

FOLLOW-UP AFTER PSYCHIATRIC HOSPITALIZATION MEASURE

Project title

Inpatient Psychiatric Facility Outcome and Process Measure Development and Maintenance

Dates

The call for public comment began Friday, January 25, 2019, and closed on Wednesday, February 13, 2019.

The draft summary of the public comments was submitted to the Centers for Medicare & Medicaid Services on April 12, 2019.

Project overview

The Centers for Medicare & Medicaid Services (CMS) 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).¹ As part of its measure development process, HSAG asked interested parties to submit comments on the candidate measures or measure concepts that could be suitable for this project.

Project objectives

CMS contracted with HSAG to develop, specify, and maintain process and structural clinical quality measures for the IPFQR. The project's primary objectives are to develop new measures that drive quality improvement, are patient-centered, are aligned with other programs, and that fill could critical gaps in the CMS IPFQR Program in the future; maintain and reevaluate existing IPF measures; and support measure implementation in the IPFQR Program.

As part of its measure development process, HSAG asked interested parties to submit comments on the Follow-Up After Psychiatric Hospitalization (FAPH) measure. This measure is primarily an expanded and enhanced version of the Follow-Up After Hospitalization for Mental Illness (IPFQR FUH) measure currently in use in the IPFQR program, and is a replacement for that measure (the Follow-Up After Hospitalization for Mental Illness [HEDIS® FUH] and the Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence [HEDIS FUA] measures were reviewed as well).

¹ During the public comment period, HSAG was the contractor for this work. HSAG's contract expired and, after the public comment period closed, Mathematica was awarded the contract for continued work (Contract #5FCMC18D0032 Task Order: #75FCMC19F0001), including writing this public comment summary report. Throughout this report, we refer to HSAG as the prior measure developer.

Developing the denominator encompassed expanding the list of qualifying principal diagnoses and reevaluating the inclusion and exclusion criteria to ensure they were appropriately specified for the patient population and harmonized with other measures. Roughly 1,000 diagnosis codes were added to the denominator, representing a wide variety of conditions including dementias; psychiatric diagnoses; and poisoning, medication, and toxic effects.

Developing the numerator encompassed reevaluating the list of qualifying follow-up visit types and determining how best to operationalize the numerator calculation and follow-up period. The measure's importance, rate reliability, and validity were evaluated by standard methods. Measure development and testing were informed by an expert workgroup and a technical expert panel (TEP) made up of patient representatives, psychiatrists, nurses, quality improvement specialists, and informaticists. The measure's importance was evaluated by assessing the gaps and variation in performance among inpatient psychiatric facilities (IPFs) nationally.

Notifying the public and receiving comments

The project team used extensive outreach to notify stakeholders and the general public about the comment period:

- Email to stakeholders and stakeholder organizations, including:
 - America's Essential Hospitals
 - American Academy of Pediatrics
 - American Association of Community Psychiatrists
 - American Board of Professional Psychology
 - American College of Psychiatrists
 - American Hospital Association
 - American Medical Association
 - American Medical Informatics Association
 - American Nurses Association
 - American Pharmacists Association
 - American Psychiatric Association
 - American Psychiatric Nurses Association
 - American Psychological Association
 - American Society of Health System Pharmacists
 - Association of Veterans Affairs Psychologist Leaders
 - Federation of American Hospitals
 - Institute for Healthcare Improvement
 - International Society for Bipolar Disorder

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- Mental Health America
 - National Alliance on Mental Illness (NAMI)
 - National Association of Psychiatric Health Systems
 - National Association of Social Workers
 - National Association of State Mental Health Program Directors
 - National Council for Behavioral Health
 - National Institute of Mental Health
 - Office of Population Affairs, US Department of Health and Human Services
 - American Society of Addiction Medicine
 - American Academy of Pain Medicine
 - American Chronic Pain Association
 - American Association for the Treatment of Opioid Dependence, Inc.
 - Bradley Hospital
 - Lifespan, Providence, RI
 - Fremont Hospital
 - HealthPartners/Regions Hospital
 - Hospital Corporation of America
 - Inpatient Psychiatry at Grady Memorial Hospital
 - NAMI Savannah
 - National Association of Psychiatric Health Systems
 - Rush College of Nursing
 - Santa Fe College
 - Sharp Mesa Vista Hospital
 - District of Columbia Hospital Association
 - Spring Harbor Hospital
 - St. Anthony Hospital
 - The Joint Commission
 - UCSF and Zuckerberg San Francisco General Hospital, Department of Psychiatry
 - Universal Health Services, Horizon Health, Mental Health Outcomes
 - University Hospital
 - Westchester Medical Center
 - Western Psychiatric Institute & Clinic
 - U.S. Department of Veterans Affairs
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- New York-Presbyterian Hospital
- Health Management Associates
- Ilex Consulting, LLC
- University of Florida
- University of Miami Miller School of Medicine
- National Committee for Quality Assurance
- University of Florida
- Agency for Healthcare Research & Quality
- Substance Abuse and Mental Health Services Administration
- National Institute on Drug Abuse
- Grand Traverse Health Advocates
- McLean Hospital
- National Association of State Mental Health Program Directors Research Institute, Inc.
- New York State Psychiatric Institute
- Schools of Medicine, Health Policy and Management, and the Armstrong Institute for Patient Safety, Johns Hopkins University
- State of Illinois-Division of Mental Health
- Systems and Psychosocial Advanced Research Center, University of Massachusetts Medical School
- Telligon
- Rutgers University Behavioral Health Care
- Vid
- Other communication vehicles/lists:
 - IPFQR ListServe

During the public comment period, CMS received comments from 29 organizations or individuals within the following categories of stakeholders:

- **15 hospital/health systems.** Virginia Commonwealth University Health System (VCUHS), Sharp Mesa Vista, Overlake Hospital, Universal Health Services, Inc. (UHS, Inc.), South Texas Behavioral Health Center (STBHC), Premier Health, Miami Valley Hospital, Carolinas HealthCare Behavioral Health, Allina Health, Trinitas Regional Medical Center, Spencer Hospital, CenterPointe Behavioral Health System, Atrium Navicent Health (two comments), Unity Behavioral Health Center, and Appling Healthcare.

- **Six professional associations.** National Association of State Mental Health Program Directors Research Institute, National Association for Behavioral Healthcare, American Psychiatric Association, American Hospital Association, NAMI, and the Healthcare Association of New York State.
- **Seven individuals.** No organization or contact information provided.

Stakeholder comments

Support for the measure

Ten stakeholders expressed support for the measure based on the expanded list of qualifying diagnoses in the denominator. Commenters said that more patients who could benefit from post-discharge follow-up visits would now be included. One commenter said the measure was very important because it will encourage adequate follow-up after discharge. Two commenters thought that expanding the measure to include both mental illness and substance use disorder (SUD) diagnoses promotes continuity of care and reduces the risk of re-admission, relapses, or other crises. One commenter believes that a follow-up visit after psychiatric hospitalization is vital to improving short- and long-term patient outcomes. One commenter specifically agreed with and supported all of the details of the numerator specifications, such as the additional CPT codes and the start of follow-up on day 0.

Response given to all supportive commenters: Thank you for your comment in support of the measure.

General concerns and suggestions

One commenter recommended adding a third category, “neurological disorders,” to the two current categories of mental illness and substance use disorders. Some of the new conditions added to the measure would be in this category—for example, Alzheimer’s disease and other forms of dementia. The commenter recommended reporting measure data by these three categories, because challenges to post-discharge follow-up care vary depending on which category a patient’s condition is in.

Response: We recognize that caring for patients with dementia likely presents different challenges than caring for patients with mental illness and SUD, and will consider the suggestion of adding a third category of neurological disorders (and the suggestion to report the measure by categories of conditions).

One commenter requested that in addition to the disparities analysis presented in the Draft Methodology Report, analyses also be conducted on disparities in measure rates by income, primary language, homelessness, and zip code.

Response: We will consider the suggestion to investigate disparities in measure rates by such characteristics as income, language, homelessness, and zip code; however, there are limitations in the data available on some of these important sociodemographic characteristics.

One commenter was concerned that the measure would not have much effect on the ultimate desired outcome of reduced re-admissions because (1) there was not enough evidence that post-discharge follow-up lowers the risk of re-admission for the newly added groups of patients, those with SUD and dementia, and that (2) the evidence that was presented for those patients with mental illness (that is, patients without SUD or dementia) showed only minimal effects of post-discharge follow-up on reducing re-admission rates. Finally, this commenter noted that the evidence only included studies on adult patients, whereas the FAPH measure included children as young as 6. Because of the weak evidence, the commenter suggested different concepts for an IPF measure: (1) evaluating whether an IPF had made all reasonable efforts to connect a patient with outpatient care following discharge, and (2) determining whether IPFs were following evidence-based guidelines.

Response: We will reassess the strength of the evidence that post-discharge follow-up visits reduce the risk of re-admission for patients with SUD or dementia, and for patients who are children ages 6 to 18. As noted by the commenter, in the Draft Methodology Report there were no discharges for mental illness among Medicare FFS patients younger than age 13, nor for SUD among patients younger than age 18. We will explore the concept of whether an IPF “has made all reasonable efforts to connect that patient with outpatient care following discharge” could be operationalized either by using claims data or imposing undue burden in a non-claims-based measure. We appreciate the suggestion that measures of IPF quality be developed based on whether IPFs are providing care consistent with evidence-based guidelines. As part of our ongoing measure maintenance and development, we do consider process measures that align with evidence-based guidelines.

Concerns about criteria for denominator inclusion and exclusion

Four commenters expressed concerns about the inclusion and exclusion criteria. One questioned the decision not to exclude patients discharged or transferred to court or law enforcement, saying they should have been excluded because there were so few of these patients (0.3 percent of all discharges), and they are unable to attend follow-up visits.

Response: The TEP was concerned about the poor reliability with which discharge status code 21 (Discharge or transfer to court/law enforcement) is used, and, conversely, noted that the low prevalence of patients discharged to court or law enforcement meant their inclusion would have minimal impact on measure rates, so opted to not exclude patients discharged or transferred to court/law enforcement, but we will reconsider this issue.

Another commenter strongly recommended including all deaths because the inpatient providers should be addressing the whole health of patients. This same commenter also expressed reservations about the exclusion of “against medical advice” (AMA) discharges, pointing out that IPF policies that preclude providers from arranging follow-up prescriptions and appointments for AMA discharges essentially punish these patients and allow facilities to sidestep accountability.

Response: We are uncertain how excluding deaths from the denominator would give inpatient providers negative incentives, but we will reconsider this issue. We will also

reconsider the exclusion of discharges with the status code of “against medical advice” from the denominator.

One commenter asked how the measure would account for patients transferred from one IPF to another—for example, would the patient be excluded from the sending facility’s denominator, and would the patient be included in the receiving facility’s denominator at the time of discharge?

Response: Your interpretation is correct, because the specifications say that “admissions or transfers to another IPF will be evaluated independently of the preceding excluded discharge and will be included in the denominator if they meet the other denominator inclusion and exclusion criteria.”

One commenter was concerned that geriatric patients who receive care in nursing homes may not receive follow-up for up to 30 days.

Response: We will reconsider the issue of patients discharged to skilled nursing facilities or nursing homes.

Concerns about numerator specifications

Three commenters conveyed their concerns about the numerator specifications. One disagreed with excluding visits with codes of medication-assisted treatment (MAT) for SUD alone. This commenter pointed out that there are facilities that provide high-quality MAT—that is, *both* medication and therapy—but that therapy codes may not appear within seven days depending on the timing of the therapy visits.

Response: We will reconsider the exclusion of MAT codes from the numerator.

A second commenter stated that various state Medicaid programs cover post-hospital discharge services that are essentially post-hospital follow-up visits, but are not covered by Medicare and therefore would not appear in the FAPH measure. The commenter gave examples from New York State, whose Medicaid program covers Personalized Recovery-Oriented Services and Assertive Community Treatment programs, and also some primary follow-up visits in drug- and alcohol-certified programs.

Response: This measure relies only on Medicare claims. We recognize that, in some states, some post-discharge services that fit the intent of this measure may be covered only by Medicaid, and because they are not covered by Medicare, they will not be detectable in Medicare claims data. The disparities analysis in the Draft Methodology Report did reveal a disparity in the 7-day rate between dually enrolled patients and patients who only have Medicare. We are yet to determine if the disparity is related to the issue raised in this comment. We will reconsider how services covered only by Medicaid may affect measure rates.

The third commenter recommended that tele-mental health services be included in the numerator, and given that visits to non-mental-health and substance use providers also potentially count in the numerator, that the numerator focus only on visits related to mental

health and not on those devoted to physical health. This commenter also suggested that the measure consider visits that extend beyond the measure's current 30-day period.

Response: Codes billed with a telehealth modifier will meet the criteria for the measure. Although it is unclear whether it can be accomplished in claims data, we will consider approaches to refining numerator specifications to limit post-discharge follow-up visits only to those focusing on mental health, rather than physical health issues. Although CMS understands that mental health treatment is an ongoing process, this measure focuses on follow-up after psychiatric hospitalizations, so CMS does not have plans to expand the measure beyond 30 days at this time.

Concerns over holding IPFs responsible

Thirteen commenters expressed serious concerns about the many factors that affect whether patients can or will keep post-hospital-discharge follow-up appointments. These include having no mental health providers nearby, having no providers that accept Medicare or are willing to make appointments; no access to transportation; racial/ethnic disparities in care; patients' low incomes; language barriers; and providers' inability to contact homeless patients and patients with unstable residences. Finally, some patients may simply not want to attend follow-up visits, especially if they were involuntarily committed.

One commenter questioned whether the measure accurately evaluates the performance of the discharging IPF, saying the measure assesses the percentage of inpatient discharges for which the patient received appropriate follow-up care in an outpatient setting; this commenter doesn't see how inpatient care can be accurately evaluated based on outpatient experiences. Another commenter believes the FAPH measure is reasonable as a "population health" measure, but that it falls short when applied to the IPF setting. FAPH is similar to the HEDIS Follow-Up After Hospitalization for Mental Illness (FUH) measure. The commenter referenced the National Quality Forum's 2017 recommendation that the FUH measure be removed from the list of measures for federal programs until it is re-specified for acute care. The Measure Applications Partnership noted that the FUH measure was designed as a health plan measure in which the plan held significant responsibility for an adequate network of providers to ensure follow-up for members post-discharge. Despite providers' commitment to helping patients make the best possible transition to outpatient care, the commenter also stated that the lack of outpatient behavioral health resources is widely reported through formal statistics and the public press, making the FUH difficult to effectively implement within IPFs. The FAPH would have the same problems, according to the commenter.

Response: We agree that there are many factors beyond the control of IPFs that will affect the rates of this measure, including the local supply of outpatient behavioral health resources and patients' sociodemographic barriers, and that IPFs' influence on patients' adherence to follow-up visits is limited. Although the measure rate is not expected to approach 100 percent, findings in the Draft Methodology Report included evidence to support that IPFs are able to influence rates of follow-up. The measure's intent is to inform IPFs' efforts at continuous quality improvement to improve care by increasing measure rates. This is clearly still an important issue and concern, and we will reconsider the effect of factors that are out of IPFs' control on measure rates.

One commenter noted that the numerator was essentially “contacting the patient prior to the first visit,” which is an arduous task for facilities that serve large populations of indigent patients without reliable contact information or means of communication.

Response: Thank you for your comment. Technically, the numerator is based on Medicare claims for visits that fit the numerator specification; however, we understand that contacting the patients to remind them of an upcoming appointment is generally a key step in getting them to keep the appointment. We agree that many factors beyond the control of IPFs will affect the rates of this measure, including the local supply of outpatient behavioral health resources and patients’ own sociodemographic barriers (including poverty, unstable living situations, or unreliable means of communication); and IPFs’ influence on patients’ adherence to follow-up visits is limited. Although the measure rate is not expected to approach 100 percent, findings in the Draft Methodology Report included evidence to support that IPFs are able to influence rates of follow-up. The measure’s intent is to inform IPFs’ continuous quality improvement efforts to improve care by increasing measure rates. This is clearly an important issue and concern, and we will reconsider the effect of factors that are out of IPFs’ control on measure rates.

Concerns on reporting

One commenter requested a review period before public reporting of measure rates.

Response: CMS will offer a review period prior to public reporting.

Concerns about data collection and reporting burdens for IPFs

Seven commenters expressed concern that the measure would place undue data collection and reporting burden on IPFs.

Response: FAPH is a claims-based measure. There is no extra effort required of facilities to collect and submit data for the measure. CMS will calculate it by linking (1) Part A and Part B claims data that are received for payment by Medicare and (2) Medicare fee-for-service (FFS) claims submitted by IPFs and subsequent outpatient providers for Medicare FFS IPF discharges.

One commenter was concerned that the numerator might be people for whom appointments had been made versus people who actually had visits, and that the latter would be difficult for IPFs to ascertain. Another commenter raised concerns that the 30-day rate would be based on appointments made for 30 days in advance, which outpatient providers would not do. A third commenter thought that outpatient providers would need to report back to the discharging facilities. The remaining commenters were generally concerned that collecting and reporting data would be more work for their already overextended staff.

Response: FAPH is a claims-based measure. CMS will calculate it by linking (1) Part A and Part B claims data that are received for payment by Medicare and (2) Medicare fee-for-service (FFS) claims submitted by IPFs and subsequent outpatient providers for Medicare FFS IPF discharges. The numerator is based only on claims for completed

outpatient visits, not on whether appointments have been made, so there will be no need for IPFs to ascertain whether appointments have been made or kept, or to collect information from outpatient providers. Facilities will not have to put in any extra effort to collect and submit data for the measure.

Comments about the FAPH measure and reimbursement

Four commenters remarked on possible associations between performance on the measure and facility reimbursement. One commenter urged CMS to consider linking IPFQR data to reimbursement for both inpatient and outpatient services based on measure performance. Two commenters said that, although measure results would be valuable information, tying them to reimbursement would be unreasonable. Another comment was a general concern that IPFQR had not accomplished much and the FAPH measure would be “yet another useless collection,” and that commenter called for increasing the supply of clinicians, creating a “reasonable reimbursement” system, and providing incentives to produce quality care.

Response: Using quality measures to determine facility reimbursement would be a separate process beyond the scope of the development of this quality measure. We thank commenters for the suggestion to create initiatives to increase clinician supply or reform the reimbursement system and will share the suggestion with CMS.

Two commenters wondered whether IPFs would be reimbursed for care managers or other resources needed to implement the measure.

Response: Thank you for your comment. The intent of the measure is to inform IPFs’ efforts to improve rates of follow-up visits after discharge, using the resources they currently have available and as part of their continuous quality improvement. Because this measure is based on Medicare claims data, facilities will not have to put any extra effort into collecting and submitting data for the measure. We assume that most, if not all, IPFs already have processes in place for discharge planning and the necessary staff to help patients with discharge planning. CMS currently has no plans for additional reimbursement to IPFs for case management or for data collection related to this measure.

Preliminary recommendations

CMS and the measure development team will review and discuss all the suggestions from commenters. We intend reconvening the TEP to review the public comments and get the TEP’s guidance, particularly on the following:

- Adding a third category of neurological disorders to the two existing categories of mental illness and SUD. This category would primarily include the dementia diagnoses.
- Possibly reporting measure data by the three resulting categories
- Conducting additional disparity analyses by income, primary language, homelessness, and zip code

- Reassessing the strength of the evidence on whether post-discharge follow-up visits lower re-admissions for patients with dementia and SUD
- Reassessing the inclusion and exclusion age limits
- Reassessing the magnitude of the effect of post-discharge follow-up visits on lowering the number of re-admissions for patients with mental illness
- Revisiting denominator inclusion and exclusion criteria (specifically deaths, discharges into courts and law enforcement, and discharges AMA)
- Considering patient-level factors that affect compliance with follow-up appointments and how to deal with patients in non-traditional discharge settings (shelters, Salvation Army, criminal justice system, etc.)
- Adding numerator codes for MAT

Overall analysis of the comments and recommendations

We received much constructive feedback on the FAPH measure. Many commenters acknowledged the importance of developing a hospital measure that addresses follow-up post-hospitalization. One commenter expressed concern about the lack of studies linking follow-up care and re-admission rates, particularly among those with SUD or dementia.

Many commenters highlighted the challenges of implementing the measure in the IPF setting, including concerns about provider availability, patient access to community-based services, patient sociodemographic barriers, and patient motivation. These factors raise concerns about accountability and reimbursement because they are beyond the IPFs' control, yet can impact compliance with follow-up. We intend reconvening the TEP to discuss the comments we received and determine the most appropriate course of action.

Public comment verbatim report and responses

Date posted	Text of comments	Name, credentials, and organization of commenter	Response
2019-02-13	<p>We believe expanding the measure to include both mental illness and SUD diagnoses does promote continuity of care for those patients after hospitalization and reduce the risk of re-admission, relapse, or another crisis. We have some concerns about access to hospital follow up appointments. The report indicates the measure increases the denominator by about 35% over previous hospital follow up measure. We assume this means more patients will need discharge appointments for us to meet the measure. Hospitals have limited availability for hospital follow ups as it is without adding additional burden. In addition, We are uncertain if this meets standard protocol for the physicians and therapists to schedule a follow up visit within 30 days of discharge. This could possibly be a change in practice resulting in a need to adjust schedules to make that type of appointment available so we could meet the measure, again impacting access for patients who were not hospitalized. The thought is we believe it can be done at NPS if needed...it would simply reduce access slightly to non-hospitalized patients in order to accommodate more hospital follow ups within the 7 day and 30 day windows. Report indicates to meet measure there would be an increase in number of patients being discharged needing follow up appointments: If all facilities achieved the benchmark follow-up rates for their Medicare FFS patients calculated using the AHRQ Achievable Benchmarks of Care (ABC) method, 53,841 additional discharges would have a 7-day follow-up visit and 47,552 additional discharges would have a 30-day follow-up visit. Additional diagnoses were added...there are 1,009 ICD-10 codes in the FAPH measure. The Expert Workgroup and TEP recommended expanding the list of diagnoses included in the FAPH measure denominator. They agreed with including the full list of mental illness codes from the IPFQR FUH and HEDIS FUH measures and the full list of SUD diagnosis codes from the HEDIS FUA measure. The Expert Workgroup identified several other mental illness diagnoses, including codes that fell outside of ICD-10-CM Chapter 5, that would require follow-up post-discharge. Codes related to injury and self-harm were added to harmonize with updates planned for the 2019 version of the HEDIS FUH measure. There is some concern about data collection but the report states no reporting is required...they get data from Medicare claims. If implemented, facilities will not be required to collect and submit data for the measure. CMS will calculate the measure results for facilities using the Part A and Part B claims data that are received by Medicare for payment purposes. Exclusion criteria – they are not excluding patients discharged into court/law enforcement (discharge status code 21). The report says this happens at a rate of 0.3% nationally so it would have little impact on the results. Why not exclude them if they won't impact anything and the patient would likely not have a chance to meet the 7 day follow up appointment? This seems odd that they would not be simply excluded. We think all the other exclusion criteria are fine. Numerator: Outpatient visits are defined as outpatient visits, intensive outpatient encounters, or partial hospitalization. This is good because I think some of the hospital discharges that come to NorthEast are seen in PHP first. If the IOP gets back up and running then those IOP visits can count too. MAT alone will not count...it must be accompanied by some other type of mental health or SUD visit code. The Expert Workgroup and TEP agreed with including most of the follow-up types from the IPFQR FUH, HEDIS FUH, and HEDIS FUA measures in the numerator for the FAPH measure. They also agreed that for patients with SUD, a claim for MAT alone during the follow-up period is not sufficient to meet the definition of an outpatient follow-up visit because those medications should always be administered in conjunction with another type of treatment to monitor use and symptoms. Therefore, to align with the approach for the HEDIS FUA measure, the follow-up code that will count toward the numerator is the code for the mental health or SUD visit and not the code for MAT. New visit type recommended to be added to FAPH numerator: (this would be BHI which would count...not sure if we are expanding billing beyond the pilot!) Psychiatric collaborative care management CPT 99492-99493 (new to CPT in 2018) The Expert Workgroup agreed with specifying the FAPH measure numerator to count appropriate follow-up visits with a mental illness or SUD diagnosis in any position on the claim. It accommodates the variation in billing requirements regarding coding sequencing and gives more credit for follow-up visits. This is good as it allows the visit to count even if the mental illness or SUD diagnosis is not primary on the claim. We know how providers often don't list these dx as primary. Follow up period starts at Day 0 (basically allows a visit on same day as discharge). This would pose a challenge but, It may be an acceptable option if we ever came up with a same day clinic option. It might be tough to get patients back in within 30 days of discharge due to access issues. Follow up calls by the Call Center definitely can play a role in helping with transition from IP to OP. Hopefully some of the zero suicide initiatives will help enhance the discharge phone call process to address high risk patients. It might help improve show rates to the appointments.</p>	<p>Sylvia Broome, R.N., Carolinas HealthCare Behavioral Health</p>	<p>Thank you for your comment, and specifically for pointing out that expanding the list of principal discharge diagnoses in the denominator adds patients who will benefit from hospital follow-up visits. We recognize that accommodating the resulting increase in necessary appointments would place more stress on the system, potentially affecting access for non-hospitalized patients.</p> <p>Thank you also for highlighting the issue of patients discharged to court/law enforcement; we will reconsider this. The technical expert panel (TEP) was concerned about the poor reliability with which discharge status code 21 (Discharge or transfer to court/law enforcement) is used and, conversely, noted that the low prevalence of patients discharged to court or law enforcement meant their inclusion would have minimal impact on measure rates, so they opted not to exclude patients discharged or transferred to court/law enforcement, but we will reconsider this issue.</p> <p>Thank you for your support of the numerator specifications.</p>

Date posted	Text of comments	Name, credentials, and organization of commenter	Response
2019-02-13	<p>APA supports this measure as a replacement to the current IPFQR FUH measure. By broadening the measure denominator, it appropriately includes those admitted into an IPF for SUD as a principal diagnosis. We have some concerns over the measures' specifications, specifically the exclusion of numerator codes for MAT. APA agrees that patients receiving MAT medication should also be engaged in other therapy services and for the facility to meet this criteria the code for a MAT prescription must be accompanied by a code for a therapeutic encounter. However, it is possible for patients in a MAT program to receive MAT medications and without a code designating the therapeutic encounter. For instance, if a patient is prescribed Vivitrol, or the new and emerging long-acting formulations, then the patient would be on MAT, but administrative claims data would not include the code for receiving the therapy within seven days. Despite this, they should receive some kind of clinical visit in those seven days (e.g., monitoring for side-effects). Alternatively, an opiate treatment program may include patients who receive MAT therapy but not to use MAT mediation. We think there should be some consideration for facilities that provide high-quality MAT (medication and therapy), but due to timing, therapy codes are excluded. We also have some concerns with the measure's exclusion criteria. We strongly recommend the inclusion of all deaths. The inpatient team should be addressing the whole health of the patient. Since the hospice exclusion covers patients that are too sick to hold the IPF accountable, this would not reflect the quality of care for these facilities. We also have concerns over the AMA discharges. Some IPF policies prevent providers from arranging follow up appointments or prescriptions when a patient leaves the IPF AMA. These policies are punitive and allow these facilities' to become unaccountable for care coordination/continuity and follow up. Punitive AMA discharge policies further incentivize the opposite of what this measure intends to achieve. (Alfandre, Journal of General Internal Medicine 2013) Some facilities do not use the term "AMA" anymore and have deleted it from the discharge options. These patients' either meet involuntary criteria or they do not. If they do not meet involuntary hospitalization criteria, then quality measures should support the facilities' efforts to promote continuity of care.</p>	Samantha Shugarman, American Psychiatric Association	<p>Thank you for your comment and support of broadening the measure denominator. Although we are unsure whether the exclusion of deaths from the denominator would give inpatient providers negative incentives, we will reconsider the exclusion of deaths from the denominator. We will also reconsider the exclusion of MAT codes from the numerator. Finally, we will reconsider the exclusion of discharges with the "against medical advice" status code from the denominator. We will reassess Medicare coding for involuntary or court commitment status.</p>
2019-02-13	<p>As an association representing behavioral healthcare provider organizations and professionals, the National Association for Behavioral Healthcare (NABH) appreciates the opportunity to provide comments on the Draft Methodology Report: Follow-Up After Psychiatric Hospitalization. We have identified some issues with the rule that concern our membership, the top two being the draft measure is a population health measure applied to the acute inpatient psychiatric setting and the measure does not take into account the national shortage of outpatient behavioral health providers and their uneven geographical distribution. As a "population health" measure the draft measure's premises are reasonable. However, when this measure is applied to the inpatient psychiatric facility (IPF) setting does fit as well. There are a number of reasons for that and NABH has discussed them in relation to the Follow-Up After Hospitalization for Mental Illness (FUH) measure. The same problems exist with this new draft measure. Specifically, the National Quality Forum, in their MAP 2017 Guidance (March 15, 2017) recommended that the Follow-Up After Hospitalization for Mental Illness (FUH) be removed from the list of measures for federal programs until it is re-specified for acute care and submitted for NQF endorsement. Discussion within the MAP noted that FUH, while it had NQF endorsement, was designed as a health plan measure in which the plan held significant responsibility for an adequate network of providers to assure follow-up for members post discharge. As it relates to access to outpatient care, despite providers' commitment to helping patients make the best possible transition to outpatient care, the lack of outpatient behavioral health resources that accept Medicare is widely reported through formal statistics and the public press. In many markets, it is virtually impossible to arrange for an outpatient behavioral health appointment within 30 days. In the face of these challenges, providers work with patients to help them understand the importance of follow-up care post-hospitalization. They make significant efforts to identify appropriate providers and to arrange timely specialty appointments. Patient preferences in the Medicare population do not always include specialist care. Often patients prefer to return for their follow-up care to a trusted relationship they have with their established primary care provider. This approach can be consistent with the trend in all healthcare to provide integrated care. Thank you, Scott Dziengelski Director of Policy and Regulatory Affairs National Association for Behavioral Healthcare 900 17th Street, NW Suite 420 Washington, DC 20006-2507 P 202.393.6700, ext. 115 Scott@nabh.org</p>	Scott Dziengelski, National Association for Behavioral Healthcare	<p>Thank you for your comment. The measure is to be applied to IPFs, so we are unsure why it is referred to as a "population health measure." We agree there are many factors beyond the control of IPFs that will affect the rates of this measure, including the local supply of outpatient behavioral health resources that accept Medicare and patients' own sociodemographic barriers; and that IPFs' influence on patient adherence to follow-up visits is limited. Although the measure rate is not expected to approach 100 percent, findings in the Draft Methodology Report included evidence to support that IPFs are able to influence rates of follow-up. The measure's intent is to inform IPFs' continuous quality improvement efforts to improve care by increasing measure rates. We will nevertheless reconsider the effect of factors that are out of IPFs' control on measure rates.</p>

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2019-02-11	Important but not always practical. Entirely dependent on resources in the community which is highly variable.	Ananda Pandurangi, M.D., VCUHS	Thank you for your comment. We agree there are many factors beyond the control of IPFs that will affect the rates of this measure, including the local supply of outpatient behavioral health resources that accept Medicare and patients' own sociodemographic barriers; and that IPFs' influence on patient adherence to follow-up visits is limited. Although the measure rate is not expected to approach 100 percent, findings in the Draft Methodology Report included evidence to support that IPFs are able to influence rates of follow-up. The measure's intent is to inform IPFs' continuous quality improvement efforts to improve care by increasing measure rates. We will nevertheless reconsider the effect of factors that are out of IPFs' control on measure rates.
2019-02-11	On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including our nearly 1,600 psychiatric and substance use disorder provider members, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) and Health Services Advisory Group (HSAG) Follow-Up After Psychiatric Hospitalization measure Draft Methodology Report. AHA understands that the IPF Quality Reporting Program (IPFQR) is undergoing significant updates, and applauds CMS for its thoughtful approach in identifying new ways to evaluate the quality of care provided to a uniquely vulnerable population. This letter includes feedback on the general importance of this topic as well as questions and recommendations for the developers as they continue to refine the specifications of the measure. Importance of Measuring Follow-Up After Psychiatric Hospitalization The AHA agrees that follow-up after psychiatric hospitalization is vital to improving short- and long-term patient outcomes. We recognize and uphold the clinical practice guidelines developed by our partners at the American Psychiatric Association and by researchers at the National Institutes for Health that emphasize the importance of continuity of care between settings for patients with mental illness and substance use disorder (SUD). We also appreciate that CMS is considering ways to include patients with SUD and dementia in IPF quality measurement, as most of the measures currently implemented in the IPFQR are specific to mental illness, particularly forms of psychosis. Finally, the AHA supports the work behind CMS's Meaningful Measures initiative, and agrees that the IPFQR should include a measure that addresses the priority areas of Prevention, Treatment, and Management of Mental Health and Prevention and Treatment of Opioid and Substance Use Disorders, as well as a measure regarding the promotion of effective communication and coordination of care. However, based on the information provided in the Draft Methodology Report, we fear that the measure for comment, Follow-Up After Psychiatric Hospitalization (FAPH), would not meaningfully achieve its intended purpose. While we agree with several points made in the Report on the measure's importance, such as the association between follow-up care and decreased risk of re-admissions, the report does not provide sufficient evidence that this association holds true for the newly included patient population (i.e. patients with SUD and patients with dementia). In addition, we do not believe that completed follow-up appointments are fully in the control of IPF providers. Of course IPF providers must do everything in their power to ensure that their patients receive appropriate care post-discharge. At the same time, many factors outside of the facility's control significantly affect the likelihood of a patient completing a follow-up appointment but would not actually reflect the quality of care provided at the IPF, including the availability of enough substance use treatment providers and dementia care providers in the area, and as CMS knows, these providers are in scarce supply in many areas of the country. The following sections further elaborate upon these points. We reiterate that we agree with the importance of follow-up and that we must hold providers accountable for doing what they can to ensure the continuity of care	Caitlin Gillooley, M.P.H., American Hospital Association	Thank you for your comment and support of the measure. We agree there are many factors beyond the control of IPFs that will affect the rates of this measure, including the local supply of outpatient behavioral health resources that accept Medicare and patients' own sociodemographic barriers; and that IPFs' influence on patient adherence to follow-up visits is limited. Although the measure rate is not expected to approach 100 percent, findings in the Draft Methodology Report included evidence to support that IPFs are able to influence rates of follow-up. The measure's intent is to inform IPFs' continuous quality improvement efforts to improve care by increasing measure rates. We will nevertheless reconsider the effect of factors that are out of IPFs' control on measure rates. We will also reassess the strength of the evidence that post-discharge follow-up visits reduce the risk of re-admission for patients with SUD or dementia, and for patients who are children ages 6 or older. As noted in the comment, in the Draft Methodology Report there were no discharges for

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2019-02-11 (continued)	<p>post-discharge; however, an outcomes measure like FAPH might not be the appropriate method of doing so. We understand that one of the goals of CMS's Meaningful Measures initiative is to avoid process measures that merely record whether a task was done rather than determining if there are true variations in quality; however, we think CMS would agree that there are some instances in which process measures are appropriate. We believe this measure topic—that is, evaluating whether an IPF has made all reasonable efforts to connect a patient with outpatient care following discharge—is such an instance.</p> <p>Concerns Regarding Measure Development: We are concerned by the incomplete evidence used to support expanding the measure's population to include SUDs and dementia. The rationale for using this particular measure appears to hinge on the idea that following up post hospitalization has the potential to reduce re-admissions. Yet, every study cited in the report that finds an association between follow-up visits and reduced risk for re-admission focuses on patients with schizophrenia and/or bipolar disorder (or psychosis disorders defined more broadly). These studies were also conducted with adult patients, whereas the FPAH measure would include children as young as six (and the dataset analyzed included too few patients under 18 to assess outcomes). In concept, following up with patients with all types of disorders could be helpful, but unfortunately, the Draft Methodology Report does not provide evidence that this intervention is associated with improved outcomes for the patient population in question. Similarly, we question whether the studies cited shows a large enough magnitude of association between follow-up visits and reduced re-admissions. One study (Marcus 2017) found that "receipt of a follow-up visit within 30 days of discharge was associated with a slightly lower adjusted odds ratio of hospital re-admission" (emphasis added), and the strongest association was found for schizophrenia patients whose index admissions were 13 to 30 days long. According to the APA, the average length of stay for patients with serious mental illness is 12 days; other studies have found it is closer to 10, and some have cited five or six day stays for facilities whose primary goal is crisis intervention and stabilization. Another cited study (Olson 1998) found that patients with schizophrenia who had telephone or face-to-face contact with an outpatient clinician before hospital discharge "did not significantly differ" from patients who did not have such contact "in the proportion who were readmitted to the hospital or who made a psychiatric emergency room visit during the follow-up period." Another study cited in the Report (Kurdyak 2018) showed only a four percent difference in re-admission rates for patients discharged with schizophrenia depending on whether that patient saw a physician within 30 days of discharge. The Draft Methodology Report cites the seemingly low national 7- and 30-day follow-up rates as rationale for the measure's impact; in other words, the developers appear to reason that implementing this measure in the IPFQR would increase the likelihood of patients receiving follow-up care. However, the measure's importance cites the need to reduce re-admissions. Because there appears to be only moderate association between follow-up care and reduced re-admissions (and no evidence provided to demonstrate this association for patients with SUD or dementia), we seriously question whether the use of this measure will have the impact on outcomes that CMS believes it would. The other serious concern we have with this measure is whether it accurately evaluates the performance of the discharging IPF. The measure assesses the percentage of inpatient discharges for which the patient received appropriate follow-up care in an outpatient setting; conceptually, it is difficult to see how we can accurately evaluate inpatient care based on outpatient experiences. Additionally, there are real-life logistical and patient-level factors that significantly impact the likelihood that a patient will complete an outpatient follow-up visit that are not yet accounted for in this measure. Primarily, sociodemographic factors, including but not limited to dual Medicare and Medicaid eligibility, can be indicators of difficulty accessing follow-up care. The Draft Methodology Report notes that Black and Hispanic patients received follow-up care at lower rates than White patients, and dually enrolled patients had a lower 7-day follow-up rate than patients with Medicare only. These disparities are important to highlight, analyze, and correct; however, there are additional factors (like income, primary language, homelessness, and zip code) that are also likely to show disparate rates of follow-up that were not addressed in the Draft Methodology Report. We encourage HSAG to investigate disparities in these categories as the measure's development progresses. While health care facilities and providers have the obligation to care for patients regardless of sociodemographic status, the fact is that geographic and patient-level characteristics are likely to influence whether a patient completes a follow-up visit even if the discharging IPF took every reasonable step to connect that patient with an outpatient clinician. One study cited in the Report to demonstrate the effect of inpatient transition intervention on attendance at the first post-discharge appointment (Batscha 2011) excluded patients "if the living situation made it unfeasible to attend appointments (undomiciled, lacking transportation, or living far away), [or] if they did not speak English." Another (Olson 1998) found that patients with significantly lower total Brief Psychiatric Rating Scale score and less self-assessed difficulty controlling symptoms (i.e. patients who are less severely mentally ill) were more likely to contact the outpatient clinician. To be clear: patients who are more severely mentally ill, who live in areas or situations where it is difficult to attend appointments, and who do not speak English are less likely to complete a follow-up appointment because completing that appointment is difficult—not because the IPF provided poor care. Again, IPFs should be doing everything feasible to</p>	Caitlin Gillooley, M.P.H., American Hospital Association (continued)	<p>mental illness among Medicare FFS patients younger than age 13, nor for SUD among patients younger than age 18.</p> <p>It is unclear to us how to operationalize that an IPF "has made all reasonable efforts to connect that patient with outpatient care following discharge" either by using claims data or without imposing undue reporting burden in a non-claims-based measure. We appreciate the suggestion to develop measures of IPF quality based on whether IPFs are providing care consistent with evidence-based guidelines. As part of our ongoing measure maintenance and development, we do consider process measures that align with evidence-based guidelines.</p> <p>We will consider the suggestion to investigate disparities in measure rates by such characteristics as income, language, homelessness, and zip code (beyond the disparities analysis presented in the Draft Methodology Report); however, there are limitations in the data available on some of these important sociodemographic characteristics.</p>

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2019-02-11 (continued)	connect patients with ongoing care; however, there are circumstances beyond the inpatient facility's control that will affect the ability for patients to complete a post-discharge appointment. To hold IPFs accountable, we recommend that CMS and its contractors consider other ways to evaluate whether IPFs are following evidence-based guidelines regarding interventions that have been shown effective to connect patients with ongoing care. Once again, we recognize the difficulty of developing measures for the inpatient psychiatric population. Patients who receive care in an IPF often have multiple comorbidities, a wide range of severity and functional status, and challenging social risk factors that significantly affect their treatment and long-term outcomes. We appreciate the efforts in which CMS and its contractors have engaged, and are hopeful that the agency can identify measures that accurately and meaningfully address quality of care in IPFs.	Caitlin Gillooley, M.P.H., American Hospital Association (continued)	
2019-02-13	NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. On behalf of tens of millions of Americans with mental health conditions, NAMI supports adoption of the Follow-Up After Psychiatric Hospitalization (FAPH) measure to replace the Follow-Up After Hospitalization for Mental Illness (IPFQR FUH) measure currently in use in the Center for Medicare and Medicaid Services' (CMS) Inpatient Psychiatric Facility Quality Reporting (IPFQR) program. The adoption of this new measure will hopefully improve discharge planning and facilitate improvements in continuity of care between inpatient and outpatient care for a broader range of conditions, including substance use disorders and certain neurological conditions. We do have some recommendations for enhancing the likelihood that the new measure will achieve the desired purposes of improving discharge planning and continuity of care. First, NAMI recommends that the FAPH measure add a third category, "neurological disorders." Currently, the draft FAPH measure only describes two categories, mental illness and substance use disorders, but some of the new conditions that have been recommended for addition fall into the neurological disorder category, for example Alzheimer's disease and the various types of dementias that are listed. Second, following from the first recommendation, we believe it is important to extrapolate distinct reporting data for the three categories of conditions that will now be included in the new FAPH measure. The challenges and barriers to follow-up care after hospitalization differ for people with mental illness, substance use disorders, and neurological conditions respectively and it is therefore important that reporting on care in the FAPH measure include distinct and separate data for each of these three populations. Third, NAMI conditionally supports the recommendation to include non-mental health and substance use providers within the criteria for defining types of visits that qualify as 7 day or 30 day follow up visits. These include general practice physicians, internal medicine specialists, nurse practitioners, and physician informants. As stated in the draft methodology report, inclusion of these categories reflects realistic mental health provider shortages, particularly in rural regions, as well as the emergence of integrated care models to treat the whole person. In addition, we believe that the measure should accommodate the use of tele-mental health services by licensed behavioral health professionals as a viable means of providing follow-up care. In light of the proposed broadening of qualifying visits, NAMI would like Medicare to consider measure specifications that reflect that follow-up visits should, in fact, be focused on ensuring continuity of and engagement in the discharge plan of care. NAMI is concerned that follow up visits, if not with a mental health professional, might focus on health issues that do not correspond to the discharge plan and the underlying condition or conditions for people with a mental illness. Fourth, NAMI urges the development of further measures to assess whether outpatient services continue beyond the 7 day and 30 day periods currently measured. This is particularly important for people with more serious mental illnesses, where ongoing care and support beyond the initial follow up visit is crucial. For a person with schizophrenia, one follow-up visit after release from the hospital is inadequate. Finally, NAMI urges that CMS consider approaches to using the data collected through the IPFQR program to link financial reimbursement for inpatient and outpatient services to outcomes achieved. While some progress has occurred, rates of re-admissions to hospitals and other adverse outcomes such as homelessness or criminal justice involvement are still very high, particularly for people experiencing more serious mental illness or symptoms of psychosis. Such an effort would advance Secretary Alex Azar's agenda for moving to a healthcare system that pays for value, and this should be implemented for mental health care as well. NAMI thanks you for your work in developing and improving measures in the IPFQR program. We appreciate the opportunity to comment on these proposed changes.	Ron Honberg, J.D., National Alliance on Mental Illness (NAMI)	<p>Thank you for your comment and support of the measure. We recognize that caring for patients with dementia likely presents different challenges than caring for patients with mental illness and SUD, and will consider the suggestion of adding a third category of neurological disorders (and possibly consider the suggestion to report the measure by categories of conditions).</p> <p>Also, the measure specifications will include the codes to define the outpatient visits, intensive outpatient encounters, and partial hospitalizations. Codes billed with a telehealth modifier will meet the criteria for the measure. Although it is uncertain that it can be accomplished using claims data, we will consider approaches to refining numerator specifications to limit post-discharge follow-up visits that focus on mental health rather than physical health. We will also review the codes to ensure they are comprehensive. Although CMS understands that mental health treatment is an ongoing process, this measure focuses on follow-up after psychiatric hospitalization, so CMS does not have plans to expand the measure beyond 30 days at this time. Using quality measures to determine facility reimbursement is a separate process beyond the scope of this effort.</p>

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2019-02-12	<p>On behalf of our member nonprofit and public hospitals, nursing homes, home health agencies and other healthcare providers across the state, the Healthcare Association of New York State appreciates the opportunity to comment on this Inpatient Psychiatric Facility Quality Reporting proposed measure. We offer the following recommendation to strengthen the IPFQR program to ensure patient-centered follow-up care while eliminating additional patient and provider burden. Across the country, states have very different Medicaid reimbursement systems, both conceptually and in the technical details. As the healthcare system moves toward a value-based payment reimbursement system for behavioral health, it is important that CMS recognize the differences in each system. Specific to this proposed measure, clinically appropriate services for some patients discharged from hospitals are not counted. In New York State, the Personalized Recovery-Oriented Services (PROS) and Assertive Community Treatment (ACT) programs bill primarily under state-specific rate codes that do not qualify as a follow-up visit under this proposed measure. Primary follow-up visits set in a drug and alcohol certified program would also be excluded in this measure. Additionally, CMS no longer recognizes same-day follow-up appointments (outpatient appointments on the same day of discharge) and therefore would not be counted in this measure. All of these factors would result in false representation of facility follow-up care performance. At issue is how claims-based measures can fairly recognize the core differences in how behavioral health services are billed, without adding an undue burden for behavioral health providers. In recognition of addressing patient-specific needs, HANYS urges CMS to allow visits on the same day of discharge to count toward the measure. In addition, we recommend that CMS explore how variations in state Medicaid reimbursement systems and programs can be properly accounted for when reporting follow-up care. A one-size-fits-all model will only further disadvantage behavioral health providers.</p>	<p>Loretta B. Willis, R.N., C.C.M., C.P.Q.H., Healthcare Association of New York State</p>	<p>Thank you for your comment. This measure relies only on Medicare claims. We recognize that, in some states, some post-discharge services that fit the intent of this measure may be covered only by Medicaid, and because they are not covered by Medicare, they will not be detectable in Medicare claims data. The disparities analysis in the Draft Methodology Report did note a disparity in the 7-day rate between dually enrolled patients and patients who only have Medicare. Whether or not this disparity is related to the issue raised in this comment is unknown. We will reconsider how services covered only by Medicaid may affect measure rates. We note that Medicare does allow and recognize same-day visits.</p> <p>Thank you for your comment and support for the measure. Your interpretation is correct, because the specifications say that "admissions or transfers to another IPF will be evaluated independently of the preceding excluded discharge and will be included in the denominator if they meet the other denominator inclusion and exclusion criteria."</p>
2019-02-06	<p>This replacement measure seems appropriate given the high co-occurring rate of MH and SUD estimated at 45% for patients being treated by inpatient psychiatric facilities (Hollen & Ortiz, 2013). The expansion of follow-up service types will ensure that facilities are given credit for the wide range of service providers (including the integration with primary care). One question is raised in a statement in the denominator that needs clarification. "Note that admissions or transfers to another IPF will be evaluated independently of the preceding excluded discharge and will be included in the denominator if they meet the other denominator inclusion and exclusion criteria". My interpretation is as follows. Discharge or transfer to IPF is excluded from the sending facility's denominator (if the patient was admitted to the second IPF). The admission to the second IPF would be evaluated for inclusion in that IPF's discharges (denominator) at the time the patient is discharged.</p>	<p>Lucille Schacht, Ph.D., C.P.H.Q., National Association of State Mental Health Program Directors Research Institute</p>	

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2019-02-06	In our opinion, there are too many things that are not taken into consideration with the FUH measure especially if performance is determined merely by claims data. Many patients do not have a way to get to their follow-up and as a regional referral IP facility, we cannot inform with our local resources if the patient lives outside of our primary service areas. Secondly, we see many patients that are either homeless and/or move frequently, so they miss follow ups as result of that. Also, a considerable number of patients simply do not want to go to a follow up appointment. Our IPF population consists of many involuntary commitment [IVC] patients who as evidence by their involuntary status, do not want to be hospitalized to start with. Some patients in the IVC population do not go to appointments unless they have an outpatient commitment. To encourage compliance with follow up appointments, we perform follow-up phone calls. More often than not, those follow up call are 'coaching sessions' to reinforce the importance to adhere to their discharge plan and follow up, but often we hear/learn once again of a lack of desire to follow up. It almost seems as though the FUH measure identifies just how many people may not be willing to follow up. If we could tell from experience that the missed opportunities were process related, then at least there would be a starting point to positively impact performance. However, from our experience, the clear majority of barriers relate to individual motivation rather than process barriers. It is our standard process to provide EVERY patient with a follow-up appointment within 7 days of discharge. Before the discharge and during post discharge call, we encourage patients to go to their follow up appointments, yet our performance while at the state level is below the national rates for FUH-7 and FUH-30. We want all patients to follow up and it seems that organizationally we are making very reasonable efforts. Ultimately, we believe there are just too many variables that can interfere with the FUH measure that are more in the patient's control and within their right to refuse treatment, that it appears unreasonable for an organization to eventually be penalized on this FUH measure, especially as a claims based measure only that does not take the patients' preferences and right to self-determination into consideration.	No information provided	<p>We agree there are many factors beyond the control of IPFs that will affect the rates of this measure, including the local supply of outpatient behavioral health resources that accept Medicare and patients' own sociodemographic barriers; and that IPFs' influence on patient adherence to follow-up visits is limited.</p> <p>Although the measure rate is not expected to approach 100 percent, findings in the Draft Methodology Report included evidence to support that IPFs are able to influence rates of follow-up. The measure's intent is to inform IPFs' continuous quality improvement efforts to improve care by increasing measure rates. We will nevertheless reconsider the effect of factors that are out of IPFs' control on measure rates.</p>
2019-02-05	Allina Health recommends this measure because it expands the current population from our Follow Up after Hospitalization for Mental Illness measure. This opens up to diagnoses for substance use disorder and additional principal mental illness like dementia. In addition, it expands follow up visits to make sure all were included. We think it could be quite informative to any mental health follow up/re-admission work. We don't note anything in the set up of the measure that is concerning in advance of actually seeing our data, but would ask for a review period in advance of publically reporting. One thing that we think is especially good is that it does exclude admission/transfers to inpatient facility within the 30 day follow-up period which we often see happen for other medical care.	Kassie Ryan, R.N. Allina Health	Thank you for your comment and support of this measure. CMS will offer a review period prior to public reporting.
2019-02-05	Both the 7 and 30 days indicators are very appropriate measures for follow-up.	James McCreath, Ph.D. Trinitas Regional Medical Center	Thank you for your comment and support of this measure.

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2019-01-30	This is a measure commonly reported in the managed care world so it is not unfamiliar to me. Our goal is to provide all patients with referrals to outpatient follow up upon discharge. There are several challenges and barriers to patients actually attending those appointments within 7 or 30 days of discharge. As a hospital, some of those challenges are within our control, some we are able to influence, and others are entirely out of our control. While I am not opposed to the measure, I would be opposed to future plans to impact reimbursement based on these measures, particularly since many factors are out of our control. Of particular concern is that there may be limited outpatient follow up providers and appointments available to accept Medicare.	Christiana Paul, M.F.T., Sharp Mesa Vista	Thank you for your comment and support for the measure. We agree there are many factors beyond the control of IPFs that will affect the rates of this measure, including the local supply of outpatient behavioral health resources that accept Medicare and patients' own sociodemographic barriers; and that IPFs' influence on patient adherence to follow-up visits is limited. Although the measure rate is not expected to approach 100 percent, findings in the Draft Methodology Report included evidence to support that IPFs are able to influence rates of follow-up. The measure's intent is to inform IPFs' continuous quality improvement efforts to improve care by increasing measure rates. We will nevertheless reconsider the effect of factors that are out of IPFs' control on measure rates. Using quality measures to determine facility reimbursement would be a separate process beyond the scope of this effort.
2019-01-30	I believe that the hospital tries as much as possible to provide appointments for patients and resources, but there's limited availability in the community, so it is not always possible to have patients be seen within a week from discharge, or even a month.	J.A Avila, M.D., Overlake Hospital	We agree there are many factors beyond the control of IPFs that will affect the rates of this measure, including the local supply of outpatient behavioral health resources and patients' own sociodemographic barriers; and that IPFs' influence on patient adherence to follow-up visits is limited. Although the measure rate is not expected to approach 100 percent, findings in the Draft Methodology Report included evidence to support that IPFs are able to influence rates of follow-up. The measure's intent is to inform IPFs' continuous quality improvement efforts to improve care by increasing measure rates. We will nevertheless reconsider the effect of factors that are out of IPFs' control on measure rates.

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2019-01-30	We have a significant number of homeless clients in our population of mental health patients. Some are discharged to the Salvation Army or other agencies in our city/county while others return to "tent cities" or "under a bridge" or give false addresses. We have no way of contacting these clients unless they remain at the agencies (i.e., Salvation Army) for an extended time; however, many are evicted for behavioral issues. Therefore, follow-up is a major issue for this population. I understand the need for the follow-up but do you have suggestions for success in this population?	Veturia Yarbrough, R.N., Medical Center Atrium NavicentHealth	We agree there are many factors beyond the control of IPFs that will affect the rates of this measure, including the local supply of outpatient behavioral health resources and patients' sociodemographic barriers; and that IPFs' influence on patient adherence to follow-up visits is limited. Although the measure rate is not expected to approach 100 percent, findings in the Draft Methodology Report included evidence to support that IPFs are able to influence rates of follow-up. The measure's intent is to inform IPFs' continuous quality improvement efforts to improve care by increasing measure rates. We will nevertheless reconsider the effect of factors that are out of IPFs' control on measure rates.
2019-01-30	While I understand the necessity of appointments patients, it will be a difficult measure for Inpatient facilities to be held responsible. They can make the appointments, educate the patient and encourage them to follow up, provide transportation resources; however, they can not ensure the patients adhere to the instructions and show up to the follow up. Even having a case manager liaison between the hospital and outpatient care, does not ensure adherence. The information would be valuable, but to tie reimbursement or penalties seems unreasonable.	Sheree Whitley, R.N., UHS, Inc.	We agree there are many factors beyond the control of IPFs that will affect the rates of this measure, including the local supply of outpatient behavioral health resources and patients' own sociodemographic barriers; and that IPFs' influence on patient adherence to follow-up visits is limited. Although the measure rate is not expected to approach 100 percent, findings in the Draft Methodology Report included evidence to support that IPFs are able to influence rates of follow-up. The measure's intent is to inform IPFs' continuous quality improvement efforts to improve care by increasing measure rates. We will nevertheless reconsider the effect of factors that are out of IPFs' control on measure rates.

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2019-01-29	My concerns rest with data collection. If contacting the patient prior to 1st visit is essentially the numerator, areas that serve large populations with indigent, undocumented, or individuals without reliable communication will provide results that may not be accurate or useful.	James Lavin, R.N.B.C. STBHC	Thank you for your comment. Technically, the numerator is based on Medicare claims for visits that fit the numerator specification; however, we understand that contacting the patients to remind them of the upcoming appointment is generally a key step in getting them to keep the appointment. We agree there are many factors beyond the control of IPFs that will affect the rates of this measure, including the local supply of outpatient behavioral health resources and patients' own sociodemographic barriers (including poverty, unstable living situations, or unreliable means of communication); and IPFs' influence on patient adherence to follow-up visits is limited. Although the measure rate is not expected to approach 100 percent, findings in the Draft Methodology Report included evidence to support that IPFs are able to influence rates of follow-up. The measure's intent is to inform IPFs' continuous quality improvement efforts to improve care by increasing measure rates. We will nevertheless reconsider the effect of factors that are out of IPFs' control on measure rates.

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Th2019-01-29	Although we agree the patients do need the follow-up at 7 and 30 days we have no means to ensure the patient will actually follow up when we make appointments. we are also finding that many of the clinics no longer will schedule appointments and only take walk-ins especially if the patient is new to their system or have had several no shows for their appointments. We provide care to patients that live up to 5 and 6 hours away from our facility and finding a place for follow up is becoming more and more difficult.	Debra Ann Brodersen, M.S.N., M.H.A., Spencer Hospital	Thank you for your comment and support for the measure. We agree there are many factors beyond the control of IPFs that will affect the rates of this measure, including the local supply of outpatient behavioral health resources willing to accept patients, and patients' own sociodemographic barriers (including distance to the nearest source of care); and that IPFs' influence on patient adherence to follow-up visits is limited. Although the measure rate is not expected to approach 100 percent, findings in the Draft Methodology Report included evidence to support that IPFs are able to influence rates of follow-up. The measure's intent is to inform IPFs' continuous quality improvement efforts to improve care by increasing measure rates. We will nevertheless reconsider the effect of factors that are out of IPFs' control on measure rates.
2019-01-29	it is unclear if this is to be calculated by the number that was set up for follow up care vs, those that actually received the care. To calculate those that received the care would be very difficult and time consuming. Many areas are underserved for mental health and getting outpt appointments may be very difficult. Geriatric patients that receive care in nursing homes my not receive follow up for up to 30 days.	Karla Quinn, M.A., CenterPointe Behavioral Health System	Thank you for your comment. This measure is based on Medicare claims data, and thus on those who actually received the care, but no extra work is required of facilities to collect and submit data for the measure. We will reconsider the issue of patients discharged to skilled nursing facilities or nursing homes.
2019-01-29	The IPFQR since its inception has done very little in regards to quality measures. It has not made any recommendations or provided for any feedback whatsoever. It's a huge amount of data collection that has essentially resulted in nothing. In my opinion all that it has done is create another financial as well as work related burden to those that collect and submit the data. The proposed FAPH is yet another useless collection. It's common knowledge that psychiatric services are lacking in a number of areas ... further data collection will yet again serve no purpose. There should be more done on the creation of an adequate number of clinicians, reasonable reimbursement and other incentives that could result in quality care.	No information provided	Thank you for your comment. FAPH is a claims-based measure. There is no extra work required of facilities to collect and submit data for the measure. We understand there are concerns over the supply of behavioral health providers, and reimbursement and incentives for behavioral health facilities and providers, but policy considerations to address those issues are beyond the scope of this measure development effort.

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2019-01-29	I appreciate the new measure and it seems its intent is to highlight the critical shortage of outpatient psychiatric providers and providers. However the resources of the inpatient facility will be stretched even further with this new responsibility. How will this new initiative be funded- who will reimburse the hospital for this new initiative?	Tom Flanagan, L.C.S.W.	Thank you for your comment. The intent of the measure is to inform IPFs' efforts to improve rates of follow-up visits after discharge using the resources they currently have available, and as part of their continuous quality improvement. Because this measure is based on Medicare claims data, facilities will not have to put any extra work into collecting and submitting data for the measure. We assume that most, if not all, IPFs already have processes in place for discharge planning and the necessary staff to help patients with discharge planning. CMS currently has no plans for additional reimbursement to IPFs for case management or for data collection related to this measure. Thank you for your comment.
2019-01-28	No concerns	Melissa Hodges, A.P.R.N.-C.N.S., Premier Health	
2019-01-28	I feel it is very important for patients to follow up as soon as possible after discharge for continuity of care and patient success. However, it is difficult to have appointments within 7 days of discharge due to lack of community resources. This is increasingly difficult in rural areas, or with patients that do not have their own transportation.	No information provided	Thank you for your comment and support for the measure. We agree there are many factors beyond the control of IPFs that will affect the rates of this measure, including the local supply of outpatient behavioral health resources and patients' own sociodemographic barriers; and that IPFs' influence on patient adherence to follow-up visits is limited. Although the measure rate is not expected to approach 100 percent, findings in the Draft Methodology Report included evidence to support that IPFs are able to influence rates of follow-up. The measure's intent is to inform IPFs' continuous quality improvement efforts to improve care by increasing measure rates. We will nevertheless reconsider the effect of factors that are out of IPFs' control on measure rates.

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2019-01-28	I am greatly concerned about this addition of f/u care within 7 days and 30 days of discharge. Our goal is to inform the patient by making first f/u care apt, within 72-96 hours of discharge, and this is challenging. We can generally make a f/u care appt within 7 days, but that also includes "walk in" appts, which many of our community mental health centers have gone to. When the pt shows for their first appt, then subsequent appts are made. Most of the Behavioral Health providers/community mental health centers would not allow us to make 30 day after care appts. While I agree, in theory that this is a good idea - in the reality of practice, this would be difficulty, if not impossible to obtain - within our current community structure. Every patient leaves the Behavioral Health Unit with their first f/u appt. (unless the pt refuses care, then they are given information on crisis center/walk in hours at the local providers.) It would be helpful if CMS would consider the community providers, that are already taxed to provided f/u appts, and work well with the hospital in accessing the first appt - let alone trying to make the 30 day appt as well. Thank you for your time and consideration in this matter.	Sharon Guenther, M.S.W., L.I.S.W.-S Miami Valley Hospital	Thank you for your comment. The measure is based on Medicare claims, so the numerator is calculated from Medicare claims for visits that meet the numerator specifications, not appointments that have been made. If the standard practice in an area or health system is to make the initial post-discharge follow-up appointment for three to four days after discharge, then those appointments that are kept and for which a Medicare claim is submitted will appear in both the 7- and 30- day rates. If the patient makes a subsequent visit within the next 26 or 27 days, and a Medicare claim is submitted, then the second visit will be counted in the 30-day rate.
2019-01-28	We need the Unity Caring Contact (care manager) to be reimbursed for the work they are doing...Resources are strained and a billing code for reimbursement for calls made, connected and follow up to ensure the patients gets the care they need and is able to attend the appointment. Essentially, we need to support a Caring Contact dedicated (.5FTE) to the patient follow-up process and care coordination and without help from the government it will be challenging as we have to use internal resources already over worked.	Trevor W. McCaskill, M.P.H., Unity Behavioral Health Center	The intent of the measure is to inform IPFs' continuous quality improvement efforts to improve rates of follow-up visits after discharge using the resources they currently have available. Because this measure is based on Medicare claims data, there will be no extra work required of facilities to collect and submit data for the measure. We assume that most, if not all, IPFs already have processes in place for discharge planning and the necessary staff to help patients with discharge planning. CMS currently has no plans for additional reimbursement to IPFs for case management or for data collection related to this measure. Thank you for your comment. FAPH is a claims-based measure. There is no extra effort required of facilities to collect and submit data for the measure. CMS will calculate it by linking (1) Part A and Part B claims data that are received for payment by Medicare and (2) Medicare fee-for-service (FFS) claims submitted by IPFs and subsequent outpatient providers for Medicare FFS IPF discharges.
2019-01-28	It will be difficult to verify follow up care appointments that were kept for discharged patients without spending a considerable amount of time/labor by the discharging facility having to contact each referral source.		

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2019-01-28	I don't think that this measure will be feasible. We will be spending more time trying to get the yearly report done and I just don't see how we will have the time or personell to get it done correctly. It will be hard to get feedback on a timely manner.	Karen Lightsey, L.P.N., Appling Healthcare	Thank you for your comment. FAPH is a claims-based measure. There is no extra effort required of facilities to collect and submit data for the measure. CMS will calculate it by linking (1) Part A and Part B claims data that are received for payment by Medicare and (2) Medicare fee-for-service (FFS) claims submitted by IPFs and subsequent outpatient providers for Medicare FFS IPF discharges.
2019-01-25	A challenge for us is the unstable home environment for some folks in this population. How will this measure account for this?	Gayle Wakeley, R.N., Atrium Navicent Health	Thank you for your comment. We agree there are many factors beyond the control of IPFs that will affect the rates of this measure, including the local supply of outpatient behavioral health resources and patients' own sociodemographic barriers; and that IPFs' influence on patient adherence to follow-up visits is limited. Although the measure rate is not expected to approach 100 percent, findings in the Draft Methodology Report included evidence to support that IPFs are able to influence rates of follow-up. The measure's intent is to inform IPFs' continuous quality improvement efforts to improve care by increasing measure rates. We will nevertheless reconsider the effect of factors that are out of IPFs' control on measure rates.
2019-01-25	Very important measure because it will provide adequacy of follow-up after discharge and will determine whether payment is adequate or penalty should be applied to providers/organizations	No information provided	Thank you for your comment and support for the measure. The measure's intent is to inform facilities' continuous quality improvement efforts to improve measure rates. Using quality measures to determine facility reimbursement would be a separate process beyond the scope of this effort.
2019-01-25	1. How will this be measured- will outpatient providers be required to report to discharging facility. 2. Lack of out-patient providers.	Jane, BSN, R.N., B.C.	Thank you for your comment. FAPH is a claims-based measure. There is no extra effort required of facilities to collect and submit data for the measure. CMS will calculate it by linking (1) Part A and Part B claims data that are received for payment by Medicare and (2) Medicare fee-for-service (FFS) claims submitted by IPFs and subsequent outpatient providers for Medicare FFS IPF discharges.