and actionable data – with attention to operational and technical data extraction, feasibility, and burden.
5. have the potential for being used to measurably improve the processes, outcomes, efficiency, and patient experiences of the care being delivered.

We continue to hear great concern from the field about a complexity of data collection and reporting demanded by the IPFQR set of measures that has not been proven to improve the effectiveness of patient care, and that has not achieved a balanced allocation of resources aimed at developing the most clinically significant and actionable data that falls within the scope of the organization being measured.

Here are some examples.

A very conservative estimate of the number of data points required to be documented, abstracted, and reported for each patient for the measure set is 44, without including the requirements for demographic data, diagnosis codes (which may be as many as 25 elements per patient), and procedure codes. Most of the data is manually extracted and must be manually reported. The numerator for each of the transition measures (NQF 647 and 648) contains 11 discrete items. If any of the combined 22 items are not reported, the measures are determined to not be met, thereby placing reimbursement in jeopardy (as per the pay-for-reporting requirements).

Several different denominators are used throughout the measure set and require different samples. Examples of these are: the denominator for the TOB-1 measure is all hospitalized patients 18 years of age or older, yet the denominator for TOB-2 and TOB-3 is the number of hospitalized patients 18 and older identified as a current tobacco users; the SUB measures require similar distinctions between patients who screen positive for an alcohol or drug use disorder. Some measures include patients under 18, others exclude them. The influenza immunization measure includes inpatients age 6 months and older discharged from October-March each year. The screening for metabolic disorders measure includes patients on certain medications. Building each of the sample denominators and applying the appropriate numerators is a very labor-intensive effort.

In the presence of a workforce crisis in psychiatric care, organizations look very carefully at the way professionals spend their time. We hear consistently that providers feel the dataset currently required drains staff time from clinical care without concomitant benefit. The number of questions asked of patients (often about issues that could be handled in outpatient settings and that are at times redundant) and the documentation required of providers takes time away from the specialty practice for which they are prepared—access to which is the reason a patient is in a psychiatric hospital.

In addition to the staff time committed to data collection and reporting, our members are very concerned about the burden the measures impose on patients. We care for patients who have very acute psychiatric illnesses and need crisis stabilization. Lengths of stay are very short. Demands on patients must be prioritized. Their needs for safety and support are paramount, and their ability to give and receive information is usually challenged.

### **Proposed New Quality Measure**

#### Medication Continuation following Inpatient Psychiatric Hospital Discharge

CMS is proposing adoption of the Medication Continuation following Inpatient Psychiatric Discharge measure for the 2020 payment year. We strongly support the value of appropriate medication in the follow-up care of psychiatric patients. In this measure, CMS identifies patients in the Medicare fee-for-service database who have Medicare Parts A, B, and D with a diagnosis of schizophrenia, major depression, or bipolar disorder. Data is collected on whether the patient has filled a prescription for a psychotropic medication within 30 days of discharge from a psychiatric hospital. Data will be publicly reported on individual hospitals and on a small percentage of discharged patients (Medicare fee-for-service patients with Medicare Part A, B, and D). We estimate this will be about 20-25% of discharges.

The literature supports that medication adherence is an important component of a patient's ability to remain stable in the community. As part of care and in anticipation of discharge, providers work individually with patients to help them understand the importance of medication in their treatment plan. They teach patients about the effect and potential side effects and dosing schedules of the drugs they will be prescribed. They work with the patients' Part D plans to assure that patients have access to the medication. When appropriate, they work with the patients' families and caregivers to engage them in post-discharge activities.

The proposed measure assesses whether a patient filled a prescription. We recognize it is a function of outpatient treatment to assess whether a patient is actually taking their medication. We note the beginning effort, based on a review of the Medicare database, to look at whether a patient filled a prescription, recognizing this is an important link to outpatient treatment. We need to focus on what factors and strategies influence patient behavior in this area. We question whether the information generated will be useful to the public in deciding the quality of psychiatric care delivered by a given hospital.

### **Accounting for Social Risk Factors in the IPFQR Program**

We agree with the CMS statement that “social risk factors such as income, education, race and ethnicity, employment, disability, community resources, and social support ...play a major role in health” (p. 20121). We acknowledge the important work being done at the national level to identify potential methods for measuring and accounting for social risk factors, including stratified public reporting. We know NQF is requiring developers to consider social risk factors in their data analysis. Although we are not prepared to offer comment on specific risk factors now, we are committed to partnering with CMS in this work as the science evolves. We know the patients we serve are challenged by many social risk factors, and accounting for these risk factors in public data reporting is very important.

### **Factors for Removal or Retention of IPFQR Program Measures**

We note the measure removal and retention factors listed in the proposed rule (p. 20122). We think the list of factors is strong and that its application to the current IPFQR measure set could result in positive improvements to the set. We strongly encourage CMS to embark on this work. The measure set has been

in use for several years and has not been evaluated by CMS to assess whether it meets the objectives listed. We are aware of the efforts of CMS to align IPFQR measures with other CMS and HHS policy goals and other CMS programs. We are concerned that these efforts have, at times, resulted in the adoption of measures that do not meet the needs of patients served through the IPFQR program. Population screening measures and measures drawn and adopted from other programs without appropriate consideration of how they evaluate critical aspects of psychiatric care are an ongoing concern. We recommend that an evaluation of the IPFQR measure set be done before more measures are added to the set. The focus needs to be on the areas that are actionable by providers and demonstrate quality of psychiatric care. While we acknowledge that there might, in some circumstances, be value in choosing measures that align with other programs, measures that do not contribute to the demonstration of the value of psychiatric specialty care should not be adopted. We look forward to working with CMS and the psychiatric field in looking at specific measures to determine whether they meet criteria for removal or retention from the IPFQR program.

We also recognize a need to review the entire set of measures on a regular basis to assess the combined burden the measures present. While certain individual measures may not appear to be unduly burdensome, when facilities are held responsible for the entire set, the total data collection and reporting burden becomes a very significant issue. Questions to be considered could be such things as: is the set balanced, which measures continue to be useful, which measures have been recommended for deletion by NQF, what is the field's perception of the usefulness and burden of specific measures, are the measures useful in public reporting, and is the total set meeting the goals of CMS?

#### **Form, Matter, and Timing of Quality Data Submission**

We support the proposal to change the submission period for the Notice of Participation (NOP) and withdrawals to prior to the end of the data submission period for each respective payment determination year. We also support the provision of precise dates that define the end of the data submission period and the notice of participation or withdrawal from participation submission deadline through subregulatory guidance each year. We are concerned about the amount of lead time facilities will get regarding the data submission timeframes. Facilities must be able to have the resources (particularly staff) in place and mobilized to submit significant amounts of data since data submission for the IPFQR program can only be done once a year. There have been, in the past, technical problems with the submission process beyond the control of the facilities which have required additional resources. Facilities need maximum notice and predictable timeframes for data submission. We ask CMS to clarify this in the final rule.

We support the changes proposed to the extraordinary circumstances exception.

#### **Public Display of Accreditation Reports**

CMS is proposing that, as a condition of deemed status, accrediting bodies be required to post the survey report of the accredited organization for public display. We strongly oppose this proposal for several reasons. The accreditation report is a quality and safety working document through which confidential information is exchanged with the accreditors. It was never intended for public display. If reports are available to the public, accredited organizations could not be as interactive with the accrediting organization in seeking to identify and remedy issues. In addition, there are many aspects of the survey report that relate to the added value of accrediting standards and have nothing to do with the requirements for CMS deemed status. We are concerned that such a requirement might be prohibited by other CMS statutes. While we support transparency and appropriate information being made available to the public for decision making purposes, we think the unintended consequences of this proposal far outweigh the benefits that would be realized.

#### **FOCUS MUST BE ON QUALITY (SUMMARY OF KEY ISSUES)**

In reviewing our comments on specific measures, there are recurring themes throughout. As CMS finalizes IPFQR measures, we urge CMS to consider the following:

- **The focus should be on the quality of inpatient psychiatric services.**
- **Limited resources should be directed** to the collection of the most clinically significant and actionable data relative to the provision of psychiatric services – with attention to operational and technical data extraction, feasibility, and burden.
- **Publicly reported data needs to help the consumer make choices on the *psychiatric care provider they may need.***

## REQUEST FOR INFORMATION ON “CMS FLEXIBILITIES AND EFFICIENCIES”

Thank you for the important opportunity to respond to your “Request for Information on CMS Flexibilities and Efficiencies” as included in the proposed rule. As you stated, “CMS is committed to transforming the health care delivery system—and the Medicare program—by putting an additional focus on patient-centered care and working with providers, physicians, and patients to improve outcomes. We seek to reduce burdens for hospitals, physicians, and patients, improve the quality of care, decrease costs, and ensure that patients and their providers and physicians are making the best health care choices possible.” The National Association of Psychiatric Health Systems (NAPHS) and our member organizations are similarly committed to working with CMS to achieve these goals.

CMS specifically invited the public to submit their ideas for regulatory, subregulatory, policy, practice, and procedural changes to better accomplish these goals. In this section, we will restate our concerns about the burden of the IPFQR measure set. These comments are our beginning response to your call for specific proposals to reduce burden and improve the quality of care.

### IPFQR Example

NAPHS fully supports the goal of CMS to balance the need for information with the burden of data collection and reporting. The NAPHS Quality Committee has identified a set of principles which we believe are consistent with the CMS goal and by which the association views performance measurement efforts. We believe that all performance measurement and outcomes data-collection efforts must:

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We continue to hear great concern from the field about a complexity of data collection and reporting demanded by the IPFQR set of measures that has not been proven to improve the effectiveness of patient care, and that has not achieved a balanced allocation of resources aimed at developing the most clinically significant and actionable data that falls within the scope of the organization being measured.

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NAPHS looks forward to continuing to work with you to further identify the many other opportunities for CMS to “maintain flexibility and efficiency throughout the Medicare program.” We have many ideas for regulatory, subregulatory, policy, practice, and procedural changes to meet the goals of a more flexible and efficient Medicare program. We are committed to being part of the “national conversation about improvements that can be made to the health care delivery system that reduce unnecessary burdens for clinicians, other providers, and patients and their families,” which you are encouraging. please contact me at 202/393-6700, ext. 100, or contact NAPHS Liaison on Quality Initiatives Kathleen McCann, R.N., Ph.D., at 202/393-6700, ext. 102.

Thank you for the opportunity to provide feedback.

Sincerely,

/s/

Mark Covall  
President/CEO