Public Comment Summary Report

Project Title

Inpatient Psychiatric Facility (IPF) Outcome and Process Measure Development and Maintenance

Dates

The Call for Public Comment was open from August 25, 2016 to September 15, 2016.

The Public Comment Summary was completed on September 28, 2016.

Project Overview

The Centers for Medicare & Medicaid Services (CMS) has contracted with Health Services Advisory Group, Inc. (HSAG), to develop, maintain, reevaluate, and support the implementation of quality outcome and process measures for the CMS Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program under the Measure & Instrument Development and Support (MIDS) Contract (Contract #: HHSM-500-2013-13007I), and Task Order Inpatient Psychiatric Facility Outcome and Process Measure Development and Maintenance (Task Order #: HHSM-500-T0004).

Project Objectives

The primary project objectives are to develop new measures that drive quality improvement, are patient centered, are aligned with other programs, and that fill critical gaps for future inclusion in the CMS IPFQR Program; to maintain and reevaluate existing IPF measures; and to support measure implementation in the IPFQR Program.

To provide an important indicator of the quality of care patients receive in the IPF setting, HSAG developed a measure that estimates the rate of *Continuation of Medications within 30 Days of Inpatient Psychiatric Discharge* for patients with major depressive disorder, bipolar disorder, and schizophrenia.

To obtain input from stakeholder organizations and interested parties, public comments were solicited for this proposed quality measure, *Continuation of Medications within 30 Days of Inpatient Psychiatric Discharge.*

Information about the Comments Received

The announcement for the Call for Public Comment was posted on the CMS Public Comment webpage. The Draft Measure Information Form and Draft Measure Justification Form were available to the commenters to review.

Public comments were solicited by notifying 28 organizations/groups about the opening of the public comment via e-mail. (Please see Appendix A for the list of stakeholder organizations.) In addition, HSAG notified 22 individuals (i.e., experts, technical expert panel members, and measure workgroup members) regarding the Call for Public Comment announcement and

requested sharing the announcement with interested colleagues. The CMS inpatient psychiatric facility quality reporting program (IPFQR) contractor informed their stakeholders by email about the opening of the Public Comment period for the measure.

Fifty-three participants submitted comments. Of the 53 participants, 29 (55%) represented an individual perspective and 24 (45%) reflected an organizational perspective.

Stakeholder Comments—Specific Categories and General Comments

The participants were requested to provide feedback on four categories: Importance/Relevance, Scientific Acceptability, Feasibility, and General Comments for the proposed measure: *Continuation of Medications within 30 Days of Inpatient Psychiatric Discharge.* There were 35 entries under Importance/Relevance, 23 under Scientific Acceptability, 39 under Feasibility, and 33 under General Comments. The comments within the entries were summarized by HSAG and are presented in this section with the responses from CMS.

Importance

Twenty-one participants (40%) expressed support for this measure and emphasized the importance of medication continuation in this population. Several entries indicated that the information provided by this measure would improve care for psychiatric patients treated at inpatient psychiatric facilities.

Response: We appreciate your comments and support of the measure.

However, six participants (11%) indicated reluctance to support the measure.

Response: We thank you for your comments.

Relevance

Eleven participants (21%) expressed that claims for medications are not indicators of patient compliance. They suggested that evaluation of patient compliance would be more relevant.

Response: The filling of a prescription is a critical step in improving compliance. We observed ample opportunity for improvement based on a mean medication continuation rate of 79% across 1,694 IPFs, with variation of 22% between the 10th and 90th percentile. Furthermore, measuring actual compliance would be burdensome for both facilities and patients and, therefore, is not as feasible to measure.

Attribution to IPF

Sixteen participants (30%) indicated that the IPF has limited control of medication continuation after their patients are discharged. Many expressed that this measure was an extension of liability for inpatient providers.

Response: We recognize that there are factors external to the IPF that influence filling prescriptions post-discharge in the psychiatric population. While it may not be possible to achieve complete post-discharge compliance with pharmacotherapies, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge processes, can help to increase

medication continuation rates.[1-11] The goal of this measure is to improve medication continuation and reduce the variation in performance across IPFs.

Five participants (9%) suggested that providing prescriptions for medications at discharge does not always result in the patient filling the medication. They indicated that claims would not accurately assess whether medications were prescribed at discharge.

Response: Providing prescriptions for evidence-based medications at discharge is only one aspect of IPF care and it is not sufficient to encourage medication continuation on its own. That is why the measure evaluates whether the medication was filled rather than simply whether or not there is documentation in the medical record that a medication was prescribed at discharge. We believe this captures a wider array of interventions that facilities might employ to improve medication continuation during the transition to home or home health.

Data Collection

Twenty-seven participants (51%) requested clarification on whether the measure would be based on chart abstracted data or claims data. Many expressed concern over the data collection burden for IPFs if the measure were to require chart abstraction.

Response: This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.

Denominator Specifications

Eleven participants (21%) recommended modifications to the denominator specifications.

Response: We will reevaluate the recommended pharmacotherapy for unspecified depressive disorder (ICD-9 311) and consider removing from the denominator, if appropriate. We will also reevaluate the recommended pharmacotherapy for schizoaffective disorder, depressive type and consider removing from the denominator if appropriate.

Numerator Specifications

Two participants (4%) recommended modifications to the medication lists.

Response: We will evaluate the evidence and consider the addition of atypical antipsychotics, lithium, Cytomel (liothyronine), and quetiapine to the list of medications in the numerator for treatment of MDD.

Two participants (4%) expressed concern that medications dispensed at discharge would not appear in the claims data and could negatively impact measure scores.

Response: The measure captures all prescriptions billed under Part B or Part D for evidence-based medications during the follow-up period, regardless of where those prescriptions are filled. The follow-up period starts on the day of discharge and extends 30 days post-discharge. However, we will consider counting medications that are filled during the admission prior to the day of discharge toward the numerator to allow for innovative programs ensuring that the patient has the medication at discharge.

Four participants (8%) expressed concern that medications provided to the patient free at discharge or during the follow-up period would not appear in the claims data and could negatively impact measure scores.

> **Response:** The patient population for this measure includes only patients with Medicare Part A, Part B, and Part D coverage. We anticipate that few patients in this population would be eligible for samples because low income Medicare patients qualify for additional support to help pay for medication copays. Furthermore, approximately 70% of the patient population for this measure is dually enrolled in Medicaid, which also provides assistance to cover medication costs that aren't covered by Medicare.

Two participants (4%) expressed concern that supplies of medications patients may have at home could extend through the follow-up period and negatively impact measure scores.

> **Response:** The measure development team assessed the day supply of evidence-based medications prescribed prior to the admission to determine if patients might have medications at home that would last through the 30-day follow-up period. For each condition, at least 93% of the prescriptions filled prior to the admission were for a 30-day supply. This indicates that most patients would not have a supply of medication at home that would last through the 30-day follow-up period. It is also important to consider that medications may be adjusted during the inpatient stay and patients may need to fill a new prescription following discharge even if they have medications at home.

Overall Analysis of the Comments and Recommendations

We appreciate the feedback from all of the participants. After review and evaluation of the public comments, we will analyze possible modifications to the proposed measure based on the recommendations of the participants, including:

- Additions to the medication list for treatment of MDD
- Removal of unspecified depressive disorder (ICD-9 311) and schizoaffective disorder, depressive type from the measure denominator
- Revising the date range for ambulatory prescriptions to include those that are provided to the patient prior to discharge

Numerous commenters expressed support for the *Continuation of Medications within 30 Days of Inpatient Psychiatric Discharge* measure and commented on the importance of measuring medication continuation. The comments received provide useful input for further development of this measure for the IPF setting.

Preliminary Recommendations

The measure will be submitted to the National Quality Forum (NQF) for review and endorsement consideration December 2, 2016.

Public Comment Verbatim Report

Verbatim comments from each participant are listed in the order in which they were received by date in Appendix B — Tables B-1, B-2, B-3, and B-4. There is one table of comments and responses for each of the specific categories: importance/relevance, scientific acceptability, feasibility and one table for the general comments category.

Comments appear as they were received and have not been edited for spelling, punctuation, grammar, or any other reasons. If the responder chose to remain anonymous, *Anonymous* is entered in the table, other missing information is entered as, *Not indicated*.

References

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Appendix A: Listing of Stakeholders Invited to Participate in Public Comment

Table A.1. Stakeholders Invited to Participate in Public Comment

	Stakeholder Organization Name
1.	American Association for Geriatric Psychiatry
2.	American Association of Community Psychiatrists
3.	American Association of Retired Persons
4.	American Board of Professional Psychology
5.	American College of Psychiatrists
6.	American Hospital Association
7.	American Medical Association
8.	American Medical Informatics Association
9.	American Nurses Association
10.	American Pharmacists Association
11.	American Psychiatric Association
12.	American Psychiatric Nurses Association
13.	American Psychological Association
14.	American Society of Health System Pharmacists
15.	Association of VA Psychologist Leaders
16.	Federation of American Hospitals
17.	Institute for Healthcare Improvement
18.	Mental Health America
19.	National Alliance for the Mentally Ill
20.	National Association of Psychiatric Health Systems
21.	America's Essential Hospitals
22.	National Association of Social Workers

	Stakeholder Organization Name
23.	National Association of State Mental Health Program Directors
24.	National Council for Behavioral Health
25.	National Institute of Mental Health
26.	Agency for Healthcare Research & Quality
27.	Inpatient Psychiatric Quality Reporting Program
28.	Substance Abuse and mental Health Services Administration

Appendix B. Listing of Verbatim Comments from Responders

All comments in the tables appear as they were received and have not been edited for spelling, punctuation, grammar, or any other reasons.

Table B.1. Verbatim Comments: Importance/Relevance

Entry ID.	Date Posted	Name, Credentials, Title, and Organization of Commenter	Type of Organization	Perspective	Text of Comments	Recommendations/ Actions Taken/ CMS Response
1	08/23/2016	Thomas Z Cady, Individual	Individual	Individual Perspective	Considering from my Senior Citizen observation and point of view; any improvement in the area of mental health care covered; the proposal should me most welcome by anyone receiving Medicare; if providers . Currently out-patient care has far too many limit for great results. Lee County, Fort Myers, FL has lost 5 private practice psychiatrists in recent months. Mainly that Medicare does not pay well enough or not at all. This situation, I have been made aware from health care professionals chatting in Publix's Supermarket, Fiddlesticks' Shoppes, south Fort Myers. In-patient care at Park Royal will not pay for a full time psychiatrist(s) or 'talk therapy' psychologist(s). 2 to 3 minute 'face-time' with the patients; often waking them up at late hours. Only then to wait another 30 to 70 minutes in uncomfortable chairs to get the face-time. One woman and 2 men; all Medicare patients say that they have returned 3 to 6 minutes time. That is likely a financial advantage for profiteering against the purpose of Medicare.	We thank you for your comments and support of the measure. We have noted your concern about Medicare reimbursement policies, however, reimbursement policy is beyond the scope of this project.
4	08/29/2016	Mary J. Mang, RN, Director Quality & Outcomes Management, Carson Tahoe Health	Provider Organization	Organizational Perspective	This measure adds no value. If the 30-day requirement for medication filling is to determine whether a patient needed and should have had a prescription at discharge, there may/may not be an association. Within the length of 30 days, the patient's psychiatric needs could be different/escalated due to new life situations that can trigger the later need for medication.	The measure denominator includes patients that are generally recommended to have a medication prescribed at discharge for their condition. Patients for which other treatment modalities could be considered have been excluded.
5	08/29/2016	Jeffrey A. Plancich, LMHC, CMHS, Director, Behavioral Health Services, MultiCare Behavioral Health	Provider Organization	Individual Perspective	Medications at discharge increase care coordination outcomes of connecting back to PCP and/or community behavioral health agency.	We thank you for your comments and support of the measure.
6	08/29/2016	Melissa Hodges, RN, Manager Clinical Data Abstraction	Hospital	Individual Perspective	Very relevant as noncompliance with prescriptions in this patient population is well known. And this is also a very underserved population when it comes to post discharge follow up.	We thank you for your comments and support of the measure.

7	08/29/2016	Gregory A Miller, MD, Chief Medical Officer Unity Behavioral Health, Legacy Health Systems, Portland, OR	Provider Organization	Individual Perspective	It is difficult to understand how higher rates of discharge prescription filling reflect better discharge planning. In fact, many organizations give patients discharge medications for up to a week or more at the point of discharge, will this count as "filling" a discharge medication prescription? There will also be data contamination by patients who already have medications and do not need prescriptions filled as well as patients who take samples and go to clinics to obtain the samples. This can be a significant number of patients in some public psychiatry settings.	We thank you for your comments on the measure There is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge process, can help to increase medication continuation rates. [1-11] Patients included in this measure have prescription drug coverage under Medicare Part D. If inpatient facilities have programs where outpatient medications are dispensed to patients through a community pharmacy these medications should be billed to the patient's Part D plan, and therefore the hospital would receive credit for the patient filling a medication. The measure development team assessed the day supply of evidence-based medications prescribed prior to the admission to determine if patients might have medications at home that would last through the 30-day follow-up period. For each condition, at least 93% of the prescriptions filled prior to the admission were for a 30-day supply. This indicates that most patients would not have a supply of medication at home that would last through the 30-day follow-up period. It is also important to consider that medications may be adjusted during the inpatient stay and patients may need to fill a new prescription following discharge even if they have medications at home. The patient population for this measure includes only patients with Medicare Part A, Part B, and Part D coverage. We anticipate that few patients in this population would be eligible for samples because low income Medicare patients qualify for additional support to help pay for medication copays. Furthermore, approximately 70% of the patient population for this measure is dually enrolled in Medicaid, which also provides assistance to cover medication costs that aren't covered by Medicare.
8	08/30/2016	Kimberly Yates, DNP, RN-BC, NEA-BC, Administrator of Psychiatry, Catawba Valley Medical Center	Accrediting Organization	Individual Perspective	I think exploring whether patients continue medications on an outpatient basis is important as non-compliance is a key contributor to readmissions. However, I do have concerns about how this information will be obtained when it comes to various patients.	We thank you for your comments and support of the measure. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.

11	08/30/2016	Tamara Brazil, RN, Clinical Quality Excellence Consultant, Memorial Health	Provider Organization	Individual Perspective	Most patients from IPF are being prescribed or already on medications that are needed. The biggest issue is with patient compliance not with physician ordering medication. Previous measure looked at the tapering of antipsychotics and feel this is just a continuum of that measure in different landscape.	We thank you for your comments on the measure. We agree that providing prescriptions for evidence-based medications at discharge is only one aspect of IPF care and that it is not sufficient to encourage medication continuation on its own. That is why the measure evaluates whether the medication was filled rather than simply whether or not there is documentation in the medical record that a medication was prescribed at discharge. We believe this captures a wider array of interventions that facilities might employ to improve medication continuation during the transition to home or home health. The goal of this measure is to improve medication continuation and reduce the variation in performance across IPFs. The goal of HBIPS-5 (Patients discharged on multiple antipsychotic medications) mentioned in the comment is to address a specific quality issue around the safe use of antipsychotics, which is a much different concept.
12	08/30/2016	Terry Olson, RN, CPHQ, Manager of Core Measures/Quality Data, Boulder Community Health	Provider Organization	Individual Perspective	The measure appears relevent from a needs perspective. Patients not refilling medications in a timely fashion is most likely leading to readmissions.	We thank you for your comments on the measure.
13	08/30/2016	Jeannie Walker, DNP-EL, RN, Director of Behavioral Health Services	Provider Organization	Organizational Perspective	This measure is relevant however I am not sure you can hold the facilities responsible for a patients behavior once they are discharged. Psychiatric patients are notorious for taking their medications until they begin to feel better then they decide they don't need them anymore. Educating a psychiatric patient is not the same as someone who does not have a psychiatric diagnosis; reality is not the same and while they are medicated and in a semi-solid reality state education can be effective but as they start to adjust or stop taking their medications reality as we know it does not exist.	We thank you for your comments on the measure. We recognize that there are factors external to the IPF that influence filling prescriptions post-discharge in the psychiatric population. While it may not be possible to achieve complete post-discharge compliance with pharmacotherapies, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge process, can help to increase medication continuation rates.[1-11] The goal of this measure is to improve medication continuation and reduce the variation in performance across IPFs.
14	08/30/2016	Michael Schwartz, MD, Chairman, Department of Psychiatry, Northwell Huntington Hospital	Provider Organization	Individual Perspective	Importance and relevance is obvious. However, if you believe that this is an important indicator of quality, why not just establish a rule that all patients who are discharged from inpatient hospitals must be given a 7-14 day supply of medications upon discharge?	We thank you for your comments on the measure. This measure allows for flexibility in the approach to improving medication continuation. IPFs can use the information provided by this measure to identify quality deficits and implement interventions as needed.

15	08/30/2016	(Anonymous), RN, MSN, Director of Patient Care Services	Provider Organization	Individual Perspective	Although medication compliance post discharge is an important indication of the chance of a successful recovery, as an indicator of quality for an inpatient stay, it is lacking. Measuring whether a pt fills a prescription does not provide any information related to compliance.	We thank you for your comments on the measure. The filling of a prescription is a critical step in improving compliance. We observed ample opportunity for improvement based on a mean medication continuation rate of 79% across 1,694 IPFs, with variation of 22% between the 10th and 90th percentile. Furthermore, measuring actual compliance would be burdensome for both facilities and patients and therefore is not as feasible to measure.
16	08/30/2016	Louis Velazquez, MD, Psychiatrist/Medical Director, Baystate Wing Hospital	Provider Organization	Organizational Perspective	This would be difficult. It would entail tasking someone to be something of a care-manager/case-manager and track the patient after discharge. It would be a cost for the hospital, and I believe it would be fruitless measure while extending unnecessary liability to where the inpatient psychiatrist has little recourse to do anything except call the police if the patient is dangerous or beseech the patient to be compliant. What are we supposed to do if we contact a patient and they lie about compliance or even if they admit to non-compliance? On a personal level, I would find it intrusive. Patients have a right to be compliant or non-compliant. If they are dangerous and/or psychotic, we then seek involuntary medication with a COMMUNITY ROGERS and a treatment guardian. As it is, inpatient psychiatry units struggle to be self-sustaining. It should suffice to provide the patient with an outpatient appointment within ten days.	We thank you for your comments on the measure. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF. We recognize that there are factors external to the IPF that influence filling prescriptions post-discharge in the psychiatric population. While it may not be possible to achieve complete post-discharge compliance with pharmacotherapies, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge process, can help to increase medication continuation rates.[1-11] The goal of this measure is to improve medication continuation and reduce the variation in performance across IPFs.
17	08/30/2016	Corinna Haller, RN, Director of Nursing, War Memorial Hospital	Nonprofit Inpatient Psychiatric Unit	Organizational Perspective	Our organization has significant concerns about this measure. There is no way to capture this information. In the past, we have reached out to CMHs and agencies and told this information no longer pertained to us and was a breach of confidentiality, which is true.	We thank you for your comments on the measure. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
19 and 32	08/30/2016 09/01/2016	Maria Ruiza Yee, MD, Medical Director ACT Program, Reading Health System	Provider Organization	Individual Perspective	ID 19: 08/30/2016 Prescribing 30 day supply of psychotropic medications on discharge is a norm in our institution. However, ensuring patients will fill the prescription is more complex than just having a shared decision, education and addressing resistance and non-compliance during the patient's hospital stay. Even when all these issues are covered during the patient's hospital stay, patients have free will to not take their medications after discharge. I don't know how this can be "forced" upon patients. The most a physician can hope for is that all the discussion on shared decision, education, resistance and compliance	ID 19: 08/30/2016 We thank you for your comments on the measure and recognize that there are factors external to the IPF that influence filling prescriptions post-discharge in the psychiatric population. While it may not be possible to achieve complete post-discharge compliance with pharmacotherapies, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge process, can help to increase medication

					sink in the short, acute (usually 3-5 days) hospital stay. I don't think the institution/physician should be held accountable for the non-filling of prescriptions, especially since the length of stay is so short and typically, the physician is not the current physician treating the patient on an outpatient basis. Unless all patients are referred and managed by an ACT Program, it is unrealistic to expect that providing a patient with 30 day prescription will ensure that patients will go from the hospital directly to the pharmacy to fill their prescription. ID 32: 09/01/2016 I would just like to add additional comments to my comments previously. The patients who are dually eligible, meaning they have Medicare and Medical Assistance or whatever MCO they are enrolled with, have their prescriptions covered by the medical plan of their respective MA/MCO. Hence, their prescriptions would be filled through them, instead of Medicare Prescription D plan. So, it may appear that they did not fill their prescription when in fact, they did.	continuation rates.[1-11] The goal of this measure is to improve medication continuation and reduce the variation in performance across IPFs by encouraging quality improvement related to care transitions. IPFs are a crucial part of the transition process from inpatient care to home or home health. ID 32: 09/01/2016 We thank you for your comments on the measure. The patient population for this measure includes only patients with Medicare Part A, Part B, and Part D coverage. Patients with Medicare Advantage are excluded from the denominator.
22	08/30/2016	James Evans, MD, Medical Director, Inpatient Psychiatry, Mount Auburn Hospital, Cambridge	Provider Organization	Individual Perspective	Agree to it's importance and relevance	We thank you for your comments and support of the measure.
24	08/30/2016	Bryan E. Flueckiger, MD, Medical Director, Citizens Memorial Hospital	Provider Organization	Individual Perspective	I do not believe this is a good indicator of the quality of care of inpatient treatment, especially for a dementia unit. Outpatient medication compliance is dependent on many factors, not the least of which is cost of medications. Many times our patients are in nursing homes and their prescriptions are filled by the pharmacies which serve the facility. Medications are frequently changed based on facility and pharmacy guidelines rather than the patient's request or failure to comply.	We thank you for your comments on the measure. We do not believe this patient population experiences barriers to medication continuation related to cost because they have Medicare Part A, Part B, and Part D coverage. Low income Medicare patients qualify for additional support to help pay for medication copays. Furthermore, approximately 70% of the patient population for this measure is dually enrolled in Medicaid, which also provides assistance to cover medication costs that aren't covered by Medicare. This measure only includes patients discharged to home or home health. Patients discharged to nursing homes are excluded from the measure denominator. This measure only requires that the patient fills an evidence-based medication during the 30-day follow-up period. Changes to the medications that were prescribed at discharge should not impact measure scores as long as the new medications are also evidence-based treatments for the patient's principal condition.
25	08/30/2016	Thomas S. Pisano, MD, Chief of	Provider Organization	Individual Perspective	In a psychiatric facility medication adherence is very important as one of the significant reasons for relapse is non-adherence to medications.	We thank you for your comments and support of the measure.

		Professional Services, Connecticut Valley Hospital				
26	08/30/2016	Susan Robus, BSN, Nurse Manager-Senior Behavioral Unit, Holy Redeemer Hospital	Provider Organization	Individual Perspective	My issue with this proposed measure is the reality that although a prescription may be dispensed, the recipient often does not take it or does not take it as prescribed. This is very common within the geriatric community. Many "psychiatric" medications cause such debilitating side affects that the "patient" will stop taking the medication once home. CMS should measure if the discharged patient is STILL taking the prescribed medication after 60 days.	We thank you for your comments on the measure. The filling of a prescription is a critical step in improving compliance. We observed ample opportunity for improvement based on a mean medication continuation rate of 79% across 1,694 IPFs, with variation of 22% between the 10th and 90th percentile. Furthermore, measuring actual compliance would be burdensome for both facilities and patients and therefore is not as feasible to measure. This measure evaluates the quality of care provided by an IPF which helps patients continue their medications during the transition from the inpatient setting to home or home healthcare. While we agree that it is important for patients to continue to refill their medications beyond 30 days of discharge from an IPF, attribution of longer-term medication continuation rates to IPFs would not be equitable as there may be additional factors and intervening treatment that would influence 60 day rates.
27	08/30/2016	Debra Ann Brodersen, MSN, Director Behavioral Health Services, Spencer Hospita	Provider Organization	Organizational Perspective	I completely understand the importance of medication compliance for patients in the measure population and agree knowing that the patient is taking his/her medication is important information for the provider.	We thank you for your comments and support of the measure.
28	08/31/2016	Michael L. Brown, MD, Medical Director, Geropsychiatry, Private Practice	Physician in Private Practice	Individual Perspective	It is my opinion that this has the potential to be a valid measure, with some concerns. There are 2 elements of the measure that must be accounted for. Element 1 is the prescribing of the medications at discharge; element 2 is the picking up of the prescription. As the prescribing physician, I have no control over Element 2, yet that is how my "quality" will be determined. I hope that my patients at discharge follow through with the discharge plan, but once they leave the hospital, I have no control over that, which is Element 2. What I can control is the writing and transmitting of the prescription, the choice of medicines that my patients can afford and which are available on a limited formulary, the education my team provides the patient at discharge, and my efforts to engage the patient in their treatment plan during their hospitalization, all of which are parts of Element 1, and which are not measured by the proposed rule. If it comes to that, then my hospital will have to hire yet another employee to go to the pharmacy and pick up the medicine for the patient in advance of discharge and hand it to them as they walk out the door.	We thank you for your comments on the measure and recognize that there are factors external to the IPF that influence filling prescriptions post-discharge in the psychiatric population. While it may not be possible to achieve complete post-discharge compliance with pharmacotherapies, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge processes listed in the comment, can help to increase medication continuation rates.[1-11] The goal of this measure is to improve medication continuation and reduce the variation in performance across IPFs. The measure evaluates the process of filling a medication rather than whether or not there is documentation in the medical record of certain interventions. We believe this captures a wider array of interventions that facilities might employ to improve medication

						continuation during the transition to home or home health and reduces the reporting burden for facilities.
29	08/31/2016	(Anonymous) RN, Senior Director	Accrediting Organization	Organizational Perspective	What exactly is being measured is if the prescription is being filled but it does not give us useful information if the patient is actually taking it. What is the purpose of the measure in terms of helping the acute hospital in changing practice? Patient go home with prescriptions but it does not mean they take the prescription fill it and take it.	We thank you for your comments on the measure. The filling of a prescription is a critical step in improving compliance. We observed ample opportunity for improvement based on a mean medication continuation rate of 79% across 1,694 IPFs, with variation of 22% between the 10th and 90th percentile. Furthermore, measuring actual compliance would be burdensome for both facilities and patients and therefore is not as feasible to measure. IPFs can use the information provided by this measure to identify quality deficits and implement interventions to improve medication continuation.
31	08/31/2016	Allison Hadley, MD, Medical Director, UCSD	Provider Organization	Individual Perspective	Would this be based on the patient receiving or filling a prescription. Whether a patient fills the prescription as an outpatient is difficult to control from the inpatient setting. This does not seem to be a key factor to indicate quality of inpatient psychiatric care.	We thank you for your comments on the measure and recognize that there are factors external to the IPF that influence filling prescriptions post-discharge in the psychiatric population. While it may not be possible to achieve complete post-discharge compliance with pharmacotherapies, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge processes, can help to increase medication continuation rates.[1-11] The goal of this measure is to improve medication continuation and reduce the variation in performance across IPFs.
33	09/01/2016	Robert Munja, MD, Associate Medical Director, Inpatient Psychiatric Care, Providence	Provider Organization	Individual Perspective	This unfortunately feels like one more form of book-keeping that is likely to only document that indeed for most patients with MDD/BPAD/and Schizophrenia are being discharge on medications indicated for their condition. It is additionally unfortunate that there is no acknowledgment that within a recovery-model that respects patient's autonomy, medication refusal may be the most appropriate decision for the clinician to accept. In other words, a patient with MDD leaving on no medication may be the best quality outcome, if indeed after motivational-enhancement, informed consent, and discussion of treatment alternative the patient ultimately refuses medication but the doctor-patient alliance is maintained. By suggesting that patient's who don't leave on medication indicates a lack of quality in their psychiatrist is a gross insult to modern day thinking that steps beyond the nature-nurture debate. CBT and other therapies are acceptable treatments for MDD (in the least) and a patient's choice to refuse medication in favor of psychotherapy would be inappropriately designated a lack of quality in care. In fact, it might be exactly the opposite. Unfortunately these narrowly defined	We thank you for your comments on the measure. The measure denominator includes patients that are generally recommended to have a medication prescribed at discharge for their condition. Patients for which other treatment modalities could be considered have been excluded. With regard to patient refusal, we agree it is possible that patients will prefer to seek other treatments or will refuse treatment. However, in a medical record review across seven test sites, we identified very few cases where this was observed and do not anticipate that patient refusal will have a significant impact to facility scores. Furthermore, introducing a patient refusal exclusion would necessitate an additional data source for the measure because patient refusal could not be captured in administrative data. Adding

					guidelines seldom capture the nuance of the doctor-patient relationship, I would find it wholly unacceptable to introduce this as a measure of quality if there was not some sort of allowance or exception made for "patient refusal" and or "patient preference for management of condition with psychotherapy". Often times, the patients that leave not on a medication are the patients that I have spent the most time with in terms of trying to address their obstacles - to say that somehow ultimately if they are not convinced in doing so, I have failed in providing quality care would rob patients of their autonomy and would be a disrespectful take on the situation. I find it hard to believe that in a world that accepts that psychotherapy is a suitable alternative to medication, and that there is no nature-nurture debate, and that patient's have the right to a recovery-model of care (including medication refusal) - that we are coming up with guidelines that describe quality as equivalent to pill-pushing. This only serves to reinforce the public mis-perception that psychiatry is solidly in bed with the pharmaceutical industry and emphasizes prescribing over healing.	a data source (e.g., medical record) would also add substantial burden to reporting facilities.
34	09/02/2016	Kassie Ryan, RN MSN, Quality Improvement Specialist, Alina Health	Provider Organization	Organizational Perspective	At Allina Health we support the rationale for this measure as it is a period of great risk for our patients and compliance with treatment needs to be enhanced.	We thank you for your comments and support of the measure.
36	09/07/2016	(Anonymous)	(Not indicated)	Individual Perspective	Unfortunately this is yet another process measure that does not answer the question most important to beneficiaries - Do patients at this facility get better?	We thank you for your comments on the measure. We disagree that this process measure is not addressing whether patients discharged from IPFs get better. Since pharmacotherapy is the primary treatment modality for patients included in the denominator, this measure assesses a process that is closely-linked to outcomes. If patients do not fill the medications prescribed at discharge, evidence suggests they are likely to experience relapse and rehospitalization. [12-14]
37	09/09/2016	Jeri Meier, RN, Director of Behavioral Health, Eastar Health Systems	Provider Organization	Organizational Perspective	Although I do understand it is important for patients to continue there medication. As the inpatient provider we provide wrap around services. Those agencies at that time should be responsible for making sure the patient has filled their medication prescriptions. Once the patient has left the hospital we have no ability to be able to track them nor the right to track the decisions they make.	We thank you for your comments on the measure. This measure evaluates the quality of care provided by IPFs that can help or encourage patients to continue their medications after discharge to home or home health. The literature supports the connection between IPF interventions and medication continuation,[1-11] which confirms that IPFs are a crucial part of the transition process. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
38	09/09/2016	Tammy Pietrzak, RN-BC, Regional Clinical Director, CHS	Provider Organization	Individual Perspective	I don't think this is going to address the gap. Unfortunately, patients often choose which prescriptions to fill based on their abilty to pay for the prescription or their prescription coverage plan. For example, many Medicare patients have Medicaid secondary that may pay for	We thank you for your comments on the measure. We do not believe this patient population experiences barriers to medication continuation related to cost because they have Medicare Part A, Part B, and Part D coverage. Low income Medicare

					their prescriptions and have a restriction of 5 prescriptions per month that the plan will pay for.	patients qualify for additional support to help pay for medication copays. Furthermore, approximately 70% of the patient population for this measure is dually enrolled in Medicaid, which also provides assistance to cover medication costs that aren't covered by Medicare as noted in the comment. This measure only requires that a patient fill at least one evidence-based medication during the 30-day follow-up period, which should not be impacted by limits on the number of prescriptions Medicaid will help to cover per month.
41	09/12/2016	Nancy Hanrahan, PhD, RN, Dean and Professor, Psychiatry, Northeastern University.	Research	Individual Perspective	both are relevant	We thank you for your comments and support of the measure.
42	09/12/2016	Katy Brown, PharmD, Regional Clinical Director, CHS	Medicare Quality Improvement Organization (QIO)	Individual Perspective	Agree to it's importance and relevance	We thank you for your comments and support of the measure.
43	09/12/2016	Christine Scully, MPH, FACHE, Regional Director, Hospital of Central CT	Provider Organization	Organizational Perspective	there are two components to this measure-discharging a patient on an evidence based medication and the second component is whether the patient fills the medication perscription. it appears they are being lumped together into one measurement.	We thank you for your comments on the measure. The measure does not evaluate whether an evidence-based medication was prescribed at discharge. Providing prescriptions for evidence-based medications at discharge is only one aspect of IPF care and it is not sufficient to encourage medication continuation on its own. That is why the measure evaluates whether the medication was filled rather than simply whether or not there is documentation in the medical record that a medication was prescribed at discharge. We believe this captures a wider array of interventions that facilities might employ to improve medication continuation during the transition to home or home health.
44	09/12/2016	Michael Gallagher, BSN, BC-NE, Director of Behavioral Health Services, Southern New Hampshire Medical Center	Public/Community Health Agency	Individual Perspective	I believe it will difficult to collect the data, most of our patient base do not have ready available phone services or sometimes addresses	We thank you for your comments on the measure. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
46	09/13/2016	(Anonymous)	(Not indicated)	Individual Perspective	This measure has relevance in terms of potential for improved functional, social, vocational, medical and psychiatric status for the defined population with adherence to all treatment recommendations. The data demonstrates the efficacy of monitoring for medication compliance as this is a large driver of maintaining symptom reduction	We thank you for your comments and support of the measure.

					or, in some cases, attaining symptom remission.	
47	09/13/2016	Jayne Hart Chambers, MBA, Senior Vice President Quality, Federation of American Hospitals	Hospital Association	Organizational Perspective	The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay, rehabilitation, and long-term care hospitals in urban and rural America, and provide a wide range of acute, post-acute, and ambulatory services. The FAH appreciates the opportunity to provide comments on the CMS Inpatient Psychiatric Facility Measure of Continuation of Medication within 30 Days of an Inpatient Psychiatric Discharge. The FAH strongly supports further development of measures that address behavioral health issues and specifically measures that focus on the continuity of care across settings. The FAH also is encouraged to see that comprehensive testing for reliability and validity of this proposed medication measure was completed prior to opening the public comment period. However, for several reasons, the FAH strongly questions whether this measure of "continuation of medication after discharge", as currently written, will have any bearing or even begin to demonstrate the quality of care provided by inpatient psychiatric facilities.	We thank you for your comments on the measure. We disagree that this measure as proposed would not be a valid indicator of the quality of care provided by the inpatient psychiatric facility. Facility-level performance comparisons to related quality measures found statistically significant correlations, which indicates that medication continuation is a valid indicator of IPF quality. Furthermore, since pharmacotherapy is the primary treatment modality for patients included in the denominator, this measure assesses a process that is closely-linked to outcomes. If patients do not fill the medications prescribed post-discharge, evidence suggests they are likely to experience relapse and rehospitalization. [12-14] Furthermore, the literature supports the connection between IPF interventions and medication continuation ,[1-11] which confirms that the quality of care provided by IPFs can influence medication continuation.
49	09/14/2016	Christine Picklo, MT, MBA, Manager, Data Abstraction & Measurement, Data Quality Measurement, Yale New Haven Health	Provider Organization	Organizational Perspective	The intent of the measure is supported. Medication non-adherence is one of the largest drivers of readmissions in this population.	We thank you for your comments and support for the measure.
54	09/15/2016	Kathleen McCann, RN, PhD, Director of Quality and Regulatory Affairs, National Association of	Provider Organization	Organizational Perspective	Assisting patients to understand and follow-through with medication regimes upon discharge is a very important responsibility of inpatient psychiatric providers. There is no perfect way to assess patient's adherence post-discharge. Surveying the claims data to determine whether a prescription has been filled is one proxy measure of	We thank you for your comments and support for this measure.

		Psychiatric Health Systems			whether a patient at least has medication in his/her possession. The thing this measure cannot do is to determine whether a patient is actually taking the medication.	The filling of a prescription is a critical step in improving compliance. We observed ample opportunity for improvement based on a mean medication continuation rate of 79% across 1,694 IPFs, with variation of 22% between the 10th and 90th percentile. Furthermore, measuring actual compliance would be burdensome for both facilities and patients and therefore is not as feasible to measure.

Table B.2. Verbatim Comments: Scientific Acceptability

Entry ID	Date Posted	Name, Credentials, Title, and Organization of Commenter	Type of Organization	Perspective	Text of Comments*	Recommendations/ Actions Taken/ CMS Response
4	08/29/2016	Mary J. Mang, RN, Director Quality & Outcomes Management, Carson Tahoe Health	Provider Organization	Organizational Perspective	Multiple flaws with this scientific acceptability. The cause and effect is flawed and influenced by multiple factors al adding variability.	We thank you for your comment. While we agree that there are many factors that may influence medication continuation, the literature supports the connection between IPF interventions and medication continuation,[1-11] which confirms the quality of care provided by is an important factor for medication continuation.
5	08/29/2016	Jeffrey A. Plancich, LMHC, CMHS, Director, Behavioral Health Services, MultiCare Behavioral Health	Provider Organization	Individual Perspective	Continued and sustained medication blood levels allow for other therapy interventions to progress.	We thank you for your comment.
6	08/29/2016	Melissa Hodges, RN, Manager Clinical Data Abstraction	Hospital	Individual Perspective	Scientific rationale is sound	We thank you for your comment.
7	08/29/2016	Gregory A Miller, MD, Chief Medical Officer Unity Behavioral Health, Legacy Health Systems, Portland, OR	Provider Organization	Individual Perspective	I do not know of any evidence support that prescription filling within 30 days reflects better discharge processes. I'm not sure this data will be any more useful than a measure of contact with a mental health professional within one week.	We thank you for your comment. There is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge process, can help to increase medication continuation rates. [1-11] IPFs can use the information provided by this measure to identify quality deficits and implement interventions to improve medication continuation and reduce the variation in performance across IPFs. We believe this will be complementary to the Follow-Up After Hospitalization for Mental Illness measure.
11	08/30/2016	Tamara Brazil, RN, Clinical Quality Excellence Consultant, Memorial Health	Provider Organization	Individual Perspective	Frequent changes and updates to medications uses are not adequately changed within measure timeframe and create fallouts. Medication use should be individualized for the patient and what creates a sense of control, adherence and control of symptoms. If a medication is not evidence based for certain disease/diagnosis, but works for the patient it should be considered.	The measure is not designed to assess dose changes or medication changes. The measure simply requires that patients hospitalized for MDD, schizophrenia, or bipolar disorder have access to evidence-based treatments for their conditions. This measure provides flexibility in the classes of medications that count toward the numerator and excludes patients who may not be able to take one of those classes of medications. We will carefully review included medications based on current evidence and clinical practice.

14	08/30/2016	Michael Schwartz, MD, Chairman, Department of Psychiatry, Northwell Huntington Hospital	Provider Organization	Individual Perspective	There is the assumption that the principal diagnoses are accurate. There are many patients with diagnoses of MDD or bipolar disorder and even schizophrenia who don't really have those diagnoses, but are given those diagnoses out of a sense of expediency. Many have primarily drug related disorders or personality disorders and "masquerade" as patients with major syndromes. Failure to fill prescriptions may reflect a degree of recklessness and irresponsibility associated with those diagnoses. I suppose you could counter that failure to make an accurate diagnosis is a measure of quality (or lack thereof), but in fact, the pressure on inpatient facilities to stabilize the patietn and discharge as soon as possible is inconsistent with the goal of making an accurate diagnosis in many instances. So to my mind there are problems with the science underlying the project	We thank you for your comment. The measure developer evaluated the validity of the claims data in identifying the correct principal discharge diagnosis through a medical record review at seven test facilities. They found that the positive predictive value of the claims data was 95% (97/102). The positive predictive values were similar across all three conditions, with 91% (30/33) for MDD, 97% (34/35) for schizophrenia, and 97% (33/34) for bipolar disorder. This indicates a high probability that a claim for a certain condition (e.g., MDD, schizophrenia, or bipolar disorder) correctly predicts the principal discharge diagnosis in the medical record. It is the responsibility of the IPF to ensure that diagnosis recorded in the medical record and submitted to CMS for billing purposes is accurate and reflect the patient's primary condition during an inpatient admission.
15	08/30/2016	(Anonymous), RN, MSN, Director of Patient Care Services	Provider Organization	Individual Perspective	Again getting a script filled only means the patient has the medication. A quality measure would be compliance with medication as evidenced by subsequent refills.	We thank you for your comment. The filling of a prescription is a critical step in improving compliance. We observed ample opportunity for improvement based on a mean medication continuation rate of 79% across 1,694 IPFs, with variation of 22% between the 10th and 90th percentile. Furthermore, measuring actual compliance would be burdensome for both facilities and patients and therefore is not as feasible to measure
16	08/30/2016	Louis Velazquez, MD, Psychiatrist/Medical Director, Baystate Wing Hospital	Provider Organization	Organizational Perspective	I do not support this measure. It is intrusive. This should only be a task of DMH case managers tracking the chronically mentally ill.	We thank you for your comment and understand the importance of maintaining patient privacy. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
19 and 32	08/30/2016 09/01/2016	Maria Ruiza Yee, MD, Medical Director ACT Program, Reading Health System	Provider Organization	Individual Perspective	ID 19: 08/30/2016 There is no question that compliance with medications that stabilized patient's symptoms during their hospital stay prevents relapses, recurrences and improves a patient's quality of life. Linking the prescribing of 30 days supply of medications as the core measure to achieve compliance in patients is what is troubling.	ID 19: 08/30/2016 We thank you for your comment. We agree that providing prescriptions for appropriate medications at discharge is only one aspect of care and is not sufficient to encourage medication continuation on its own. That is why the measure evaluates the process of filling a medication rather than simply whether or not there is documentation in the medical record that a medication was prescribed at discharge. We believe this captures a wider array of interventions that facilities might employ to improve medication continuation during the transition to home or home health.

24	08/30/2016	Bryan E. Flueckiger, MD, Medical Director, Citizens Memorial Hospital	Provider Organization	Individual Perspective	There are too many variables to make the measure meaningful.	We thank you for your comment and recognize that there are factors external to the IPF that may influence rates of medication continuation in the psychiatric population. While it may not be possible to achieve complete post-discharge compliance with pharmacotherapies, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge process, can help to increase medication continuation rates.[1-11] The goal of this measure is to improve medication continuation and reduce the variation in performance across IPFs.
25	08/30/2016	Thomas S. Pisano, MD, Chief of Professional Services, Connecticut Valley Hospital	Provider Organization	Individual Perspective	Not sure since filling prescriptions and taking the medications are not equivalent.	We thank you for your comment. The filling of a prescription is a critical step in improving compliance. We observed ample opportunity for improvement based on a mean medication continuation rate of 79% across 1,694 IPFs, with variation of 22% between the 10th and 90th percentile. Furthermore, measuring actual compliance would be burdensome for both facilities and patients and therefore is not as feasible to measure.
28	08/31/2016	Michael L. Brown, MD, Medical Director, Geropsychiatry, Private Practice	Physician in Private Practice	Individual Perspective	It is not at all scientifically acceptable, insofar as it purports to measure one thing ("quality of care provided to patients") while actually measuring another (patient decisions to act or not act on information given to them during hospitalization and at discharge). The former may be indirectly assessed by the latter, but it is only one of many determinants, none of which are assessed by the measure. In order for this to be scientifically acceptable, the "quality of care" presumption should be eliminated. If we call it a measure of "patient education effectiveness" or "treatment facility persuasiveness" then we are closer to the truth of the measure. But don't call it "quality assessment." That is a far more complicated issue.	We thank you for your comment and recognize that there are factors external to the IPF that may influence rates of medication continuation in the psychiatric population. While it may not be possible to achieve complete post-discharge compliance with pharmacotherapies, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge process, can help to increase medication continuation rates.[1-11] The goal of this measure is to improve medication continuation and reduce the variation in performance across IPFs.
33	09/01/2016	Robert Munja, MD, Associate Medical Director, Inpatient Psychiatric Care, Providence	Provider Organization	Individual Perspective	The fact that the medications for evidence base in depression does not include any atypical antipsychotics, lithium, or cytomel is not reflective of the current state. While these medications are not often used in monotherapy, there are certainly cases in which their use in monotherapy is in the best interest of the patient. Whether it is the STAR-D trial, FDA indication, or otherwise, these all have well respected evidence in the treatment of MDD and should be included in the list of evidence based medicines for MDD	We thank you for your comment. We will evaluate the evidence and consider the addition of atypical antipsychotics, lithium, and cytomel to the list of medications in the numerator for treatment of MDD.
34	09/02/2016	Kassie Ryan, RN MSN, Quality Improvement Specialist, Alina Health	Provider Organization	Organizational Perspective	It's utility and validity will be dependent on how it is measured. Something we would request be included is that we would want not only outpatient pharmacy prescriptions to count, but also if patients fill their medication through the hospital pharmacy before they discharge from the hospital that this should be counted. This is a common workflow not only for access to the patient, but also to help them be compliant with filling the prescription.	We thank you for your comment. The measure captures all prescriptions billed under Part B or Part D for evidence-based medications during the follow-up period, regardless of where those prescriptions are filled. The follow-up period starts on the day of discharge and extends 30 days post-discharge. However, we will consider counting medications that are filled during the admission prior to the day of discharge toward the numerator to allow for innovative

					Also, we would want detail in the measure on how the "resume" medication will be monitored as the patient sometimes is not given a prescription at discharge if he or she has adequate medications at home and does not need any new refill at time of discharge. We assume that this measure applies only to prescriptions the patient is provided upon discharge and not subsequent refills.	programs ensuring that the patient has the medication at discharge. The measure development team assessed the days supply of evidence-based medications prescribed prior to the admission to determine if patients might have medications at home that would last through the 30-day follow-up period. For each condition, at least 93% of the prescriptions filled prior to the admission were for a 30-day supply. This indicates that most patients would not have a supply of medication at home that would last through the 30-day follow-up period. It is also important to consider that medications may be adjusted during the inpatient stay and patients may need to fill a new prescription following discharge even if they have medications at home. This measure includes any claim for an evidence-based medication during the follow-up period, without distinguishing whether a prescription for that medication was provided upon discharge.
36	09/07/2016	(Anonymous)	(Not indicated)	Individual Perspective	My primary concern is how the data will be reported - the measure information indicates it would include two years of data. Does this mean the results will only be reported once every two years? Or it will be reported annually and each year of data will end up being reported twice? I believe the measure should include annual data to mesh with the existing IPFQR measure requirements and to avoid any duplication. Reporting the measure annually while including two years of data each time is deceptive to readers and makes it more difficult to see change/improvement year over year.	We thank you for your comment. If implemented, this measure would be reported once per year with a measurement period that includes the two most recent years for which Medicare FFS and Part D claims data are available. This means that data from a given year would be included in the measurement period for two different reporting periods. A two-year measurement period was selected because it was the shortest timeframe that provided enough cases for reliable calculation of measure scores. Use of two years of data is aligned with the approach for the IPF Readmission measure in the IPFQR program.
37	09/09/2016	Jeri Meier, RN, Director of Behavioral Health, Eastar Health Systems	Provider Organization	Organizational Perspective	It is obvious that patients that our compliant reduce readmission rates. But expecting inpatient behavioral health units to track this measure is not reasonable. Also, in my opinion we are violating the patients right to privacy by seeking this information after they are discharged.	We thank you for your comment. We understand the importance of maintaining patient privacy. This measure is calculated by CMS from Medicare FFS and Part D claims data and does not require additional data collection by the IPF.
41	09/12/2016	Nancy Hanrahan, PhD, RN, Dean and Professor, Northeastern University	Research	Individual Perspective	appear to be valid	We thank you for your comment.
43	09/12/2016	Christine Scully, MPH, FACHE, Regional Director, Hospital of Central CT	Provider Organization	Organizational Perspective	Not sure there is a direct corelation between filling a perscription and good discharge planning.	We thank you for your comment and recognize that there are factors external to the IPF that may influence rates of medication continuation in the psychiatric population. While it may not be possible to achieve complete post-discharge compliance with

						pharmacotherapies, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge process, can help to increase medication continuation rates.[1-11]The goal of this measure is to improve medication continuation and reduce the variation in performance across IPFs.
44	09/12/2016	Michael Gallagher, BSN, BC-NE, Director of Behavioral Health Services, Southern New Hampshire Medical Center	Public/Community Health Agency	Individual Perspective	I believe this is value data due the rate of readmission are from lack of medications	We thank you for your comment.
46	09/13/2016	(Anonymous)	(Not indicated)	Individual Perspective	There is clear scientific validity for the use of evidenced-based medications to address psychiatric symptoms across a spectrum of diagnoses and the measurement of patient adherence with their prescribed medication regimen.	We thank you for your comment.
47	09/13/2016	Jayne Hart Chambers, MBA, Senior Vice President Quality, Federation of American Hospitals	Hospital Association	Organizational Perspective	The measure calls for reporting the percentage of patients who fill a prescription. While useful to know if a patient has filled a prescription, the proposed measure does not address the real overarching concern - whether patients are taking the medication and truly adhering to the physician's prescribed regimen. Until this measure examines adherence rates, the FAH does not believe that it should be put forward for implementation.	We thank you for your comment. The filling of a prescription is a critical step in improving compliance. We observed ample opportunity for improvement based on a mean medication continuation rate of 79% across 1,694 IPFs, with variation of 22% between the 10th and 90th percentile. Furthermore, measuring actual compliance would be burdensome for both facilities and patients and therefore is not as feasible to measure.
49	09/14/2016	Christine Picklo, MT, MBA, Manager, Data Abstraction & Measurement, Data Quality Measurement, Yale New Haven Health	Provider Organization	Organizational Perspective	Not all of the evidenced based therapies are listed. For instance, quietipine is an antipsychotic medication (listed for treatment of Bipolar and Schizophrenia) but it also has an FDA indication as monotherapy for major depression The ICD-9 codes that are listed include far too many codes where the actual evidenced based treatment is not as clean. For instance, antidepressants are FDA approved for Major Depressive Disorder (ICD-9 296.2 and 296.3). It is not FDA approved for unspecified depressive disorder (ICD-9 311) yet that diagnosis is listed. There are other similar concerns related to the schizophrenia diagnoses and bipolar diagnoses: included are diagnostic codes where the evidence is not as clear. For instance, Schizoaffective disorder, depressive type, may not always require treatment with an antipsychotic medication.	We thank you for your comment. We will evaluate the evidence and consider the addition of quetiapine to the list of medications in the numerator for treatment of MDD. We will reevaluate the recommended pharmacotherapy for unspecified depressive disorder (ICD-9 311) and consider removing from the denominator if appropriate. We will reevaluate the recommended pharmacotherapy for schizoaffective disorder, depressive type and consider removing from the denominator if appropriate.

53	09/15/2016	Catherine Frank, MD, Chief, Behavioral Health Services, Henry Ford Health System	Provider Organization	Organizational Perspective	On behalf of the Behavioral Health Services program at Henry Ford Health System (HFHS), I would like to comment on the proposed measure of "Continuation of Medications within 30 Days of Inpatient Psychiatric Discharge" as part of the measure set for inpatient psychiatry facilities. Although I acknowledge the clinical importance of appropriate post-discharge medications for patients with the selected diagnoses in the measure specifications, I am very concerned about the suitability of the measure as described as a quality of care measure for inpatient facilities. The concerns have both conceptual and technical elements. The Henry Ford Health System is a large, integrated health care system serving the Detroit Metropolitan Area in Southeast Michigan and the Jackson, MI area of South-Central Michigan. The System includes a large multi-specialty group practice of salaried physicians, five acute care hospitals, a large managed care plan, home health care, and a set of retail health care services like eye care and durable medical equipment. HFHS was a recipient of the Malcolm Baldrige National Quality Award for the HFHS in 2011. More relevant for the current discussion, though, is the presence in the system of 258 licensed psychiatric beds (including 30 child/adolescent) at three hospitals: a 136-bed psychiatric facility (Kingswood Hospital) and 85 beds at Henry Ford Macomb Hospital and 38 beds at Henry Ford Wyandotte. The HFHS Behavioral Health Services program team includes 45 psychiatrists, 24 psychologists, 27 Advanced Practice Providers (APPs) and more than 80 therapists. <u>Conceptual Concerns</u> There is little doubt about the clinical value of medication therapy for schizophrenia, major depressive disorder, or bipolar disorder. There is clearly some doubt, though, about whether, or to what extent, inpatient facilities are responsible for the filling of prescriptions after hospital discharge. None of the extensive evidence cited in the supporting materials for the measure supports this concept, by, for example, showing that formal inpatient responsibility yield better medication adherence rates and outcomes than some alternative responsibility for post-discharge medications. The supporting materials provide no compelling or detailed argument for why the filling of post-discharge medications should be a hospital responsibility, as opposed to the responsibility of an individual physician caring for the patient after discharge, or a community-based mental health services program caring for the patient, or any other medical or social services agency with whom the patient has a relationship after discharge. The measure is based on a fallacy that because rates of medication therapy CAN be calculated at a facility level, that those rates then reflect "performance" or "quality" of the facility (see pages 15-16 of the measure justification document). One could presumably calculate county-level or state-level rates of medication use, and then conclude that the county or state was "performing" if rates were high. There is no clearer reason for making that conceptual leap for	We thank you for the detailed introduction of your health system and the detailed comments on the measure. We disagree with the assertion that inpatient psychiatric facilities do not have a role in influencing medication continuation rates. There are many interventions that have proven effective at improving medication continuation. Even in our testing of the measure, we identified innovative programs where IPFs were working with ambulatory pharmacies to ensure patients had their medications prior to leaving the facility. Furthermore, our expert panel composed of a variety of stakeholder perspectives, including providers and clinicians, were 100% in agreement of the face validity of the measure. Validity was supported by correlations with two other measures of quality which have a conceptual relationship to the measure as specified. We acknowledge that adherence will be affected by a multitude of factors that include resources that are available to support patients after discharged. While many of these resources are not in the IPF's control, the IPF is a critical participant in discharge planning and facilitating connections to providers who can support adherence. It is understood that a single IPF will not be able to remove all barriers to adherence (and thus, achieve 100% measure scores) but the relative

					hospitals than there is for counties or states or any other unit of analysis that could be applied to rates of medication use. To be valid and useful in the context of quality measurement and reporting, there has to be a much stronger conceptual foundation linking the entities being measured to formal accountability for the events being measured. There is no such foundation presented here. In fact, many inpatient psychiatric facilities have little or no control over the care that patients receive after discharge, and have no effective means of exerting that control. Studies showing some effect by hospitals on post-discharge medications in selected settings do not change this general truth. Use of a measure like the one proposed may incentivize hospitals to try to exert more control, but in many settings, no effective control is possible.	comparison of IPF measure scores to the national rate should provide insight into performance and related to patient transition into the outpatient setting.
					Data presented in the supporting materials from one academic facility indicate clearly that the provision of medications by the discharging hospital is NOT a problem. Essentially all patients in that sample received medications, and there was only a question about appropriateness of those medications for 8 out of 150 cases reviewed. If there is a problem in the filling of prescriptions AFTER discharge, it does not seem to be very much linked to a problem of patients receiving medications AT discharge. If data from the one site are generalizable, hospitals seem to be doing a good job at what they could be clearly expected to do; the measure makes them accountable for something they are not clearly expected to do.	It is important to note that the measure focuses on adherence to medications and not on IPFs initiating appropriate therapy on discharge. The cited validation study confirmed that the majority of patients were intended to receive medication once discharged but we demonstrated the large proportion of prescriptions that were not filled.
					<u>Technical Concerns</u> There are several essential elements of the technical case for the value of the measure as a measure of inpatient care quality that have not been made. The first is the matter of effect size. The extensive supporting materials and literature review, with only one exception on page 14, make no mention of the effect size, or the percent variance explained, of either medication adherence to outcome, or from specific interventions designed to enhance adherence to adherence rates. This information is essential. To illustrate why this is essential, consider a simple "thought experiment". Let's say that a clinical intervention "X" has been associated with a 10% improvement in outcome "Y" in a set of good randomized controlled trials. "X" then becomes the subject of an evidence-based guideline and a proposed quality measure. Let's then say that the performance of "X" at the level of some unit being compared (e.g., hospital) varies by 10%, so that "good" hospitals do "X" 80% of the time, and "bad" hospitals do "X" 70% of the time. Just on that bit of information, we would expect a difference in outcome in a good vs. bad hospital of just 1%. That is actually going to be an over-estimate, as RCT results rarely are replicated as strongly in "real life", because the intervention isn't done as faithfully, or the denominator includes now large numbers of patients who would have been excluded from the RCTs. So we	The case for an adherence measure is somewhat straight-forward as long as efficacy trial estimates of drug effects are available and can be extrapolated into real-life or pragmatic or observational studies that have estimated effectiveness. Thus Y could be approximated as the effectiveness of the indicated medication in preventing outcomes such as readmission because failure to fill the prescription would result in no therapy. What has indeed not been quantified is the effect of IPF intervention (let's say X1) on adherence (X2). We hope that as the measure is implemented information on best practices and their impact of measure scores will become available. If implemented, the measure would be reported as an overall facility score and the state average. Hospitals would not be labeled as good or bad.

					label hospitals as "good" vs. "bad" on the basis on an outcome difference of less than 1%. The illustration is hypothetical, but it indicates that measures should only be brought forward and used as quality measures if they highlight clinically meaningful differences in outcome, or in processes strongly linked to outcome. The evidence for effect sizes or variance explanation along the causal chains related to this measure is not presented. The discussion in the measure justification materials about reliability and "signal" vs. "noise" is technically appealing, but fundamentally wrong. Between-hospital variation is considered to be "signal" regardless of its meaning or causal origin. Let's imagine two hospitals that are identical to each other in terms of patients served and all of their capabilities and processes. Their "signals" in this hypothetical example should be identical. The first hospital is in a community with a very strong community-based mental health services program, a very strong outpatient psychiatry network, strong community support services, and a generally coherent community culture in general so that people who are not compliant with medications and having problems get identified and helped. The second hospital is in a community with the opposite characteristics. The probability of post-discharge medications being filled is clearly higher in the first than in the second, but again, in this hypothetical example, the two hospitals are identical. They would have different "performance" rates, though. The supposed "signal" in the measure is actually no signal at all in this hypothetical example – it is all "noise" reflecting community-level variables that are not elements of hospital quality. In practice, large fractions of the supposed "signal" according to the approach used in the supporting documentation are actually confounding "noise" based on individual and community variables that have nothing to do with inpatient quality of care. With that in mind, the measure as specified does not include any sort of adjustment for patient-level or community-level variables that could affect the filling of post-discharge prescriptions. The number and availability of pharmacies, the state of local transportation, the ability of patients to afford prescription co-pays, and the ability of local mental health care networks to take up the care of discharged patients are all potentially relevant variables representing "noise" in this measure that are not subject to any form of adjustment. Without adjustment, the measure will be at least uninformative, and potentially misleading.	Reliability refers to measure precision and not validity. The signal to noise ratio assesses whether the measure has sufficient precision to discern differences between IPFs, not whether these differences accurately reflect quality (which is a validity question). We agree with the concern that medication continuation is dependent on many factors, many of which are not in the IPFs control. We don't consider risk adjustment necessary for this measure. Furthermore, measures that are risk adjusted do not include community variables in those models.

Table B.3. Verbatim Comments: Feasibility

Entry ID.	Date Posted	Name, Credentials, Title, and Organization of Commenter	Type of Organization	Perspective	Text of Comments*	Recommendations/ Actions Taken/ CMS Response
1	08/23/2016	Thomas Z Cady, Individual	Individual	Individual Perspective	I do not know. Health care was never in any of my feasibility presentation as a Sales and Marketing Director or a traveling National Instructor for the National Home Builders Assn or it Commercial Divisions.	We appreciate your participation in this public comment period.
2	08/29/2016	(Anonymous)	(Not indicated)	Individual Perspective	I DON'T THINK AN INPATIENT PSYCHIATRIC FACILITY SHOULD HAVE TO TRACK DOWN PEOPLE WHO WERE DISCHARGED TO FIND OUT IF THEY GOT THEIR PRESCRIPTION FILLED WITHIN 30 DAYS AFTER DISCHARGE. ONCE A PATIENT IS DISCHARGED, THEY ARE NO LONGER THE RESPONSIBILITY OF THE INPATIENT PSYCHIATRIC FACILITY. IF THEY ARE GIVEN A PRESCRIPTION AT DISCHARGE, IT IS THE PATIENT'S OR THE FAMILY'S RESPONSIBILITY TO GET THE PRESCRIPTION FILLED. THE INPATIENT FACILITY SHOULD NOT HAVE TO PARTICIPATE IN A "QUALITY MEASURE" THAT IS BASED ON THE BEHAVIOR OF ONE OR MORE PEOPLE THAT ARE BEYOND THE CONTROL OF THE FACILITY.	We thank you for your comment. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF. We recognize that there are factors external to the IPF that may influence rates of medication continuation in the psychiatric population. While it may not be possible to achieve complete post-discharge compliance with pharmacotherapies, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge process, can help to increase medication continuation rates.[1-11] The goal of this measure is to improve medication continuation and reduce the variation in performance across IPFs.
4	08/29/2016	Mary J. Mang, RN, Director Quality & Outcomes Management, Carson Tahoe Health	Provider Organization	Organizational Perspective	The measure is feasible, the scope is way to broad to target a direction for improvement or a goal for improvement.	We thank you for your comment. There are many interventions that have been effective at improving medication adherence. [1-11] IPFs can use the information provided by this measure to identify quality deficits and implement interventions to improve medication continuation rates.
5	08/29/2016	Jeffrey A. Plancich, LMHC, CMHS, Director, Behavioral Health Services, MultiCare Behavioral Health	Provider Organization	Individual Perspective	Feasibility can be measured by data collected through blood panels and care coordination data.	We thank you for your comment. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
6	08/29/2016	Melissa Hodges, RN, Manager Clinical Data Abstraction	Hospital	Individual Perspective	Claims data would be the only feasible way to get this data. it would not be amenable to abstraction.	We thank you for your comment. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.

7	08/29/2016	Gregory A Miller, MD, Chief Medical Officer, Unity Behavioral Health, Legacy Health Systems, Portland, OR	Provider Organization	Individual Perspective	It will be difficult to obtain accurate measures due to the number of people in public psychiatry settings who get their medications through samples and/or discharge medications provided to the patient.	We thank you for your comment. Patients included in this measure have prescription drug coverage under Medicare Part D. If inpatient facilities have programs where outpatient medications are dispensed to patients through a community pharmacy these medications should be billed to the patient's Part D plan, and therefore the hospital would receive credit for the patient filling a medication.
8	08/30/2016	Kimberly Yates, DNP, RN-BC, NEA-BC, Administrator of Psychiatry, Catawba Valley Medical Center	Accrediting Organization	Individual Perspective	If this is claims based looking at patients filling prescriptions, I'm not sure how that will capture all patients. For example, we have many non-insured patients and we provide them with a supply of medication prior to discharge as well as a prescription. Additionally, there are companies that provide sample medications and I realize they create a paper trail but will that be uncovered to obtain the information you are gathering. Lastly, some areas have Cooperative Christian Ministries and such that provide patients with supplies of medication they are prescribed. Also, some patients may already have medication at home, which would mean they don't have to get a refill perhaps within 30 days. I think this particular measure would be hard to collect accurate data on.	We thank you for your comment. The patient population for this measure includes only patients with Medicare Part A, Part B, and Part D coverage. Low income Medicare patients qualify for additional supports to help pay for medication copays. Furthermore, approximately 70% of the patient population for this measure is dually enrolled in Medicaid, which also provides assistance to cover medication costs that aren't covered by Medicare. Therefore, we anticipate that few patients in this population would seek out free samples rather than filling their medications with their insurance. However, we will take these concerns into consideration. The measure development team assessed the day supply of evidence-based medications prescribed prior to the admission to determine if patients would have medications at home that would last through the 30-day follow-up period. For each condition, at least 93% of the prescriptions filled prior to the admission were for a 30-day supply. This indicates that most patients would not have a supply of medication at home that would last through the 30-day follow-up period. It is also important to consider that medications may be adjusted during the inpatient stay and patients may need to fill a new prescription following discharge even if they have medications at home.
11	08/30/2016	Tamara Brazil, RN, Clinical Quality Excellence Consultant, Memorial Health	Provider Organization	Individual Perspective	Follow up in this patient population outside of discharge can be very difficult as some areas have limited resources for those that are mentally impaired.	We thank you for your comment. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
12	08/30/2016	Terry Olson, RN, CPHQ, Manager of Core Measures/Quality Data, Boulder Community Health	Provider Organization	Individual Perspective	It is not clear as to how the hospitals are going to be able to collect the element question on the filling of the perscription. This seems to like it would be a very large burden on the system to collect and validate this question.	We thank you for your comment. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
15	08/30/2016	(Anonymous) RN, MSN, Director of Patient Care Services	Provider Organization	Individual Perspective	The measure has an implication that an inpatient facility now has the additional responsibility of making sure pts get their meds filled. Patients often do not have copays available at the time of discharge and thus leave without getting a script filled. Hospitals cannot take	We thank you for your comment. The patient population for this measure only includes patients with Medicare Part A, Part B, and Part D coverage. Low income Medicare patients qualify for additional

					on the cost of providing copays to ensure meds are in hand at the time of discharge nor do outreach as an unfunded intervention to ensure meds were filled.	supports to help pay for medications. Furthermore, approximately 70% of the patient population for this measure is dually enrolled in Medicaid, which also provides assistance to cover medication costs that aren't covered by Medicare. IPFs will not be expected to cover copays. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
16	08/30/2016	Louis Velazquez, MD, Psychiatrist/Medical Director, Baystate Wing Hospital	Provider Organization	Organizational Perspective	This would be expensive, unfunded, and a deterrent for hospitals to provide inpatient psychiatric care. Also, some psychiatrists would likely find the extension of liability unacceptable.	We thank you for your comment. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
17	08/30/2016	Corinna Haller, RN, Director of Nursing, War Memorial Hospital	Nonprofit Inpatient Psychiatric Unit	Organizational Perspective	Our organization has significant concerns about this measure. There is no way to capture this information. In the past, we have reached out to CMHs and agencies and told this information no longer pertained to us and was a breach of confidentiality, which is true. Not only do we no longer have viable input into the patients care following discharge back to their agency, but we often would lose track of the patient as many of our patients are homeless, etc. and move from place-to-place rapidly. We will be out of compliance with this measure in every case, and I believe other units will as well. This is not a feasible measure for an inpatient setting. It may be an excellent measure to put into place for CMH agencies, however. Our unit would support this being monitored by ACT teams, etc.	We thank you for your comment. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF. We thank you for your support for use of this measure in other applications.
18	08/30/2016	Jennifer Miller, RN, Clinical Quality Manager, War Memorial Hospital	Accrediting Organization	Organizational Perspective	Unable to capture data.	We thank you for your comment. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
19 and 32	08/30/2016 09/01/2016	Maria Ruiza Yee, MD, Medical Director ACT Program, Reading Health System	Provider Organization	Individual Perspective	ID 19: 08/30/2016 As I have outlined, it is unrealistic to expect that prescribing patients the 30 days supply with automatically mean that patients will fill the prescription, especially in the context of very short hospital stay (3-5 days). It is insufficient time to achieve a therapeutic alliance with patients.	We agree that providing prescriptions for evidence-based medications at discharge is only one aspect of IPF care and that it is not sufficient to encourage medication continuation on its own. While it may not be possible to achieve complete post-discharge compliance with pharmacotherapies, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge process, can help to increase medication continuation rates. [1-11] The goal of this measure is to improve medication continuation and reduce the variation in performance across IPFs.

20	08/30/2016	Lisa Youngs, RN, Nurse Manager, Finger Lakes Health	Public/Community Health Agency	Organizational Perspective	the question is who will be collecting this data? How will it be collected? Inpatient psych units are already taxed with collecting PI data. It may be very difficult if one has to collect this data manually!	We thank you for your comment. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
22	08/30/2016	James Evans, MD, Medical Director, Inpatient Psychiatry, Mount Auburn Hospital, Cambridge	Provider Organization	Individual Perspective	However, this is not feasible. While CMS may be able to track prescriptions linked to charges, hospitals have no such means of tracking this. We do not know where a patient fills their prescriptions, as prescriptions are routinely given in hand to a departing patient.	We thank you for your comment. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
23	08/30/2016	Priscilla Adams, APRN, Clinical Nurse Specialist, Bryan Medical Center	Provider Organization	Organizational Perspective	I am concerned about how you will track the dispensing of medications. I wonder if you plan to use billing information. In Nebraska Medicare participates who meet specific income criteria and do NOT have prescription coverage are eligible for free medications through a state funded program (LB95). They would not have an billing information even though medications were dispensed. Our local communities health endowment also has criteria for free medications. We have used these programs heavily to insure our patients have medications but if billing data is who this is abstracted they might be lost. Perhaps this measure is only for medicare patients with prescription coverage.	We thank you for your comment. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF. The patient population for this measure includes only patients with Medicare Part A, Part B, and Part D coverage. We do not anticipate that this patient population would qualify for free medications because low income Medicare patients qualify for additional supports to help pay for medications. Furthermore, approximately 70% of the patient population for this measure is dually enrolled in Medicaid, which also provides assistance to cover medication costs that aren't covered by Medicare.
24	08/30/2016	Bryan E. Flueckiger, MD, Medical Director, Citizens Memorial Hospital	Provider Organization	Individual Perspective	The personnel and resources required for follow up would be far too costly to offset any financial benefit to the government.	We thank you for your comment. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
25	08/30/2016	Thomas S. Pisano, MD, Chief of Professional Services, Connecticut Valley Hospital	Provider Organization	Individual Perspective	I am not sure how this can be tracked in a reasonable way, for example I work in a state inpatient psychiatric facility that serves the entire state.	We thank you for your comment. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
27	08/30/2016	Debra Ann Brodersen, MSN, Director Behavioral Health Services, Spencer Hospital	Provider Organization	Organizational Perspective	I am not sure how the data will be collected. We are an acute care facility that has a psychiatric hospitalist that sees all our patients and does not do outpatients at all so we do no follow-up with patients after discharge other than a follow-up phone call 3 days after discharge to check in on how they are doing. Of course we make all the appointments they need prior to discharge and send the RX electronically in most cases.	We thank you for your comment. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
28	08/31/2016	Michael L. Brown, MD, Medical Director, Geropsychiatry, Private Practice	Physician in Private Practice	Individual Perspective	The measure is feasible. Just track pharmacy records. Nothing could be simpler. Yes or no. Quality or not quality. There it is. The patient doesn't have to actually improve. We just have to arrange for the patient's prescriptions to be picked up. By anyone.	We thank you for your comment. The filling of a prescription is a critical step in improving compliance. We observed ample opportunity for improvement based on a mean medication continuation rate of 79% across 1,694

						IPFs, with variation of 22% between the 10th and 90th percentile. Furthermore, measuring actual compliance would be burdensome for both facilities and patients and therefore is not as feasible to measure.
29	08/31/2016	(Anonymous), RN, Senior Director	Accrediting Organization	Organizational Perspective	There are probably more important measures to look at but this is not helpful	We thank you for your comment. IPFs can use the information provided by this measure to identify quality deficits and implement interventions to improve medication continuation rates.
30	08/31/2016	Donna Moore, RN, Director Quality, Affinity Medical Center	Provider Organization	Organizational Perspective	If the patient is discharged home the prescription is given to the patient or the caregiver with instructions on filling the prescription and instruction how to take, how frequently, and the purpose. How would we ensure that the prescription is filled? If we are aware of barriers to filling the prescription we make attempts to assist the patient prior to discharge. No matter how the information is obtained, the facility is being held accountable to something they do not control. Patients that are discharged to another facility, such as a skilled nursing facility, may discontinue medications due to their regulations. Is the plan to use the Medicare FFS and Part D claims data to obtain this information? Filling a prescription does not necessarily mean the patient will be compliant.	We thank you for your comment and recognize that there are factors external to the IPF that may influence rates of medication continuation in the psychiatric population. While it may not be possible to achieve complete post-discharge compliance with pharmacotherapies, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge process, can help to increase medication continuation rates.[citations from tech report] The goal of this measure is to improve medication continuation and reduce the variation in performance across IPFs. The measure only includes patients discharged to home or home health. Patients discharged to skilled nursing facilities are not included in the denominator for this measure. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF. The filling of a prescription is a critical step in improving compliance. We observed ample opportunity for improvement based on a mean medication continuation rate of 79% across 1,694 IPFs, with variation of 22% between the 10th and 90th percentile. Furthermore, measuring actual compliance would be burdensome for both facilities and patients and therefore is not as feasible to measure.
33	09/01/2016	Robert Munja, MD, Associate Medical Director, Inpatient Psychiatric Care, Providence	Provider Organization	Individual Perspective	The guideline does not address (that I could see) how it will handle newly released medications and what the mechanism is for allowing them to be included on the list of evidence based medicines.	We thank you for your comment. Medications that define the numerator for this measure will be evaluated each year and updated to reflect evidence-based guidelines and current clinical practice during the measurement period. Retired medications will remain in the measure specifications for up to three years past the retirement date.
34	09/02/2016	Kassie Ryan, RN MSN, Quality Improvement Specialist, Alina Health	Provider Organization	Organizational Perspective	The feasibility seems to be possible with this appearing to be a claims based measure with access to Medicare information rather than manual abstraction.	We thank you for your comment.

					However, if the measure does not include refills from the hospital pharmacy before discharge it would not be a good representation of performance.	The measure captures all prescriptions billed under Part B or Part D for evidence-based medications during the follow-up period, regardless of where those prescriptions are filled. The follow-up period starts on the day of discharge and extends 30 days post-discharge. However, we will consider counting medications that are filled during the admission prior to the day of discharge toward the numerator to allow for innovative programs ensuring that the patient has the medication at discharge.
35	09/02/2016	Joy Beeter, LRDN, Performance Improvement Coordinator, Sanford Health Fargo, ND	Provider Organization	Organizational Perspective	The proposed measure is not feasible because we can't measure if a patient fills a medication script outside of our pharmacy. There are so many possible places for the patient to fill the prescription there is no way we could measure this even if we worked with these outside entities. Currently the EMR does not have this type of capability, it would need to be a pharmacy national board to report that. We can only abstract what happens when the patient is within our care - after discharge we can not be expected to abstract any information, including scripts filled.	We thank you for your comment. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
36	09/07/2016	(Anonymous)	(Not indicated)	Individual Perspective	As it is a claims-based measure, I see no issue with the feasibility of the measure.	We thank you for your comment.
37	09/09/2016	Jeri Meier, RN, Director of Behavioral Health, Eastar Health Systems	Provider Organization	Organizational Perspective	We admit patients from all over the state of Oklahoma and board states as well. Our Patients are discharged with a 3-14 day supply of medication and prescriptions. Attempting to track if these prescriptions were actually filled would be almost an impossible task and one that should not be placed onto the inpatient provider or hospital.	We thank you for your comment. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
38	09/09/2016	Tammy Pietrzak,RN-BC, Regional Clinical Director, CHS	Provider Organization	Individual Perspective	What is the impact on the facility going to be? How can facility's be held accountable for a pateint not filling their prescription? A lot of these patients have medical co-morbids and they have to make hard choices. We work diligently to link patients to other resources where they can get medications at reduced rates or free from drug companies butt that can take time.	We thank you for your comment and recognize that there are factors external to the IPF that may influence rates of medication continuation in the psychiatric population. While it may not be possible to achieve complete post-discharge compliance with pharmacotherapies, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge process, can help to increase medication continuation rates.[1-11] The goal of this measure is to improve medication continuation and reduce the variation in performance across IPFs. The patient population for this measure includes only patients with Medicare Part A, Part B, and Part D coverage. We do not anticipate that the patients included in this measure experience the same barriers of access to medications that some other patients may encounter because low income Medicare patients qualify for additional supports to help pay for medications. Furthermore, approximately 70% of the patient population for this measure is dually enrolled in

						Medicaid, which also provides assistance to cover medication costs that aren't covered by Medicare.
39	09/09/2016	Jennifer Nickel, MSN, RN, CCRN, CRRN, CCMSCP, Corporate Rehab Educator	Community Health Systems (CHS)	Organizational Perspective	Community Health Systems (CHS) appreciates the opportunity to comment on the quality reporting measures specific to inpatient rehab quality as well as skilled nursing. CHS is concerned that the soon-to-be-implemented and proposed quality measures related to the IMPACT Act are not ready for use. We believe that the Secretary should suspend, or CMS defer, implementation of all quality measures specified for use to meet IMPACT Act requirements until the Agency has solved the significant flaws. The very short timeframe from the first CMS conference in May 2016 in Dallas for IRF and June 2016 for SNF to the implementation date of October 1, 2016 for both the IRF and SNF QRPs is extremely short when considering the substantial amount of training that is required for staff in order to correctly and accurately report on the new measures. These new measures require not only extensive training but also additional manpower and delegation of duties, which takes some time to get staff acclimatized to. At CHS, the first priority is quality care for all patients; these new measures hinder the first and some of the most important hours of care by requiring staff to deviate towards assessments that do not necessarily impact the care during their stay. We respectfully request deferment at a minimum, and ultimately suspension of these measures.	This comment is out of scope for this project.
42	09/12/2016	Katy Brown, PharmD, Regional Clinical Director, CHS	Medicare Quality Improvement Organization (QIO)	Individual Perspective	Feasible - claims based measure	We thank you for your comment.
43	09/12/2016	Christine Scully, MPH, FACHE, Regional Director, Hospital of Central CT	Provider Organization	Organizational Perspective	Filling the prescription is not a measure of medication compliance. Not filling the medication does not necessarily mean poor discharge planning, rather is is more indicative of the patient's willingness to cooperate/engage in treatment.	We thank you for your comments on the measure. The filling of a prescription is a critical step in improving compliance. We observed ample opportunity for improvement based on a mean medication continuation rate of 79% across 1,694 IPFs, with variation of 22% between the 10th and 90th percentile. Furthermore, measuring actual compliance would be burdensome for both facilities and patients and therefore is not as feasible to measure. We recognize that there are factors external to the IPF that may influence rates of medication continuation in the psychiatric population. While it may not be possible to achieve complete post-discharge compliance with pharmacotherapies, there is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge process, can help to increase medication continuation rates.[1-11] The goal of this measure is to improve medication

						continuation and reduce the variation in performance across IPFs.
44	09/12/2016	Michael Gallagher, BSN, BC-NE, Director of behavioral Health Services, Southern New Hampshire Medical Center	Public/Community Health Agency	Individual Perspective	I believe it would be difficult to do because of reasons already stated	We thank you for your comment. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
45	09/12/2016	Rachel Wyatt, Senior Business Analyst, Utah State Hospital	Provider Organization	Organizational Perspective	If this were a chart-extracted measure, Utah State Hospital would be strongly opposed due to the structure of our state mental health care system. We are unable to contact clients after their discharge. However, because it is a claims-based measure as proposed, Utah State Hospital feels it will be feasible because CMS will collect the data.	We thank you for your comment.
46	09/13/2016	(Anonymous)	(Not indicated)	Individual Perspective	The feasibility of collecting this data is concerning. Who will be charged with monitoring patient adherence and subsequently submitting the data for analysis? If this will be expected of the IPF who discharged the patient, there would be an undo burden placed on the facility staff whose priority focus needs to be on the current population requiring the acute level of care provided by the IPF. Assuming this data will be collected by the insurer who will be monitoring claims data, how will that data inform policy and practice guidelines for IPFs and/or outpatient providers to drive improvements in adherence rates?	We thank you for your comment. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF. There are many interventions that have been effective at improving medication adherence.[1-11] IPFs can use the information provided by this measure to identify quality deficits and implement interventions to improve medication continuation rates.
47	09/13/2016	Jayne Hart Chambers, MBA, Senior Vice President Quality, Federation of American Hospitals	Hospital Association	Organizational Perspective	While the fill-rate measure is feasible, the measure relies on data derived from claims data, which severely limits the timeliness of the data. It is unclear whether data that is at least two years old will or can aid in quality improvement efforts and be useful for public reporting. In addition, the measure does not sufficiently account for the various ways in which a patient will receive their prescriptions. For example, state hospitals provide a two-week supply to patients at discharge and then the outpatient provider prescribes any follow-up medications. As currently specified, state facilities would then fail the measure due to the inability of the measure to account for this difference in prescribing, and the measure would not reflect the true quality of care provided by these state hospitals. While the measure is well specified, and the FAH appreciates that the measure excludes those patients for whom these medications	We thank you for your comment. Claims data are used for the calculation of this measure because the burden of data collection on facilities would be too great to implement as a chart-abstracted measure. A two-year measurement period was selected because it was the shortest timeframe that provided enough cases for reliable calculation of measure scores. Use of two years of data is aligned with the approach for the IPF Readmission measure in the IPFQR program. The measure evaluates medication continuation during a 30-day follow-up period. If facilities provide a two week supply of medications at discharge, the patient would need to fill a medication during the follow-up period to avoid gaps in treatment. A claim for a medication will count toward the numerator regardless of the prescribing entity (e.g., outpatient provider). This measure was tested in ICD-9 data because ICD-10 data were not yet available. ICD-10 specifications

					are not appropriate, the measure is specified in ICD-9 coding and not ICD-10 codes. Measures should be specified for the most current coding system (ICD-10), and currently this measure does not meet that standard.	will be included in all future technical documentation for this measure.
49	09/14/2016	Christine Picklo, MT, MBA, Manager, Data Abstraction & Measurement, Data Quality Measurement, Yale New Haven Health	Provider Organization	Organizational Perspective	- Homeless patients will present a challenge. They may not have established contact information to allow the follow-up phone call or other intervention - This measure uses ICD-9 codes and there are material differences between ICD-9 and ICD-10. This should be updated with ICD-10 codes because the cross walk between them is not as clean as one might think	We thank you for your comment. We recognize that some interventions to improve medication continuation may not be feasible for some patients. However, there are interventions that can be implemented during the IPF stay that have been shown to be effective in increasing medication continuation rates. [1-11] This measure was tested in ICD-9 data because ICD-10 data were not yet available. ICD-10 specifications will be included in all future technical documentation for this measure.
50	09/14/2016	Sandra Sheikh, MSN, RN, CPHQ, Coordinator, Quality Analytics & EBC, Covenant Health	Provider Organization	Organizational Perspective	This measure will be extremely challenging to implement and has the potential to be very resource intensive. Given our patient demographic, a lot of the time it is challenging (at best) to even contact patients after discharge, let alone ensure they are filling their prescription.	We thank you for your comment. We recognize that some interventions to improve medication continuation may not be feasible for some patients. However, there are interventions that can be implemented during the IPF stay that have been shown to be effective in increasing medication continuation rates.[1-11]
54	09/15/2016	Kathleen McCann, RN, PhD, Director of Quality and Regulatory Affairs, National Association of Psychiatric Health Systems	Provider Organization	Organizational Perspective	Since the measure is a claims-based one, it will not present a feasibility issue for provider organizations.	We thank you for your comment.

Table B.4. Verbatim Comments: General

Entry ID.	Date Posted	Name, Credentials, Title, and Organization of Commenter	Type of Organization	Perspective	Text of Comments*	Recommendations/ Actions Taken/ CMS Response
1	08/23/2016	Thomas Z Cady, Individual	Individual	Individual Perspective	Overall impression is a great step in attempt not to have "profit-driven and drugged induce walking zombies/patients" to continue using the 'revolving door' the elderly to be more confused by incomplete intentions by Medicare and/or Medicaid purpose to heal.. From what I hear, within our tri-countries Metropolitan-base area: even those with the appearance of good-intention by physicians; find the best coders to insure payment and cheap front desk reception. Use to we got the code numbers automatically at check out.	We thank you for your comment.
3	08/29/2016	Barry Ginsberg, MD, Medical Director, Inpatient Behavioral Health, Lahey Health Behavioral Services	Provider Organization	Individual Perspective	While filling prescriptions after discharge is important, the ability of an inpatient unit to affect this behavior is limited. The measure is a better indication of the level of more systematic mental health care (i.e. including post-discharge case management, community-based support, pharmacy cost/accessibility) than an indication of the quality of the inpatient service from which the patient was discharged	We thank you for your comments on the measure and recognize that there are factors external to the IPF that influence filling prescriptions post-discharge in the psychiatric population. However, the literature supports the connection between IPF interventions and medication continuation,[1-11] which confirms that IPFs are a crucial part of the transition process.
4	08/29/2016	Mary J. Mang, RN, Director Quality & Outcomes Management, Carson Tahoe Health	Provider Organization	Organizational Perspective	Assuming this would be measured by manual abstraction at the time of patient discharge and then by pharmacy claims for 30 days post discharge, this would be another measure that organizations could not obtain real-time data for targeted, up-to-date improvement. Claims data is grossly historical and does not identify newest problems in care; by the time an organization acts on out-dated claims data, there is a new problem that remains unidentified until the problem is a historical claims point. Quality improvement is forced to act on old data, not the latest data. If claims data is going to continue to be the quality iniative driver, CMS needs to provide more real-time claims data to add value to organizational PI.	We thank you for your comments on the measure. This measure would be calculated by CMS entirely from Medicare FFS and Part D claims data and would not require additional data collection by the IPF. Use of other data sources, such as chart-abstraction, to evaluate medication continuation or compliance would significantly increase the reporting burden for IPFs and therefore is not as feasible to measure. The measure will be calculated on the two most recent years for which Medicare claims data are available.
5	08/29/2016	Jeffrey A. Plancich, LMHC, CMHS, Director, Behavioral Health Services, MultiCare Behavioral Health	Provider Organization	Individual Perspective	This has long been the missing piece to inpatient to outpatient connection. Creation of a formal tracking system can provide valuable data and potentially lead to research and meaningful outcome measures.	We thank you for your comments and support on the measure.

8	08/30/2016	Kimberly Yates, DNP, RN-BC, NEA-BC, Administrator of Psychiatry, Catawba Valley Medical Center	Accrediting Organization	Individual Perspective	The planning of collecting data for this measure should be carefully thought out. There will be patient populations missed because of how they get their medications. Some patients may have medications at home and not need a refill for over a 30-day period of time. There are many homeless patients that inpatient units see and these patients have a tendency to travel outside of the area. Thank you!	We thank you for your comments on the measure. The measure development team assessed the day supply of evidence-based medications prescribed prior to the admission to determine if patients might have medications at home that would last through the 30-day follow-up period. For each condition, at least 93% of the prescriptions filled prior to the admission were for a 30-day supply. This indicates that most patients would not have a supply of medication at home that would last through the 30-day follow-up period. It is also important to consider that medications may be adjusted during the inpatient stay and patients may need to fill a new prescription following discharge even if they have medications at home. Measure scores should not be impacted by transient patients because the IPF will get credit for a claim for an evidence-based medication during the 30-day follow-up period regardless of where the medication is filled.
9	08/30/2016	(Anon.) RN, Quality Analyst, Westlake Hospital	(Not indicated)	Individual Perspective	Will this be a chart abstracted measure? If so, how will the IPF get this information (yes med was filled, or no it was not filled within 30 days). If/ when the meds are filled at a pharmacy, will that pharmacy have to send info back to the IPF? Thank you.	We thank you for your comments on the measure. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF and pharmacies will not be required to send information back to the IPF.
10	08/30/2016	Wanda Johnson, RN, Director Special Projects, OFMQ	Healthcare Consultants	Individual Perspective	I'm not convinced this measure should be labeled a process measure. Wouldn't this be considered an outcome measure because it's calculated using claims? Labeling it a process measure suggests that the discharging facility has an impact on the outcome based on the quality of discharge planning, so a process measure would focus on that process prior to discharge. This measure evaluates the OUTCOME of the transition/discharge planning. From the MJF: IPFs can implement a variety of processes to improve medication continuation during the transition from inpatient to outpatient care. Examples that have been shown to increase medication compliance and prevent negative outcomes associated with nonadherence include patient education, enhanced therapeutic relationships, shared decision-making, and text-message reminders, with emphasis on multidimensional approaches (Douaihy, Kelly, & Sullivan, 2013; Haddad, Brain, & Scott, 2014; Hung, 2014; Kasckow & Zisook, 2008; Lanouette, Folsom, Sciolla, & Jeste, 2009; Mitchell, 2007; Sylvia et al., 2013a).	We thank you for your comments on the measure. We will take this recommendation into consideration.
12.	08/30/2016	Terry Olson, RN, CPHQ, Manager of	Provider Organization	Individual Perspective	The measure is important but I do not see how we are going to be able to collect the filling of the perscriptions. For this to be	We thank you for your comments on the measure. This measure would be calculated by CMS from

		Core Measures/Quality Data, Boulder Community Health			valid, we would need a response from a pharmacy indicating it was filled. Relying on patient feed back would leave questions on the validity of the data. Asking organizations to find which pharmacy this may have been filled in is not feasable, will be costly to the organization and probably not possible.	Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
14	08/30/2016	Michael Schwartz, MD, Chairman, Department of Psychiatry, Northwell Huntington Hospital	Provider Organization	Individual Perspective	See my comments in number 9. Is the point of this to determine whether it is a valid measure of quality of inpatient care - or has it already been decided that this is a valid measure of quality? If it is the latter -.the value in filling (and taking) prescripitions that were helpful to the patient when hospitalized seems rather obvious - why bother with the measure. Just mandate that patients be given a 1 or 2 week supply of medications upon discharge and then monitor whether that was being done.	We thank you for your comments on the measure. Facility-level performance comparisons to related quality measures found statistically significant correlations, which indicates that medication continuation is a valid indicator of IPF quality. The technical expert panel also unanimously voted in agreement on the validity of the measure concept. We observed ample opportunity for improvement based on a mean medication continuation rate of 79% across 1,694 IPFs, with variation of 22% between the 10th and 90th percentile. The goal of this measure is to provide information that informs quality improvement around care coordination and care transitions. Providing medications at discharge is one of many interventions that may be effective. However, it is not required for a high quality discharge process.
15	08/30/2016	(Anonymous) RN,MSN, Director of Patient Care Services	Provider Organization	Individual Perspective	The measure does not add quality to care as it now exists	We thank you for your comments on the measure. The goal of the measure is to provide information to IPFs to help identify quality deficits and implement interventions to improve medication continuation as needed
16	08/30/2016	Louis Velazquez, MD, Psychiatrist/Medical Director, Baystate Wing Hospital	Provider Organization	Organizational Perspective	I do not support this measure. It is intrusive. This should only be a task of DMH case managers tracking the chronically mentally ill.	We thank you for your comments on the measure. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
17	08/30/2016	Corinna Haller, RN, Director of Nursing, War Memorial Hospital	Nonprofit Inpatient Psychiatric Unit	Organizational Perspective	Our unit, as well as our quality management team, and our CMS designee, respectfully ask that this measure be discontinued for consideration.	We thank you for your comments on the measure.
18	08/30/2016	Jennifer Miller, RN, Clinical Quality Manager, War Memorial Hospital	Accrediting Organization	Organizational Perspective	Our organization does not have the ability to capture this data.	We thank you for your comments on the measure. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
19. and 32.	08/30/2016 09/01/2016	Maria Ruiza Yee, MD, Medical Director ACT Program, Reading Health System	Provider Organization	Individual Perspective	ID 19: 08/30/2016 The intention is noble and admirable. The operationalization of the core measure is more problematic.	ID 19: 08/30/2016 We thank you for your comments on the measure. We thank you for your comments on the measure. This measure would be calculated by CMS from

						Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
21.	08/30/2016	Carol Olson, MD, Chair, Psychiatry Department	(Not indicated)	Individual Perspective	I work in a large facility in which almost all patients are undergoing court ordered psychiatric evaluation or treatment. Many such patients are discharged when the court decides not to order treatment (and the patient is unwilling to have treatment, which is why they were admitted for court ordered evaluation in the first place). Even when the patient does receive a court order for treatment, they often have very little insight into their mental health condition, even at time of discharge, and thus the percentage of our patients who do not fill a prescription after discharge would be significantly higher than the percentage of patients who fail to fill their discharge prescriptions after a period of voluntary inpatient treatment. In addition, when we transfer our patients for medical treatment at our acute care ED or med/surg units, it is considered a discharge, even though the patient is readmitted to the Psychiatry department once medically cleared. To the extent that the patient then stays longer than 30 days, I am concerned they would "fall out" on this measure because they would not be outpatients in the 30 days after their initial "discharge".	We thank you for your comments on the measure. This measure only includes patients who are discharged to home or home health care. Patients who are discharged against medical advice or to another setting, such as an acute care unit or law enforcement, are not included and therefore should not impact measure scores. However, we will take this issue into consideration.
22	08/30/2016	James Evans, MD, Medical Director, Inpatient Psychiatry, Mount Auburn Hospital, Cambridge	Provider Organization	Individual Perspective	I am concerned about the increasing number of quality initiatives which place responsibility of the inpatient unit for outpatient behavior. Are you seriously proposing that the quality of inpatient care is directly linked to behaviors 30 days later? The irony here is the increased scrutiny regarding handoffs to the outpatient team soon after discharge...but then the inpatient unit is still responsible for patient outcome AFTER the outpatient team takes over?	We thank you for your comments on the measure and recognize that there are factors external to the IPF that influence filling prescriptions post-discharge in the psychiatric population. However, the literature supports the connection between IPF interventions and medication continuation,[1-11] which confirms that IPFs are a crucial part of the transition process.
24	08/30/2016	Bryan E. Flueckiger, MD, Medical Director, Citizens Memorial Hospital	Provider Organization	Individual Perspective	I recommend that it be scrapped.	We thank you for your comments on the measure.
27	08/30/2016	Debra Ann Brodersen, MSN, Director Behavioral Health Services, Spencer Hospital	Provider Organization	Organizational Perspective	Another concern is we are a rural state with limited beds. We frequently see patients from across the state (up to 300-400 miles away) in every direction. The patient may be here for one inpatient visit and we will never see them again. This is not an ideal situation for the patients but it is what is happening in rural America. In the reading I did it was not clear to me how the data will be abstracted.	We thank you for your comments on the measure. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
28	08/31/2016	Michael L. Brown, MD, Medical Director, Geropsychiatry, Private Practice	Physician in Private Practice	Individual Perspective	I have nothing more to add.	We thank you for your comments on the measure.

30	08/31/2016	Donna Moore, RN, Director Quality, Affinity Medical Center	Provider Organization	Organizational Perspective	Patients are provided information concerning the importance of medication compliance. Patients on a limited income will decide what they will or will not spend their dollars on. Facilities would be held accountable for something beyond their control.	We thank you for your comments on the measure. We do not believe this patient population experiences barriers to medication continuation related to cost because they have Medicare Part A, Part B, and Part D coverage. Low income Medicare patients qualify for additional support to help pay for medication copays. Furthermore, approximately 70% of the patient population for this measure is dually enrolled in Medicaid, which also provides assistance to cover medication costs that aren't covered by Medicare.
34	09/02/2016	Kassie Ryan, RN MSN, Quality Improvement Specialist, Alina Health	Provider Organization	Organizational Perspective	Thank you for the opportunity to respond!	We thank you for your comments on the measure.
35	09/02/2016	Joy Beeter, LRDN, Performance Improvement Coordinator, Sanford Health Fargo, ND	Provider Organization	Organizational Perspective	This measure seems unreasonable with the current capabilities of the EMRs available.	We thank you for your comments on the measure. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF.
36	09/07/2016	(Anonymous)	(Not indicated)	Individual Perspective	I feel little need to add additional process measures to the IPFQR program, but at least this one actually has to do with psychiatric care. I would happily include this measure as a replacement for any of the measures not tested for use in IPFs.	We thank you for your comments and support on the measure.
37	09/09/2016	Jeri Meier, RN, Director of Behavioral Health, Eastar Health Systems	Provider Organization	Organizational Perspective	This measure will be almost impossible to track and will require additional employees to manage. At a time when provider rates are being cut, I do not believe it is reasonable to create measures that will cost the facility. Although the information may be interesting it will not change or reduce the number of admissions to inpatient behavioral health units.	We thank you for your comments on the measure. This measure would be calculated by CMS from Medicare FFS and Part D claims data and would not require additional data collection by the IPF. Continuation of medication in the patient population is critical for management of symptoms and better outcomes. For patients with MDD, schizophrenia, and bipolar disorder, medication non-adherence may lead to relapse and readmission. IPFs can use the information provided by this measure to identify quality deficits and implement interventions to improve medication continuation.
40	09/11/2016	Hema Iyer, MD, Vice-Chair, Department of Psychiatry, Reading Health System	Provider Organization	Individual Perspective	1. A clinical decision is made at times to dispense less than 30 days of medications at a time-for e.g., if they are scheduled to see their outpatient psychiatrist within the 30 day period especially if there are significant safety concerns around access to large amount of medications. An individual with repeated overdoses would be an example. 2. It is not always practical to ensure that every medication prescribed is covered by the individual's insurance. This is especially challenging when insurance declines to pay for	We thank you for your comments on the measure. The measure evaluates whether at least one evidence-based medication was filled within 30 days of discharge from an IPF for a diagnosis of MDD, schizophrenia, or bipolar disorder. The measure does not require that the medications filled are for a 30-day supply. This measure only includes patients with Medicare Part A, Part B, and Part D coverage.

					relatively older medications such as Prozac, Risperdal or Zyprexa. I do my best to ensure coverage esp on medications that often require PA before the patient leaves the hospital but I am always caught off guard by the 'commonly ' prescribed medications. 3. Psychiatrist writing a 30 day script does not automatically ensure that the patient will fill the script or take the medications as prescribed. Poor medication adherence remains a challenge.	We agree that providing prescriptions for evidence-based medications at discharge is only one aspect of IPF care and that it is not sufficient to encourage medication continuation on its own. That is why the measure evaluates whether the medication was filled rather than simply whether or not there is documentation in the medical record that a medication was prescribed at discharge. We believe this captures a wider array of interventions that facilities might employ to improve medication continuation during the transition to home or home health.
44	09/12/2016	Michael Gallagher, BSN, BC-NE, Director of Behavioral Health Services, Southern New Hampshire Medical Center	Public/Community Health Agency	Individual Perspective	I believe it would be valuable data	We thank you for your comments and support of the measure.
45	09/12/2016	Rachel Wyatt, Senior Business Analyst Utah State Hospital	Provider Organization	Organizational Perspective	At the Utah State Hospital, as with other state-run psychiatric facilities, we have a forensic population, approximately 30% of whom are discharged to a jail or prison. Some of these patients will have had active Medicare while patients at our facility. We want to ensure that they will be excluded from the data set if they are considered incarcerated and no longer Medicare eligible following discharge.	We thank you for your comments on the measure. This measure only includes patients who are discharged to home or home health care. Patients who are discharged to another setting, such as law enforcement, are not included and therefore should not impact measure scores.
46	09/13/2016	(Anonymous)	(Not indicated)	Individual Perspective	What are the actionable items expected to be addressed with the receipt and analysis of this data? How will evidenced-based, outcomes driven treatment approaches be identified, reviewed and disseminated to raise the rates of adherence and guide practice algorithms for this population?	We thank you for your comments on the measure. IPFs can use the information provided by this measure to identify quality deficits and implement interventions to improve medication continuation. The evidence-based medications that define the numerator for the measure will be evaluated annually based on new evidence and accepted clinical practice to ensure it is comprehensive and appropriate. If implemented, the measure specifications will be updated as needed and communicated to facilities through the IPFQR program.
47	09/13/2016	Jayne Hart Chambers, MBA, Senior Vice President Quality,	Hospital Association	Organizational Perspective	It is the FAH's understanding that while the Technical Expert Panel (TEP) was asked to provide input on this measure, their input was sought late in the development process. The FAH encourages CMS to involve the TEP earlier when defining the	We thank you for your comments on the measure. We disagree with the assertion that the TEP was involved late in the development of this measure. The TEP helped to inform the measure concept prior

		Federation of American Hospitals			measure intent and initial specifications. The FAH believes that many of the questions and concerns we raised in these comments could have been addressed through TEP member input earlier in the process, and the time and resources spent on testing could have been invested on a measure that truly addresses the important aspect of care medication adherence.	to the start of measure development. Once the measure concept was selected for further development, a subgroup of 6 volunteers from the TEP participated in workgroup meetings to inform the measure specifications. The larger TEP was convened to review the draft measure specifications in May 2016 prior to field testing. All TEP suggestions were evaluated and incorporated into the measure specifications, with the exception of the exclusion of patients who receive an LAI, which was not excluded due to concerns about the validity of the LAI claims data. The TEP was convened again in July to review additional testing results and vote on the measure's validity. All 10 TEP members who were present for the vote agreed with the validity of the measure as specified.
48	09/13/2016	Kristine A Hoffman, RN, CPHQ, Quality Data Analyst, Northern Arizona Healthcare	Provider Organization	Organizational Perspective	Our behavioral health clinical team feels that this could be potentially a useful quality indicator of our discharge process as we look at improving the transition of our patients into the outpatient setting. We recognize that medication compliance among persons with MDD, schizophrenia and bipolar disorders is critical to improving the quality of life for this population. We also recognize that medication non-compliance in this group has historically been an issue, and we feel this would be a useful measure to generate improvement in this area. We also appreciate that this measure would be starting with a narrow population of Medicare recipients. We understand that this measure would be calculated from Medicare FFS and Part D claims data and we would like to provide some comments related to this. There may be some scenarios where a Medicare claim may not be generated within the 30 day timeframe. For example: • The hospital has a pharmacy where the patient can get home prescriptions filled prior to discharge. Would these claims be included? • Some patients may already be on an evidence-based medication for one of the target conditions and have almost a full supply at home. They might then have a dosage reduction while inpatient, and would then have enough medication at home to last for > 30 days. These patients may not generate a claim within the 30 day timeframe.	We thank you for your comments and support of the measure. The measure captures all prescriptions billed under Part B or Part D for evidence-based medications during the follow-up period, regardless of where those prescriptions are filled. The follow-up period starts on the day of discharge and extends 30 days post-discharge. However, we will consider counting medications that are filled during the admission prior to the day of discharge toward the numerator to ensure medications filled at the hospital pharmacy are captured in the numerator. The measure development team assessed the day supply of evidence-based medications prescribed prior to the admission to determine if patients might have medications at home that would last through the 30-day follow-up period. For each condition, at least 93% of the prescriptions filled prior to the admission were for a 30-day supply. This indicates that most patients would not have a supply of medication at home that would last through the 30-day follow-up period. It is also important to consider that medications may be adjusted during the

					• A claim may not be generated if a patient is on an injectable medication and a dose if administered on the day of discharge, and the next dose is not scheduled for > 30 days following discharge. We appreciate your willingness to solicit comments from healthcare professionals and stakeholder organizations, and we hope you will review them carefully as you move toward adopting this measure. Respectfully, The Behavioral Health Clinical Team, Northern Arizona Healthcare	inpatient stay and patients may need to fill a new prescription following discharge even if they have medications at home. If the LAI is billed to Medicare Part A or Part B, the LAI administered on the day of discharge would count toward the numerator. If the LAI is administered during the admission prior to the date of discharge, the patient would need to fill an evidence-based medication within 30-days of discharge since LAIs are generally for 28 days or less..
49	09/14/2016	Christine Picklo, MT, MBA, Manager, Data Abstraction & Measurement, Data Quality Measurement, Yale New Haven Health	Provider Organization	Organizational Perspective	- Can foresee there could be an issue with patients who are given discharge prescriptions for medications/doses they were on before admission. In those cases, they may not need to fill the new RX immediately since they still have the home supply especially those non-adherent prior to admission. - Measure clarification needed: If a patient is discharged on multiple agents such as valproic acid and olanzapine for bipolar disorder, do they have to fill RXs for both agents to pass the measure?	We thank you for your comments on the measure. The measure development team assessed the day supply of evidence-based medications prescribed prior to the admission to determine if patients might have medications at home that would last through the 30-day follow-up period. For each condition, at least 93% of the prescriptions filled prior to the admission were for a 30-day supply. This indicates that most patients would not have a supply of medication at home that would last through the 30-day follow-up period. The measure evaluates whether there was at least one claim for an evidence-based medication during the follow-up period. The measure does not evaluate whether the medications that were filled matched the medications that were prescribed at discharge it cannot be captured in administrative data. Adding a data source (e.g., medical record) would add substantial burden to reporting facilities.
51	09/14/2016	Samantha Shugarman, MS, Deputy Director of Quality, The American Psychiatric Association	Medical Specialty Society	Organizational Perspective	The American Psychiatric Association appreciates the opportunity to comment on such an important measure. Continuity of care, including medication monitoring is area of care that is imperative to maintain quality treatment. The APA strongly supports this measure, however we do have concerns with the exclusion analysis. The denominator exclusions include patients who receive ECT or TMS post discharge, are pregnant or received free medication at the time of discharge. Another potential exclusion which should be considered are those patients who had a prescription filled for one of the indicated medications before admission (may not have been taking the medication as prescribed, may have just started the medication before admission etc.) While this is unlikely to be a large or even significant number, we think it should be included in the exclusion analysis.	We thank you for your comments and support of the measure For each condition (MDD, schizophrenia, or bipolar disease), over 93% of the prescriptions filled prior to the admission were for a 30-day supply. This indicates that most patients would not have a supply of medication at home that would last throughout the 30-day follow-up period. As stated, we believe this would be a rare case but we will consider adding the additional component as suggested to the exclusion analysis.

					Additionally, we noted that the specifier language about "for patients who received medications during their inpatient stay" seems to assume that all hospitalized patients receive medications if they are sick enough to be hospitalized. This is not the case. The denominator should exclude patients who refused/declined medications. Thank you for the careful consideration of our comments, as we think they will provide an opportunity to measure this important area of care.	We agree it is possible that patients may refuse treatment. However, in a medical record review across seven text sites, we identified very few cases (<1%) where this was observed and do not anticipate that patient refusal will have a significant impact to facility scores. Furthermore, introducing a patient refusal exclusion would necessitate an additional data source for the measure because patient refusal could not be captured in administrative data. Adding a data source (e.g., medical record) would add substantial burden to reporting facilities.
52	09/15/2016	Linda Rosenberg, MSW, President & CEO, National Council for Behavioral Health	National association	Organizational Perspective	The National Council for Behavioral Health (National Council) welcomes the opportunity to provide comments on the Centers for Medicare and Medicaid's (CMS) proposed measure, "Continuation of Medications within 30 Days of Inpatient Psychiatric Discharge." The National Council is a non-profit association representing 2,800 community-based mental health and addiction treatment providers. Along with our member organizations, we are dedicated to fostering clinical and operational innovation and promoting policies that ensure that all Americans have access to high quality health care services. The Continuation of Medications within 30 Days of Inpatient Psychiatric Discharge measure is defined as "the percentage of psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder who were dispensed a prescription for evidence-based medication within 30 days of discharge during the measurement period (24 consecutive months)." The National Council strongly supports the use of a process measure to monitor whether IPF patients with a primary diagnosis of MDD, schizophrenia or bipolar disorder receive a prescription for evidence-based medications between settings of care, which can reduce the risk of relapse and re-hospitalization. This measure reinforces the critical importance of medication management in establishing effective transitions of care, as reflected by its listing as the first item on the National Transitions of Care Coalition's seven essential intervention categories for effective care transitions. The National Council recommends that CMS strengthen the proposed measure by disaggregating according to treatment type, specifically in regard to clozapine and long-acting injectable antipsychotic medications. The Draft Measure Justification Form notes that at the time clinical guidelines were developed, "clozapine was considered a superior treatment compared to typical antipsychotics in six of eight published double-blind randomized trials." It also notes that a meta-analysis of five of these studies showed that "clozapine-treated patients were 2.5 times more likely to improve compared to those treated with a	We thank you for your comments and support of the measure. The measure includes a wide range of evidence-based medications for each condition to allow flexibility in prescribing based on the severity of the patient's condition and the patient's preferences. Disaggregating the measure scores based on the type of medication filled may not provide meaningful or interpretable results because lower scores may not indicate lower quality.

					typical antipsychotic." There is also favorable clinical evidence to support higher long-acting injectable (LAI) anti-psychotic prescription rates, in regard to both efficacy and adherence. LAIs increase medication adherence and significantly reduce emergency department use and re-hospitalization among patients with schizophrenia and bipolar disorder. Despite the strong evidence base to support use of LAIs to increase adherence and reduce relapse, however, LAIs are not widely used in routine practice. The National Council there recommends the following modifications to the draft measure numerators: Discharges with a principal diagnosis of schizophrenia in the denominator population for which patients were dispensed evidence-based medication within 30 days of discharge, disaggregated by treatment (typical antipsychotic; clozapine; other atypical antipsychotic, LAI typical antipsychotic; LAI atypical antipsychotic). Discharges with a principal diagnosis of bipolar disorder in the denominator population for which patients were dispensed evidence-based medication within 30 days of discharge, disaggregated by treatment (typical antipsychotic; clozapine; other atypical antipsychotic, LAI typical antipsychotic; LAI atypical antipsychotic). Thank you for your consideration of this important issue. Please do not hesitate to contact Chuck Ingoglia, Senior Vice President of Policy and Practice Improvement, at ChuckI@TheNationalCouncil.org if you or your colleagues have any questions.	