National Association for Behavioral Healthcare

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22 November 2021

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Request for Comment on Potential New Measures for the Medicare Inpatient Psychiatric Facility Quality Reporting Program

Dear Administrator Brooks-LaSure:

On behalf of the National Association for Behavioral Healthcare (NABH), thank you for the opportunity to comment on the development of two new measures for potential use in the Medicare Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program.

NABH represents behavioral healthcare systems that provide mental health and addiction treatment across the entire continuum of care, including inpatient, residential treatment, partial hospitalization, and intensive outpatient programs, as well as other outpatient programs, including medication assisted treatment centers. Our membership includes behavioral healthcare providers in 49 states and Washington, D.C.

The Covid-19 pandemic has magnified the need for improved access to good quality behavioral healthcare. National surveys and research studies have repeatedly indicated significantly elevated levels of anxiety and depression and suicidal ideation during the pandemic.[i, ii, iii, iv] Drug overdoses have spiked to unprecedented levels with more than 100,000 deaths as of April 2021.[v] Based on previous epidemics, we expect the impact on behavioral health will continue for years to come.[vi]

In the context of these ongoing concerns, we appreciate the Centers for Medicare & Medicaid Services' (CMS) interest in ensuring Medicare beneficiaries receive good quality behavioral healthcare in inpatient psychiatric settings. We respectfully submit the following comments on the proposed measures.

1. Improvement in Depression Symptoms during the Inpatient Psychiatric Facility (IPF) Stay

This measure calculates the percentage of adult patients discharged from an IPF with a documented improvement in PROMIS Depression Short Form (8b) scores between admission and discharge. The PROMIS Short Form is an eight-item inventory of depression symptoms with a one-week, look-back period.

Comments

We are concerned that the electronic version of the PROMIS measure is not in the public domain, which means that providers would have to purchase access. Providers are not permitted to implement their own version of the PROMIS depression scale. Moreover, the vendor with the licensing rights for the electronic form requires providers to purchase the entire PROMIS suite even if providers need only the part regarding depression. Any measure used for the IPFQR Program should be in the public domain in both electronic and paper formats to ensure access.

In addition, it is not clear that the PROMIS depression measure is appropriate because it has not

been validated in samples of patients with any psychiatric illness, much less in samples of patients with depression specifically. If the PROMIS measure is used, it should first be validated in samples of psychiatric patients and particularly for patients with depression.

Furthermore, it is unclear which patients would be included in the denominator. Would all patients be screened for improvements in depressive symptoms, or only those with a diagnosis of depression? We ask CMS to clarify this point.

Patients with depressive symptoms who enter an IPF will have varied levels of severity of these symptoms. Therefore, any measure of improvement of depressive symptoms should be risk-adjusted for diagnosis and other demographic characteristics.

Depressive symptoms vary significantly across different age groups and other patient populations. Therefore, requiring a specific scale for all patients could undermine the accuracy of the results and utility for quality assurance.

We recommend that IPFs be permitted to choose from among a set of validated depression scales that are within the public domain and that are appropriate for the population they serve.

2. 30-day Risk Standardized All-Cause Mortality Following Inpatient Psychiatric Facility (IPF) Discharge

Description
This measure reflects the percentage of adult patients who died from any cause, within 30 days of discharge from an IPF. This data will be risk-adjusted to account for sociodemographic characteristics and medical acuity (i.e., by age, sex, gender, primary discharge diagnosis, and history of suicide attempt, ideation, or intentional harm).

Comments
The co-occurring physical health conditions highlighted in the rationale for this measure take a toll on individuals with serious mental illness (SMI) over long periods of time. It seems illogical to suggest that a short inpatient stay is the best way to address this issue. The framing document also mentions suicide as another significant cause of death following inpatient hospitalization, but surprisingly the document does not discuss how to address this issue.

There are many factors that contribute to premature mortality among individuals with SMI, most of which are outside of the control of an inpatient provider. These include lack of housing, exposure to violence, and lack of access to community-based mental health and physical healthcare. Inpatient providers are particularly challenged with addressing all the needs of individuals with SMI given the very short lengths of stay that payors — and particularly managed care plans— allow. Therefore, this measure is not a good indicator of the quality of care provided in an inpatient setting because inpatient providers are not able to affect measure performance and therefore the measure is unlikely to improve quality. It is better suited to measure the quality of care health plans and payors provide that can affect access to community-based services.

Quality measures for inpatient providers should be aligned more closely with an activity or outcome that the inpatient provider can control; for example, screening for suicidal ideation and risk of violence as well as availability of means to commit suicide or other violence back in the individual's home or community. Additional measures addressing co-morbid conditions could focus on improving screening and access to treatment for those conditions with screening during inpatient stays, and efforts to connect individuals who screen positive with treatment during the stay and/or as a component of discharge planning.

Thank you for considering our concerns and recommendations. If you have any questions, please contact me

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directly at shawn@nabh.org or 202-393-6700, ext. 100, or contact NABH Director of Policy and Regulatory Affairs, Kirsten Beronio at kirsten@nabh.org or 202-393-6700, ext. 115.

Sincerely,

Shawn Coughlin
President and CEO

About NABH

The National Association for Behavioral Healthcare (NABH) represents provider systems that treat children, adolescents, adults, and older adults with mental health and substance use disorders in inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient programs, medication assisted treatment centers, specialty outpatient behavioral healthcare programs, and recovery support services in 49 states and Washington, D.C.. The association was founded in 1933.

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[i] Ettman CK, Abdalla SM, Cohen GH, et al: Prevalence of Depression Symptoms in US Adults Before and During the Covid 19 Pandemic. JAMA Network Open (Sept. 2, 2020).

[ii] Vahratian A, Blumberg SJ, Terlizzi EP, Schiller JS: Symptoms of Anxiety or Depressive Disorder and Use of Mental Health Care Among Adults During the COVID-19 Pandemic — United States, August 2020–February 2021. MMWR Morb Mortal Wkly Rep. ePub: 26 (March 2021).

[iii] Czeisler MÉ , Lane RI, Petrosky E, et al: Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1049–1057.
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[iv] Ahmad FB, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2021.

[v] Ahmad FB, Rossen LM, Sutton P: Provisional drug overdose death counts. National Center for Health Statistics. (2021).

[vi] Hawryluck L, Gold WL, Susan, S. SARS Control and Psychological Effects of Quarantine, Toronto, Canada, *Emerg Infect Dis*, July 2004, vol.10 no.7, 1206–1212; Sara Reardon, "Ebola's mental-health wounds linger in Africa: health-care workers struggle to help people who have been traumatized by the epidemic", Nature, vol. 519, no. 7541, 2015, p. 13; Emily Goldmann and Sandro Galea, “Mental health consequences of disasters,” Ann Rev Public Health, Volume 35, pp. 169–83, 2014.