AMERICAN PSYCHIATRIC ASSOCIATION

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August 21, 2017

Seema Verma, M.P.H.
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1677-P
P. O. Box 8011
Baltimore MD 21244-1850

Re: Medicare Program; CY 2018 Updates to the Quality Payment Program; Proposed Rule (CMS-5522-P, 82 Fed. Reg. 30010, June 30, 2017)

Dear Administrator Verma:

The American Psychiatric Association (APA), the national medical specialty society representing over 37,000 psychiatric physicians and their patients, would like to take the opportunity to comment on the 2018 proposed rule for the Medicare Quality Payment Program (QPP). Our comments focus specifically on issues that impact the care of patients with mental health and substance use disorders (MH/SUDs), particularly quality measurement for mental health services pursuant to the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs) considered in this proposed rule. We particularly urge CMS to address the following top priorities:

- **Support the Collaborative Care Model by deeming the APA's Collaborative Care training as a MIPS improvement activity and adopting incentives for Advanced Alternative Payment Models to offer Collaborative Care services;**
- **Adopt consistent standards for future MIPS program requirements, particularly the low-volume threshold for 2018 and beyond;**
- **Finalize the proposed MIPS advancing care information (ACI) hardship exemption for small practices;**
- **Recognize the unique circumstances of psychiatrists, which include their lack of access to appropriate EHR systems, the fact that many practice across multiple sites, as well as the fact that psychiatrists work with patients whose mental health does not easily show month-to-month improvements, unlike many physical illnesses; and**
- **Include in the final rule the various proposals designed specifically to decrease the administrative burden for MIPS eligible clinicians.**

The Centers for Medicare and Medicaid Services (CMS) estimates that the provisions outlined in this proposed rule will redistribute more than $173 million in budget-neutral payments within the QPP in payment year 2020— based upon reporting for 2018 (the second QPP performance year). In addition, there will be exceptional performance payment adjustments under MIPS of up to $500 million, and incentive payments to qualifying participants (QPs) in Advanced APMs of approximately $590 to $800 million. Overall, this rule will transfer more than $1 billion in payment adjustments for MIPS eligible clinicians and incentive payments to QPs in Advanced APMs.

THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

MIPS Low-Volume Threshold

APA commends CMS for its efforts to ease the administrative burden on psychiatrists and other Medicare practitioners who see few Medicare Part B patients. For the 2018 performance period, CMS proposes to raise the now-current 2017 low-volume threshold for MIPS eligibility, from no more than $30,000 in allowed charges or no more than 100 beneficiaries treated during the low-volume threshold determination period, to no more than $90,000 or no more than 200 beneficiaries. If a MIPS eligible clinician or group were to exceed one or two of the low-volume threshold criteria, they would have the ability to volunteer for MIPS reporting, but would not be subject to payment adjustments.

These levels could change again for the 2019 performance period. CMS also proposes that, starting with the 2019 performance period, individual MIPS eligible clinicians and groups who are excluded, but exceed one of the low-volume thresholds, would be able to opt in to MIPS and be subject to the MIPS payment adjustments.

Raising the low-volume threshold will exempt many more psychiatrists in small practices from MIPS reporting requirements and adjustments**. However, as with other proposed changes, it is crucial for CMS to designate predictable parameters for the MIPS low-volume threshold.** Psychiatrists and other clinicians are making decisions now that require devoting substantial resources and efforts. They need to be able to rely on a stable policy for the future. This is particularly true when they look to decide whether to adopt or update new electronic health record (EHR) systems, invest in staff to help with MIPS reporting, form virtual groups, or participate in qualified registries or qualified clinical data registries (QCDRs). Many psychiatrists are using the 2017 transition year to learn about the MIPS program and to see whether participation is worthwhile. The same is true for their consideration of whether to participate in APA's new mental health registry, PsychPRO, which has received designation as a QCDR.

These decisions are not to be taken lightly. Many MIPS eligible clinicians are likely to decide whether to become or to remain a Medicare provider, and then not revisit that decision again unless their practices change. If CMS were to lower the low-volume threshold levels in future years, there could be serious repercussions for beneficiaries' access to care. Some MIPS eligible clinicians would elect to opt out of Medicare, or to no longer see Medicare patients, rather than undertake MIPS participation and reporting in future years.

In addition, there is widespread belief that private payers are waiting for Medicare to set MIPS policies before they follow suit with adopting programs like MIPS. Consequently, future shifts in the low-volume threshold for the MIPS program could lead to similar future shifts in comparable programs adopted by private payers. This could seriously impact their future participation in such programs.

We strongly support CMS's proposal to allow clinicians who are below the MIPS low-volume threshold to "opt in" for full MIPS participation – including reporting, receiving MIPS scores, and most

importantly, qualifying for MIPS payment adjustments. We understand that CMS has graciously offered to allow these clinicians to do MIPS reporting and receive a MIPS score, so they can learn how they would fare in the MIPS program. APA is strongly encouraging its members to take full advantage of this opportunity to see how they are doing on MIPS quality performance metrics vis-à-vis their peers. Additionally, their situation may change in later years, and this could help ease their participation in other value based purchasing programs.

For the 2019 performance period, there might be a third low-volume threshold criterion: CMS is considering an as-yet-undefined "number of Part B items or services." This would potentially become another metric for determining MIPS eligibility. **APA recommends that CMS give more detail about how it might implement the "number of Part B items or services" as an exclusionary criterion. Unless this is balanced for the expected/typical/mean/median number of items or services provided by a specialty type, it has the potential to disadvantage psychiatrists and other who do not report items or services in multiple units or frequent visits.**

MIPS Virtual Groups

CMS is proposing to begin allowing MIPS reporting by virtual groups, starting with the 2018 MIPS performance year. The composition of virtual groups could be a combination of two or more a) solo practitioners (with distinct National Provider Identifiers, or NPIs) and/or b) groups with 10 or fewer eligible clinicians (with distinct Tax Identification Numbers, or TINs). At least one of the group's clinicians would have to be MIPS eligible. However, the MIPS adjustment would apply only to the MIPS eligible clinicians in the virtual group. A solo clinician would be able to join a virtual group if they were not otherwise excluded from MIPS, based on: being newly enrolled in Medicare, being a QP, being a partial QP, or being below the low-volume threshold. And, there would be no upper limit on the size of a virtual group.

APA agrees that virtual groups should be subject to the same MIPS policies as other groups. APA also agrees with the CMS proposal to give MIPS adjustments to each MIPS eligible clinician who participates as part of a virtual group, as is done with non-virtual groups. Virtual groups would be a benefit to small and rural clinicians. Because some psychiatrists are isolated geographically, they might not have enough contact with other psychiatrists in their immediate locale to form a virtual group.

APA is also pleased that CMS would allow virtual groups to form regardless of location or specialty. The benefits of forming a virtual group include the ability for geographically or specialty-diverse clinicians and practices to share the burdens and benefits of MIPS reporting, while drawing on each other's clinical and administrative strengths (e.g., the CMS Collaborative Care validated program). Members of groups and virtual groups would be currently assessed and scored at the group level across all categories, but the payment adjustments would be applied at the TIN/NPI level. A TIN that joins the virtual group (and is also part of an APM) during the performance year must send in performance data for all eligible clinicians associated with that TIN, including those in the APM, to be certain that all the TIN's eligible clinicians are measured under MIPS.

For virtual groups without participants in MIPS APMs or Advanced APMs, each MIPS eligible clinician would receive a MIPS payment adjustment based on the virtual group's combined performance assessment (combination of the TIN's assessment). MIPS eligible clinicians who are participants in both a virtual group and a MIPS APM would be assessed under each. However, they would receive a payment adjustment based only on the APM Entity's MIPS score. Likewise, eligible clinicians who are in a virtual group – but also a "qualifying participant" in an Advanced APM – would be excluded from the MIPS payment adjustment, and receive the incentive for being a QP in and Advanced APM.

Stage 1 of the virtual group election includes having a designated virtual group representative send basic identification information to CMS prior to the 2018 performance period (that begins January 1, 2018):

- Each TIN associated with the virtual group;
- Each NPI associated with those TINs;
- Affiliation of the virtual group representative to the virtual group;
- Contact information for the virtual group representative; and
- Confirmation that a formal written agreement has been completed between each member of the virtual group.

Stage 2 involves the eligibility determination. A potential virtual group could request an eligibility determination before beginning to develop formal agreements of group participation. If a potential virtual group were to begin the election process at Stage 2, and if its TIN size is determined not to exceed 10 eligible clinicians and is not excluded based on the low-volume threshold exclusion at the group level, then the group would be determined eligible to participate as a MIPS virtual group. Its virtual group eligibility determination status would be retained for the duration of the election period and applicable performance period.

CMS would use claims information to determine whether each NPI is eligible for the MIPS group; then CMS would e-mail the virtual group representative about the agency's decision. **APA has concerns about the use of email for such an important notification; emails frequently go unnoticed by the recipient or are not received because the recipient's address has changed. Such notice should be sent via postal mail, and made available on a secure website.** Virtual groups must re-register with the QPP Service Center before each performance period. **APA suggests, to reduce administrative burden, that returning virtual groups be allowed to simply verify and/or update their existing registration information for reporting periods beyond the initial year of participation as a virtual group.**

The proposed rule discusses that if a TIN within a virtual group were acquired or merged with another TIN, or is no longer operating as a TIN during a performance period, the virtual group would continue with the remaining TIN(s) or NPI(s). It is possible that could result in a virtual group of one practitioner who would report as a virtual group. (The rule also proposes that when the virtual group TIN/NPIs move to an APM, CMS would exercise its waiver authority so that it could use the APM score instead of the virtual group score.) **APA recommends that CMS treat the virtual group-of-one as a solo practitioner if the departure occurs before the midpoint of the year. After the midpoint, the lone practitioner would remain designated as a virtual group for the remainder of the year.**

MIPS Definitions of "Small Practice" and "Group"

CMS defines a small practice as one with 15 or fewer clinicians, including solo practitioners. In the 2017 final rule, CMS stated that it would have small practices attest to the size of their group practice, at the beginning of the performance period. CMS now proposes to replace attestation with a claims-based determination, using a prior 12-month claims data collection period. For 2018, small practices would be identified based on claims data collected between September 1, 2016 and September 30, 2017 (including the additional 30 days for receipt of claims). **APA appreciates the CMS effort to improve its small practice identification process by using claims-based determinations rather than attestation. Giving practices the ability to prepare for the performance period as a small or non-small practice provides them more time to adjust their resources.**

CMS also plans to clarify that a group could be an entire single TIN. Or, it could be the portion of a TIN that participates in MIPS, chooses to participate at the MIPS group level, and is scored on the applicable criteria – while the rest of the TIN participates in a MIPS APM or Advanced APM.

Multiple MIPS Submission Methods

CMS proposes to change its policy of allowing only one submission mechanism for each performance category. For performance years 2018 and beyond, CMS proposes to allow individual MIPS eligible clinicians and groups to submit measures and activities through multiple submission mechanisms within a performance category as available and applicable to meet the requirements of the quality, improvement activities, or advancing care Information performance categories. **APA supports this change and appreciates CMS's efforts to be more flexible.**

MIPS Performance Period Dates

For MIPS payment years 2021 and beyond, the quality and cost categories' performance periods would continue to be January 1 through December 31, in the two years before the applicable payment year (e.g., the 2018 performance period would be January 1, 2018 through December 31, 2018 for payment adjustments in 2020). For the improvement activity and advancing care information categories, CMS proposes performance periods for only payment year 2021. The 2021 performance period would be a minimum 90-day continuous period within the calendar year, in the two years before the applicable payment year, up to and including the full calendar year 2019.

MIPS QUALITY PERFORMANCE CATEGORY

MIPS Quality Measure Performance Reporting Criteria

APA appreciates CMS's goal of providing "meaningful" or "applicable" quality measures for participant use in all its quality programs. MIPS quality data collection is valuable and highlights patient and provider needs (i.e., establishes where increased access is needed, informs allocation for federal funding, identifies rate of practice for evidence-based care, elucidates how the exceptional performers are providing the highest quality care at low costs, etc.). To continue to demonstrate its benefit and increase the number of enrolled psychiatrists in Medicare, MIPS administrators must understand the hurdles psychiatrists experience when they attempt to identify six "meaningful" or "applicable" quality measures that can be reported on at least 50 percent of their eligible practice, and include at least one outcome or high priority measure. Given these difficulties, there is a limited likelihood for them to earn bonus points for this performance category.

APA remains concerned that CMS does not recognize the limited number of quality measures available to psychiatrists. Many APA members who plan to participate in MIPS are frustrated by the expectation of meeting the six-quality measure reporting criteria. To attempt to meet these criteria, they must use more cross-cutting quality measures than do other eligible clinicians. We do not mean to imply that no MIPS quality measures hold "meaning" or "applicability" to the patient or the psychiatrist. However, the cross-cutting measures that psychiatrists *can* use often do not equate to measures they *should* use.

As an example, a behavioral health appointment is best spent discussing the patient's current psychiatric or substance-related problem. However, due to the six-quality measure criteria imposed by the MIPS quality performance category, the psychiatrist spends a portion of the limited appointment time asking the patient whether they have had an influenza vaccine or a pneumonia vaccine. This is completely inappropriate when the health issue that the psychiatrist should address is not impacted by an influenza or pneumonia vaccine. In this case, according to MIPS, these are the measures "appropriate" for psychiatrists' use. Measurement for measurement's sake is a waste of data collection, and of the psychiatrist's and patient's time. It enforces a poor administration of care and is not in the scope of "meaningful" quality measurement — a foundation of MIPS.

APA appreciates that there are cross-cutting and behavioral health quality measures that various psychiatrists can use in their practice; however, not all psychiatrists can use all the available quality measures. **APA recommends that CMS administrators better identify measure appropriateness.** Although it might be appropriate at times to ask patients about medical history items such as vaccinations, the measures applicability determination process should include deliberation, rather than strict code review.

With the recently developed APA mental health registry, PsychPRO, still in its initial year, it is still evolving as a tool for quality measure development. However, we anticipate that with its growth there will be an emergence of additional "meaningful" quality measures. Until this time, **APA requests that CMS not assume that all MIPS quality measures available to psychiatrists are "meaningful" or "appropriate." For psychiatrists, they frequently do not enrich physician practice, patient outcomes, or provide robust data descriptive of the care administered.**

MIPS Quality Measure Updates

APA supports the continuity of quality measures over MIPS program years, as well as limited and necessary updates. This provides psychiatrists with expectations and promotes stability in quality reporting. We suggest that CMS promote limited changes to the available MIPS quality measures. However, we do understand that measures affected by changes in evidence and/or care delivery, and problematic measures yielding unintended negative consequences, must be removed and replaced with others to prevent gaps in care.

APA supports the CMS proposal to maintain, or retire and replace, the quality measures that focus on dementia care management. Please be advised that the dementia care measures currently listed in the proposed rule incorrectly cite the American Academy of Neurology (AAN) as sole stewards. We request a correction to this error, in the final rule. APA and AAN equally share stewardship responsibilities for these measures, including the recent update project. The quality measures requiring a correction of the stewardship are presented below.

Quality Identification Numbers	Quality Measures Failing to Reflect Co-Stewardship by American Psychiatric Association & American Academy of Neurology
282	Dementia: Functional Status Assessment
283	Dementia: Neuropsychiatric Symptom Assessment
286	Safety Concern Screening and Follow-Up for Patients with Dementia
288	Dementia: Caregiver Education and Support

- APA agrees with CMS's proposed removal of dementia care management quality measures which co-stewards APA and AAN have retired, as those are replaced with the new and updated measures that better meet this gap area. APA supports the changes made to update Measure 286: *Dementia: Caregiver Education and Support.* As stated in the update rationale, "These changes were made to reflect a more comprehensive assessment from which the results may provide additional insight about the patient's condition and alterations needed in the treatment plan, therefore making this a more robust measure." Although outcomes quality measures are prioritized in MIPS, patients with this condition do not have achievable outcomes as identified for those diagnosed with this degenerative condition. This process measure will improve communication between care providers and the patient treatment team, thereby improving patient quality of life, while also helping to identify changes in patient condition.

- APA supports the proposed changes to quality measure #283: *Dementia: Neuropsychiatric Symptom Assessment* and the removal of quality measure# 284: *Management of Neuropsychiatric Symptoms*. The proposed updates to quality measure #283 (that include the assessment of neuropsychiatric symptoms plus depression screening and the management of those symptoms) result in a more robust measure from which richer quality data can be extracted. By collapsing the formerly two quality measures into one, we anticipate reduced data collection and reporting burden.

- APA is pleased with changes to the PCPI stewarded *Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention* (Quality ID 226). The changes made to this measure, while requiring users to collect an increased amount of data (three distinct elements, instead of a nondescript single element), will reveal potential gaps in care and how performance can be improved to diminish those gaps, as they apply to tobacco users. APA also welcomes the addition of several measures to the 2018 Mental/Behavioral Measure Set. We support the proposed inclusion of extant quality measure #374: *Closing the Referral Loop: Receipt of Specialist Report*, not only for being added to the specialty set, but for also specifying that the measure may be submitted in an alternate method, via registry. This additional data submission mechanism will increase the number of psychiatrists able to submit performance data on this high priority quality measure.

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS, a vendor accessible survey, has 12 Summary Survey Measures (SSMs) that patients use to report on the care received within a group practice of at least two eligible clinicians. APA understands that two of 12 SSMs are recommended for removal from MIPS, due to low reliability and duplication of the survey questions, to promote alignment with other CMS quality programs. **APA recommends that psychiatrist groups using the CAHPS for MIPS survey should be allowed to continue to collect the**

data on the two SSMs removed from the scoring process, as this data informs internal quality improvement efforts. **We request that CMS communicate with the CAHPS for MIPS vendors to maintain these two measures, but exclude them from MIPS scoring.**

- APA's PsychPRO is among the first quality registries developed by medical organizations to collect patient-reported outcomes, particularly through a patient portal. This feedback is necessary to inform psychiatrists' understanding of desired treatment outcomes. In that vein, we support the concept and efforts of the Agency for Healthcare Research and Quality (AHRQ) via the beta version of the CAHPS Patient Narrative Elicitation Protocol. However, before commenting on its possible inclusion for future MIPS quality reporting, APA requests to review the five open-ended questions that make up this version of the CAHPS, and/or its scientific test results.

MIPS Quality Data Collection, Data Completeness, and Benchmarks

APA supports the proposed quality measure data collection criteria for the 2018 performance year. We appreciate the CMS proposal to update the 2017 final decision to increase the data completeness criteria prescribed by the data collection mechanism. We agree that the slow integration of programmatic changes, following the 2017 transition year, is necessary. With eligible clinicians expected to attempt full participation in the 2018 performance year, we support maintaining the data completeness criteria at 50 percent of *total patients* meeting the quality measure numerator for eligible clinicians using an EHR, QDR, QCDR, or claims reporting. We also support keeping these criteria for claims reporting at 50 percent of *Medicare Part B eligible patients who fit the measure denominator.* Maintaining continuity in these requirements will increase the rate at which the measures are correctly submitted, so that CMS and eligible clinicians will have a more accurate picture of quality care.

APA previously supported the 2017 MIPS final rule provision that "MIPS eligible clinicians would receive between 3 and 10 measure achievement points for each submitted measure that can be reliably scored against a benchmark, which requires meeting the case minimum and data completeness requirements." This floor assured that participating psychiatrists earned achievement points, even on quality measures for which they did not anticipate poor performance. This floor is available only on quality measures used for benchmark comparison scores and for quality measures assigned to the CMS Web-Interface reporting mechanism (available to groups of more than 15 clinicians), when performance is below 30 percent. Based on MIPS "Pick Your Pace" for the 2017 performance year, psychiatrists who were successful by limiting their participation to submitting data on a single quality measure might not anticipate poor scores in their performance during the 2018 reporting period. Additionally, it is unlikely they will have historical data to provide benchmark comparisons that will impact the 2020 payment year.

Given the reduced benchmark data due to the "Pick your Pace" participation options from the 2017 MIPS transition year, **APA recommends that CMS continue to assign a 3-point minimum floor to all quality measures in the quality performance category.** This will allow new participants in MIPS or past participants who limited their activity to the "one measure, one time" option in the "Pick Your Pace" reporting, to earn historical data in the 2018 performance period and receive future benchmark scores. Also, by retaining the 3-point floor, these participants would still earn measure achievement points, if they experience unexpectedly low performance during their first full participation year (2018).

MIPS Quality Improvement Scores

APA appreciates that the MIPS program can provide psychiatrists with the ability to review their performance against other psychiatrists and the national performance standards. Moreover, the MIPS quality performance category scores and related data act as a report card for eligible clinicians. The ability to review personal quality performance over time can help psychiatrists identify treatment areas in which they might like to become more adroit. APA views the improvement activity score as essential to the MIPS quality performance category. Considering the great effort psychiatrists make to ensure they provide quality care to their patients, they value the ability to compare their performance from year to year, on quality measures that provide significance to their patients and their practice.

APA agrees that continuous participation from year to year not only enriches the quality of the data in MIPS, but strengthens eligible clinicians' ability to improve their administration of quality care. Furthermore, improvement score assignments within the quality performance category rely on eligible clinicians' continued participation. If the proposed recommendation that eligible clinicians use the same numeric identifier for at least two consecutive performance years were finalized and then used as a method to track and assign quality measure comparison scores, it would be reasonable to consider the automatic assignment of an improvement score percentage floor. The proposed rule suggests that the floor would equal an automatic 30 percent improvement score assignment. However, considering the number of quality measures on which psychiatrists are required to report, and that many of the quality measures provide little or no value to the care provided to their patients, an automatic assignment of at least 30 percent for their improvement score is the minimum that should be assigned.

Psychiatrists' practice settings generally vary much more than those of other physicians. As such, their TINs also vary as they move to different treatment sites, but their NPIs remain the same for the length of their career. Considering the infrequency of the change in psychiatrists' NPIs, we think it is unnecessary to require psychiatrists to use the same numeric identifier, for two consecutive years, to earn an improvement score. **APA recommends that CMS use the individual clinician's NPI as a simplified means of tracking improvement scores and internally (within CMS) promoting the continuity of participation benefiting the MIPS quality data collection.**

Facility-Based Measurement for MIPS Quality and Cost Performance Categories

APA is concerned about the potential for the MIPS facility-based measurement method (for cost and quality) to give an edge to those who participate in facility-based measurement over non-facility-based solo practitioners or groups. Facility-based measures could disadvantage psychiatrists who treat patients in multiple facilities, if the criteria CMS uses to identify them as such are flawed. Potential problems related to the CMS facility-based eligible clinician determination include the unintentional exclusion of actual facility-based clinicians, who might be misclassified due to poor facility attribution. Other inequitable advantages for facility-based clinicians are:

- If finalized for the 2018 performance year, this method of MIPS participation should provide an increased number of quality measures for data submission. Currently, the quality measures available to those designated as facility-based eligible clinicians exclude many medical specialties,

including psychiatry. Not only does this cost and quality performance category participation method put facility-based eligible clinicians who can participate in this method at a greater advantage than non-facility-based eligible clinicians, but it also disadvantages those who fit the criteria for facility-based eligible clinician but who do not have measures available to them.

- It is a concern that in the proposal for a facility-based eligible clinician to choose to participate in both MIPS and the facility-based measurement option, CMS would select the measures with the highest scores to assign their quality performance category score. This has the potential to reward facility-based clinicians with higher quality performance category scores (at a proposed 60 percent of the total MIPS score for 2018) at a higher rate. It is troubling that the MIPS program would automatically shift the positive payments toward the facility-based clinicians, even though their own MIPS quality measures show they are not providing quality care meriting their positive payment adjustment in the facility setting.

- Furthermore, not only does APA have concerns with this method of participation for the above stated reasons, but also with the step that would permit facility-based eligible clinicians to review data from the Hospital-Based Value Payment Program (HBVPP), the program from which the quality and cost measures related data originate, before they decide to use this method, does not present them with any risk. In other words, these eligible clinicians are advantaged by either choosing to submit data previously collected, that illustrates high quality care, or opting to participate in the original quality and cost performance categories, because the data reviewed demonstrated a lower provision of quality care. Not only can these eligible clinicians choose original MIPS participation, but they can also benefit from the minimum floor allowances, and other protections that non-facility-based eligible clinicians are allowed.

APA recommends measurement procedures that include some degree of risk for eligible facility-based participants. For example, limited time periods for the eligible facility-based eligible clinician to view HBVPP data could occur after the performance year, rather than at the start of the year. This method could allow the eligible facility-based eligible clinician to participate in MIPS quality measure data collection and submit it at the close of the year like everyone else, and/or view the HBVPP data to decide whether to submit through the facility-based measurement option. This method at least ensures that if a facility-based eligible clinician does not plan to rely on the unknown quality data collected in the HBVPP, they will make the effort to provide and collect quality care data. **In accord with our concerns about the current details of this method, we recommend CMS implement this very carefully to avoid unfairly disadvantaging psychiatrists who practice either in multiple facilities or in no facilities.**

Multiple Mechanisms for Reporting MIPS Quality Measures

Under the proposed rule, beginning with the 2018 performance period, eligible clinicians could report quality measures using multiple reporting mechanisms. For 2017, psychiatrists could only report using a single reporting method – potentially leading to failure on the data completion or case minimum criteria. By proposing that participating psychiatrists submit quality measure data through multiple data reporting mechanisms, CMS increases the opportunity for psychiatrists to achieve higher scores in this performance category, as well as earn an improvement score for future program years.

While this proposed change can increase the number of "meaningful" MIPS quality measures available to various eligible clinicians, APA continues to have concerns about the measure appropriateness determination process and its relationship to the various quality measure data submission mechanisms. If a psychiatrist submits some quality measure data through claims and others through an intermittently accessible qualified data registry (QDR), and still does not meet the data completion criteria, that psychiatrist would be subject to the CMS applicability process for eligible measures. If the process determines that the psychiatrist "should" have been able complete a QDR measure, the psychiatrist would be subject to lower measure achievement points. The process, as proposed, would miss the fact that the QDR is not reliably accessible to the psychiatrist. We request that CMS overhaul the quality measure applicability process by making it a deliberative process, and include the eligible clinician as a collaborative partner, rather than a determination which is based on codes and lacks consideration for therapeutic appropriateness.

APA supports the proposal to allow MIPS eligible clinicians to use a different reporting mechanism for each performance category during a single reporting period. **We request that CMS finalize the ability to report quality measures utilizing multiple data submission mechanisms, and that the measure applicability process recognize truly "meaningful" and "applicable" quality measures, rather than penalizing psychiatrists for submitting a reduced number of quality measures. MIPS administrators may interpret some quality measures to present meaning, applicability, or appropriateness to psychiatry practice, but some of those quality measures are actually disruptive and create barriers to quality psychiatric care.** Considering the possibility for eligible clinicians who choose the multiple data submission methods proposed, we support the concept of eligible clinician measure achievement points being tabulated based on the measures submitted on performance that earns the highest possible measure achievement points. Table 25 intends to explain the mathematics used to determine total measure achievement points and bonus points assigned for individual MIPS participants who submit quality measures across multiple submission mechanisms. **APA questions the CMS computation in this table. Based on our calculations, the total available measure achievement points should equal 36.6, not 35.6 as shown in the table. If the correct result is 35.6, we request a more detailed explanation of the calculation.**

"Topped-Out" MIPS Quality Measures

CMS defines "topped out" measures for each quality measure domain in MIPS (e.g., process, outcome, or patient experience survey). A "topped-out" measure is described as a quality measure where most eligible clinicians perform at or very near the top of the decile distribution for that measure, leaving little or no room for the majority of MIPS eligible clinicians who submit the measure to improve their own performance. APA has concerns with the method CMS proposes for identifying "topped out" measures. The language used to describe a "topped out" measure is not standardized across public and private quality programs, nor is it standardized within the MIPS quality program categories. **APA recommends CMS use a consistent method to identify "topped out" measures for all its quality programs.**

Identifying a quality measure as "topped out" based on what appears to be an arbitrary choice of quality reporting success—without describing the cause for the success – could be very harmful to the program and to the patients that it serves. For instance, when reporting rates of a process measure show that users are in the 95th percentile for compliance, that could be attributed to the fact that the quality

measure is actively being measured ("what gets measured, gets done"). Retiring "topped out" measures from the quality reporting programs could result in a decline of what is being measured. That is a serious concern when the process being measured contributes to positive health outcomes.

APA supports the assignment of measure achievement points to eligible clinicians who report their performance on "topped out" measures, before they are removed from the quality performance category. Psychiatrists often report quality measures that CMS would begin to identify as "topped out" because those measures are available to report with ease (e.g., cross-cutting claims measure, such as a tobacco use screen). If the eligible clinician attempts to achieve the reporting of six quality measures, including an outcome or high priority measure, "topped out" measures may be the only option that are available to the eligible clinician. Assigning a three-point floor, with an earning cap of up to six points allowed toward the eligible clinicians "total measure achievement points," earned by reporting "topped out" measures, is a reasonable points assignment.

APA recommends that CMS further examine the mechanisms that assist in determining when a measure is "topped out," before arbitrarily assigning this status, capping the permitted achievement points, and before summarily retiring otherwise good quality measures, even when staged over several performance years.

MIPS COST PERFORMANCE CATEGORY

For the 2018 performance year, CMS proposes to again reweight the cost performance category to zero percent, to give clinicians more time to familiarize themselves with cost performance measures; without agency intervention, the category weight would be 10 percent. The agency plans to develop more episode-based measures during 2018. The result would be that MIPS clinicians and groups would be spared the cost category in performance years 2017 and 2018—and 2019 would be the first performance year when the cost category is assessed and would immediately become weighted at 30 percent (statutorily required) of the total score. CMS states that it has heard from public comments that clinicians are satisfied with the jump from zero percent to 30 percent, without a ramp-up period. As stated above, APA agrees with the CMS proposal to retain the zero weight in the cost category for the 2018 performance year.

APA appreciates the proposal to weight the cost performance category at zero percent for this second MIPS program year. CMS is providing itself and psychiatrists a benefit by requesting feedback on the scoring methods applicable to this category in this proposed rule. If CMS decides to finalize the cost performance category score weight at zero percent, MIPS administrators should apply the cost measures to the cost data submitted. This will permit those who participate in the 2018 MIPS performance year to learn what their cost performance category score *would* have been, and how it *would* potentially have impacted their 2020 payment.

If CMS were to provide the scores for the 2018 performance year when the 2019 performance year arrives (presuming the cost performance category for 2019 will be weighted), psychiatrists who receive their 2018 cost score would be better prepared to make changes that could positively impact their resource use during the 2019 performance year, allowing them an increased the opportunity to earn a

higher cost performance category score in the 2019 performance year and creating benchmark data for future cost improvement scores.

APA appreciates that there are differences between the proposed scoring methods applied to the cost performance category and quality performance category. While the quality performance category derives the improvement score from performance category level data (since it relies on the psychiatrist's choice, their quality measure selection can change each year), the cost performance category extracts its improvement score from measure level data, since the same cost measures are planned to be used on the same psychiatrist numeric identifier (i.e., TIN/NPI) each year.

MIPS Cost Improvement Scores

CMS should not finalize the proposed recommendation that would require psychiatrists to use the same numeric identifier for at least two consecutive years to earn an improvement score. Psychiatrists treat patients in a variety of settings, with an ever-changing percentage of time spent at each setting. Consequently, their identifier codes could change more frequently than every two years. This variation in numeric identifiers could prevent or confound improvement score assignments for this performance category for multi-site practitioners. Cost measures should be applied to accurately measure the resource use by these psychiatrists, without inadvertently penalizing them for using an increased amount of resources in different treatment settings.

Psychiatrists' practice settings, for which they bill Medicare Part B, generally vary more than other physicians. Psychiatrists treat a diverse patient population, which often requires a disproportionate allocation of financial resources to provide high quality care. Considering that psychiatrists can practice in multiple sites in a given week, they might not treat the same patient population on a day-to-day basis, as other physicians who treat in a single setting as it applies to billing Medicare Part B. For instance, during a portion of a day or week, a psychiatrist can treat patients at a community-based mental health treatment facility and in a psychiatric private practice. The portion of the patients seeking care at the community-based facility might also rely on the psychiatrist to act as their primary care provider, while the same is not usually the case in the psychiatric private practice setting. When acting as the patients' primary care provider at the community-based facility, these multi-site practitioners are more likely to bill Medicare Part B for treatment services than if they were in an alternate treatment setting. When providing care at these two varied settings, the psychiatrist will utilize their NPI, but not necessarily the same TIN, to designate the care they provided during the encounter.

APA welcomes discussion of methods that will ensure psychiatrists with multiple practice sites are not inadvertently awarded poor cost performance category scores, when these eligible clinicians are not correctly identified as facility-based and therefore are unable to take advantage of this performance reporting method.

In addition, psychiatrists experience high variation among the patients they treat and the resources used for the different populations. Because of this, the cost improvement scores could yield unanticipated poor performance. This disparity among settings and patient populations could inadvertently impact the psychiatrist's year-to-year cost achievement scores and improvement scores, creating the potential for cost performance category administrators to misconstrue the variation among achievement scores.

Given these potential problems related to the cost measure scores, for this physician population, we support a 30 percent improvement score automatic assignment. APA agrees that cost performance category participants must fully participate by meeting all the data collection criteria, to earn a cost improvement score.

MIPS Cost Measures and Attribution

The agency is not proposing to adopt the 10 episode-based cost measures from the 2017 MIPS performance period. CMS is not proposing changes to the cost category's payment standardization, risk adjustment, or specialty adjustment methodologies for the Medicare Spending per Beneficiary (MSPB) or Total Per Capita Cost measures. CMS proposes to maintain the case minimums of 35 for the MSPB measure and 20 for the Total Per Capita Cost measure.

In the proposed rule, the agency indicates that new episode-based cost measures which are being developed for the cost performance category, would be greatly improved by extensive stakeholder input. APA agrees and nominated a psychiatrist to serve on the Neuropsychiatric Disease Management Clinical Subcommittee, which has been tasked with the development of measures that focus on mental and behavioral health, and related attribution and risk adjustment.

According to the proposed rule, CMS would stop providing cost measure performance feedback on the existing 10 episode-based measures, after 2017. The agency cites the ceased maintenance of these measures, plus the negating effect of new procedure and diagnostic codes. Although the payment calculation for 2020 would not include episode-based measures, during that period CMS would provide clinicians with confidential feedback on their performance in newly developed episode-based measures, so that they become familiar with the episode-base concept as well as the specific episodes that could be used in future calculations. Any feedback generated in the summer of 2018 would be only for the clinicians for whom CMS can calculate the claims-based data for scoring.

APA appreciates CMS's efforts to provide timely and actionable feedback to MIPS clinicians. However, the lack of feedback in years subsequent to 2018 would leave new MIPS participants without the feedback resource needed to increase their chances of success on the previously unscored cost performance category. CMS should reconsider and continue to provide feedback beyond 2018—with the knowledge that many clinicians have yet to participate in MIPS.

CMS plans to post the operational list of episode measures and patient condition groups in December 2017. **APA notes that it is imperative that CMS post the list no later than the stated target date. Any delay would disadvantage those who wish to fully participate in the program.**

CMS proposes to include the Total Per Capita Cost measure (previously used in the Value-Based Modifier program) for the 2018 and future MIPS performance years. A provider would need at least 20 cases for the measure to be applicable. To calculate attribution in this measure, CMS basically identifies the attribution clinician by TIN. Then, all Part A and Part B payments for the clinicians' patients are added together. The result is then divided by the number of attributed patients. The result is the *total per capita cost.*

> *(Part a Payments to Provider TIN X + Part B Payments to Provider TIN X) / (# Attributed Beneficiaries) = Total Per Capital Cost*

APA members have expressed concerns about the possibility that they may be attributed costs that their patients may be incurring, for care that is not related to treatment of their mental or substance use disorders. We urge CMS to be vigilant in preventing this from occurring.

MIPS IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY

CMS is proposing to add several new MIPS improvement activities starting with the 2018 performance year. **APA commends CMS for its proposal to add a new activity, IA_PSPA_XX, for *CDC Training on CDC's Guidelines for Prescribing Opioids for Chronic Pain*.** This is an important step in encouraging MIPS eligible clinicians to participate in this important training. We support addition of IA_AHE_XX, *MIPS Eligible Clinician Leadership in Clinical Trials or CBPR*. There are a significant number of psychiatrists working on research regarding MH/SUDs, and this will encourage those who also have a clinical practice to participate in MIPS. Finally, we support addition of IA_AHE_XX, *Provide Educational Opportunities for New Clinicians*, and IA_BMH_XX, *Unhealthy Alcohol Use for Patients with Co-occurring Conditions of Mental Health and Substance Use and Ambulatory Care Patients.*

APA Collaborative Care Training

APA strongly urges CMS to officially designate the Collaborative Care Model training provided by APA's Transforming Clinical Practice Initiative (TCPI) Support and Alignment Network grant as a MIPS improvement activity, either as a separate activity or as meeting the requirements for an existing or newly proposed activity. It would be extremely helpful for our efforts to train and recruit physicians in the Collaborative Care Model, to have that training be designated for credit as a MIPS improvement activity. This would encourage primary care physicians and psychiatrists to undertake this training, which in turn will help disseminate and encourage adoption of the model, as well as providing improved care to the patient enrolled in the program.

Through the CMS TCPI, the APA's Support and Alignment Network is training 3,500 psychiatrists and 300 primary care physicians in the "Collaborative Care Model" and connecting them with Practice Transformation Networks across the country. This is an integrated care model that integrates effective psychiatric care into primary care practices. **We commend CMS for recognizing this model and moving the health care field forward on collaborative care.** It is the only model with a clear evidence base and has been tested in more than 80 randomized controlled trials.

Initially, we believed that this training would meet the requirements of the MIPS improvement activity which was approved for use starting with the 2017 performance year, designated as IA_CC_4, "Participation in the CMS Transforming Clinical Practice Initiative." CMS had provided no specific details or established any specific requirements for this activity.

We posed the training question to the CMS Quality Payment Program Helpline for clarification and to ensure that our interpretation was correct. The Helpline staff could not answer this question, and so reached out to CMS staff. It was then communicated to us that CMS staff did not believe that the TCPI Collaborative Care Model training would meet the requirements for this activity. Unfortunately, we received that response after the open call deadline for submitting new activities to CMS for potential consideration and adoption starting in 2018. (The "MIPS Validation Criteria 2017" was recently added to the Resource Library on the QPP website.) Likewise, there was no mention of our request in the 2018 proposed rule.

CMS has recognized the value of the Collaborative Care Model in several ways. In addition to APA's TCPI grant, CMS adopted new billing codes and Medicare reimbursement for services based on the Collaborative Care Model, which took effect on January 1, 2017. In the 2018 Medicare Physician Fee Schedule proposed rule, CMS has proposed to adopt a new code and payment allowing federally qualified health centers (FQHCs) and rural health centers (RHCs) to separately bill for collaborative care services. This is only the second category of services for which FQHCs and RHCs will receive separate payment, in addition to their bundled rate (AIR); the other being a group of chronic care coordination and behavioral health integration services.

Under the MACRA, CMS clearly has wide discretion to develop policies defining MIPS improvement activities as well as discretion to develop procedures for accepting suggestions for add new activities and refining existing ones – including allowing exceptions to any deadlines. **CMS should exercise that discretion and take this important opportunity to encourage primary care physicians and psychiatrists to work together under the Collaborative Care Model, by granting such training status as a MIPS improvement activity.** This training truly represents a "clinical practice improvement activity" that will enhance behavioral health integration, improve patient access and outcomes, reduce costs, and raise the quality of care for the millions of patients who receive their mental health care through primary care providers.

APA Performance Improvement Projects

APA also urges CMS to approve the APA's Performance Improvement Projects (PIPs) as MIPS improvement activities. APA also made this request as part of our response to the open call for new activities, and CMS did not address these activities in the proposed rule. We note that it is also possible that the PIPs may qualify for the activity CMS is proposing in the rule, IA_PSPA_XX, *"Completion of an Accredited Safety or Quality Improvement Program:"*

> **Completion of an Accredited Safety or Quality Improvement Program**
> Description: Completion of an accredited performance improvement continuing medical education program that addresses performance or quality improvement according to the following criteria.
>
> 1. The activity must address a quality or safety gap that is supported by a needs assessment or problem analysis, or must support the completion of such a needs assessment as part of the activity;
> 2. The activity must have a specific measurable aim for improvement;
> 3. The activity must include interventions intended to result in improvement;
> 4. The activity must include data collection and analysis of performance data to assess the impact of the interventions; and
> 5. The accredited program must define meaningful clinician participation in their activity, describe the mechanism for identifying clinicians who meet the requirements, and provide participant completion information.

APA requests that CMS specify the type of data collection and analysis that would be required under #4 above. Would be sufficient for a specialty society to provide the CME, and then collect data through its qualified clinical data registry, on MIPS or QCDR quality measures that measure

performance on services that the CME was designed to improve? Or must the individual performance of the CME participants be directly measured?

Unfortunately, the requirements for many MIPS improvement activities are difficult to discern at times, even after reviewing the documentation requirements CMS has posted to the QPP website. **We urge CMS to provide additional further clarification and definitions for MIPS improvement activities in general, and widely publicize their availability.** It is difficult for most clinicians who are seeing patients and addressing all the documentation regulations from their health care systems and CMS, to contact the QPP Helpline and then await further instructions from CMS staff, every time they have a question about an improvement activity. Moreover, such questions would quickly overwhelm the Helpline.

MIPS ADVANCING CARE INFORMATION PERFORMANCE CATEGORY

The advancing care information (ACI) performance category assesses the use of electronic health records (EHRs), and accounts for 25 percent of each clinician's MIPS composite score. Under the proposed rule, half of the ACI score will be from a "base" score; the other half will be from a "performance" score. For the 2018 performance year, the ACI category continues most of the measures requirements from the 2017 performance year, with some opportunities for additional bonuses. The MACRA also grants CMS authority to decrease the weight of this category to as low as 15 percent in years where there is a high percentage (at least 75 percent) of "Meaningful Use" adoption by eligible clinicians, to be determined by March 31, 2018.

APA appreciates that the proposed rule takes into consideration that adopting EHRs into practice can be administratively and financially burdensome for solo and small groups (of up to 15) clinicians. **APA is especially pleased that the proposed rule offers an exception to the ACI category for these practice settings, with a proposal to re-weight the category to zero.** However, APA is concerned that, if clinicians take this exception, the weighting of their quality category would be increased, which would be a unique burden for psychiatrists (please see our comments on the quality category, above). APA recommends that, if the MIPS eligible solo or small group clinician is granted an exception to their ACI performance category, then such an exception should be absolute and not a mere reweighting.

APA also appreciates the proposed exception for clinicians who are using certified EHR technology (CEHRT) that has been decertified. A search through the Office of the National Coordinator for Health Information Technology (ONC) Certified Health IT Product List (CHAPL) reveals zero CEHRT options tailored to psychiatry. When the original EHR Incentive Program (Meaningful Use) began, there were many mental and behavioral health-focused CEHRT products available for psychiatrists to choose from. For a variety of reasons, however, those companies did not maintain current certification with the ONC (some are now entirely defunct), and psychiatrists who purchased these products were left behind.

The use of EHRs within medicine, while more widespread in recent years, is not ubiquitous across the healthcare landscape. Unfortunately, many, if not most, non-hospital-based psychiatrists have been slow to adopt EHRs into their practice for a variety of reasons, including cost, a lack of high-quality EHRs tailored to the practice of psychiatry, and concerns regarding the safety and security of highly sensitive mental health/substance use disorder data. This is particularly true for the many psychiatrists who have their own small or solo practices. **While APA supports CMS's general goal of using certified EHRs and other technology to improve the coordination, safety, and quality of care for patients, some of the**

requirements outlined within the ACI section continue to place undue financial and workflow burdens on psychiatrists.

APA understands that the need for greater integration and use of EHRs within healthcare delivery is critical to the goal of improving health outcomes of individuals and of the population. However, in its current iteration, the ACI category would not create a reporting environment favorable to those goals. Specifically, while some psychiatrists may be able to satisfy the requirements of the "base" score, APA anticipates that the "performance" score of ACI will pose as an obstacle toward successful EHR adoption and scoring highly enough to earn reasonable reimbursement. This has the potential to discourage psychiatrists from participating in Medicare, resulting in fewer clinicians serving an already under-resourced population within mental health. **The proposed scoring methodology for ACI, especially with respect to the "performance" score, will make it extremely difficult for psychiatrists to receive any of the 25 percentage points under this category.**

Aside from the challenges posed by the requirements outlined in the "performance" score methodology, the "base" score requirements could also pose challenges for some psychiatrists. APA has received testimony from many member psychiatrists—especially those practicing in solo or small group settings— that the adoption and maintenance of a complete EHR system has resulted in decreased efficiency for their practices. Even more disturbing, it has also resulted in a shift away from focusing on the patient, and poses a serious obstacle in the therapeutic alliance, which is central to the psychotherapeutic process. Because of this, many psychiatrists have opted out of integrating an EHR into their practice. This makes them ineligible for the "base" score and, by extension per the proposed rule's scoring methodology, also ineligible for the "performance" score, resulting in an ACI score of zero percent.

Although there has been a proliferation of EHR systems over the past decade, including some that purport to cater to mental health specialists, these EHRs generally do not have psychiatry-specific outcome measures integrated into their systems. The ones that do, however, typically must custom-build them into the base EHR design and this is done at the clinician's expense. This further increases the financial burden that solo practitioners and small-group practices already shoulder when bringing an EHR system online in their practice. Moreover, psychiatrists who are contemplating the purchase of a new EHR system may be discouraged from doing so because the MIPS ACI standards may seem unattainable and impossible to meet.

Despite the above concerns, there are psychiatrists who do use EHRs and who will be working toward meeting the requirements of the MIPS program, including the ACI category. While psychiatrists might be challenged by many of the objectives and measures of ACI that are like those in Meaningful Use, APA appreciates CMS's commitment toward increased flexibility in reporting on these measures. Specifically, we applaud CMS's plans to abandon the current arbitrary reporting thresholds with high percentages. We are optimistic that this will allow some clinicians to successfully report on measures in the "performance" category who previously would not have been able to do so.

APA also offers the following comments regarding specific ACI objectives and corresponding measures.

MIPS ACI "Protect Patient Health Information" Objective

Security Risk Analysis Measure: APA appreciates the importance of safeguarding the sensitive and confidential nature of psychiatrists' patients' health information. **We however seek clarification on: 1) whether this measure duplicates the intent of the Health Insurance Portability and Accountability Act (HIPAA) Security Rule and the federal regulations identified in the measure, and 2) whether it, therefore, may place an additional burden on providers who are already constrained by time and limited technical expertise to meet these requirements.**

For example, as a part of the explanation for the Security Risk Analysis measure in Stage 3 of Meaningful Use, CMS indicates: "To address inquiries about the relationship between this measure and the HIPAA Security Rule, we explain that the requirement of this proposed measure is narrower than what is required to satisfy the security risk analysis requirement under 45 CFR 164.308(a)(1). The requirement of this proposed measure is limited to annually conducting or reviewing a security risk analysis to assess whether the technical, administrative, and physical safeguards and risk management strategies are sufficient to reduce the potential risks and vulnerabilities to the confidentiality, availability, and integrity of ePHI created or maintained by CEHRT."

We appreciate the clarification regarding the scope of this measure, as well as CMS's identification of the various tools that are available to providers. However, some practitioners might still be burdened by this measure, as they must satisfy its stipulations in multiple scenarios (each year, every time their EHR is updated, etc.), often with limited guidance and low technical expertise. **APA recommends that the final rule identify additional resources that offer more guidance for conducting a security risk analysis, especially for small group or solo providers.**

Electronic Prescribing (e-Prescribing) Measure: While this measure may be easily fulfilled by psychiatrists who have already adopted electronic prescribing into their practice, APA would like to underscore that the degree to which providers use electronic prescribing is highly dependent upon the extent to which pharmacies are able to receive these prescriptions, and this is greatly influenced by whether state laws mandate the use of e-prescribing.

A numerator of "one" to satisfy the base score requirements is appreciated. However, other barriers to e-prescribing are not addressed, such as the geographic availability of pharmacies that accept electronic prescriptions. While many pharmacies do, and with more adopting the technology to make e-prescribing possible, a patient should not have to select a pharmacy based on this single criterion for the sake of the clinician's need to meet the requirements of this measure. This would likely have a severe negative impact on psychiatrists practicing in rural or remote areas of the United States. **APA recommends that an exception be granted allowing for the electronic prescribing measure to be given a weight of zero for clinicians practicing in locations where the most pharmacies within 10 miles do not accept electronic prescriptions.**

MIPS ACI "Patient Electronic Access" Objective

Provide Patient Access Measure: APA acknowledges the fundamental importance of patients' rights to receive their medical information in a timely and appropriate manner. **APA also appreciates CMS's understanding that this should be subject to the clinician's discretion.** This is a very helpful stipulation in the proposed rule from the perspective of psychiatry, which involves highly sensitive patient information. There might be adverse effects if the patient were to view the data, while experiencing symptoms of psychopathology or other prohibitive issues, that indicated the patient's lack of internet access or relevant technology; minimal technological sophistication; cognitive limitations; and/or severe psychosis or mood disturbance.

View, Download, Transmit (VDT): **APA remains concerned that this measure (like the others under the "Coordination of Care Through Patient Engagement" and "Provide Patient Electronic Access" objectives in the proposed rule) is contingent upon the behavior of the patient.** The clinician has no control over a patient's behavior, e.g., whether they log into a patient portal (a feature that many EHRs lack) and engage with their record. This is especially pertinent, as the ability to meet this measure is based on the patient population that the psychiatrist serves. For example, some psychiatrists who provide services to children and adolescents and attempted to attest to Meaningful Use Stage 1 on similar measures were unable to enroll patients between the ages of ten and seventeen into a patient portal due to concerns about parental access and state-based confidentiality regulations. The minor patients remained in the denominator for measures related to patient portal use but were unable to be counted for the numerator, which resulted in the providers being unable to meet the percentage reporting threshold. While the proposed requirement is only for one patient to engage with the record, APA is concerned that future rules will increase the threshold requirements and **urges CMS to consider patient populations served by eligible clinicians in the final rule and in future proposed rulemaking**.

Patient-Specific Education Measure: APA acknowledges that proper patient education regarding their psychiatric condition is paramount to providing a high standard of care. And while this proposed rule states that such resources only be provided to at least one unique patient (for at least the initial year of the program), this raises a concern. Specifically, if the measure is based on having the educational resources available in the EHR, there is a concern that many mental health EHRs do not currently possess this functionality (i.e., educational resources built into the software based on various psychiatric diagnoses), thereby preventing the clinician from successfully meeting the measure's goals.

MIPS ACI "Coordination of Care Through Patient Engagement" Objective

Secure Messaging Measure: EHRs must provide a secure and efficient means of communication between psychiatrists and their patients. However, similar to the issue raised above regarding the patient access measure, psychiatrists cannot control the extent to which the patient logs into the EHR and engages in secure messaging with their doctor. This may be because the patient lacks the means to do so or simply does not want to.

The *type* of content that is conveyed during secured messaging should also be considered for this measure, as it may affect the numerator. Specifically, messaging appointment reminders may be benign and easily completed. However, questions about the confirmation of diagnosis and care plan goals or even information about patient progress may contain highly sensitive material and psychiatrists might

avoid engaging in this type of messaging, especially for patient for whom this type of engagement might exacerbate symptoms of their psychiatric diagnosis.

APA acknowledges that the EHR MU Incentive Program—a preceptor to much of what has been built into ACI—has yielded positive results, including widespread adoption of EHRs, in general, among physicians and hospitals. To build upon this widespread adoption within ACI and the MIPS, **APA believes that a shift in focus regarding the technological specifications of EHRs is necessary if the program is to be successful.** For instance, as the program emphasizes increased capabilities of the EHR to engage the patient and to share data with providers, the agency should focus on improving user-centered functionality and—especially—interoperability between these systems. These improvements should be the focus of certification on the part of the vendor, and not rolled into the various requirements of physicians as a routine part of practice.

CALCULATION OF MIPS COMPOSITE SCORES

MIPS Risk Adjustment

APA applauds the CMS effort to consider eligible clinicians working with patients who present with high social risk factors that negatively impact patient outcomes, regardless of the provision of high quality care. We notice the similarities between this inclusion and comparable language in the Medicare Hospital Inpatient Prospective Payment System Proposed Rule for 2018. APA supports CMS's effort to align this concept across its multiple quality programs. Generally, and depending on its intended use, APA encourages the practice of risk adjusting for certain variables, such as social risk factors/socio-economic status (SES) to prevent "cherry picking" the lower-risk patients and inaccurately assigning the provision of poor quality care resultant from psychiatric inpatient readmissions, among other reasons. However, there are several limitations to the currently available data sources from which these risk-related variables are extracted, including the absence of sufficient indicators or psychosocial complexity that will allow the exploration into how quality can vary between these factors.

APA supports the inclusion of risk adjustment methods in quality measurement for psychiatric settings. But we look forward to the results of the NQF two-year risk adjustment measure-testing project, to help inform how to best capture this information. Considering the previously mentioned limitations to data extraction and the ability to reliably capture certain social risk factors, this could prevent MIPS participants from rejecting higher risk patients. However, due to the limitations of many certified electronic health records, and the other data submission mechanisms available to psychiatrists, it is unlikely that the information collected at the point of care, or from billing, would include information displaying the full picture of the patient or quality of care. **APA recommends further, vigilant examination and identification of any potential, unintended consequences that may result from the application of risk adjustment, when stratifying by SES or by psychiatric condition acuity level.** We invite CMS to engage in discussions with APA member experts, so that a comprehensive process that would positively impact patients, clinicians, and facilities, may be identified.

MIPS Complex Patient Bonus

CMS proposes a new Complex Patient Bonus to discourage MIPS participants from selectively treating lower risk patients; protect access to high-quality care for "complex patients;" and avoid placing MIPS eligible clinicians who treat complex patients at a disadvantage in scoring and payment adjustments. CMS describes "patient complexity" as the "multitude of factors that describe and have an impact on patient health outcomes; such factors include the health status and medical conditions of patients, as well as social risk factors." CMS recognizes "as the number and intensity of these factors increase for a single patient, the patient may require more services, more clinician focus, and more resources in order to achieve health outcomes that are similar to those who have fewer factors."

APA supports the two methods proposed to identify the eligible clinicians whose patients meet this criterion, but only if they are duly implemented. Considering that on Table 36 of the proposed rule, both psychiatry and addiction medicine rate highly among the average Hierarchical Condition Category (HCC) risk scores and dual-eligible ratios, when compared to other medical specialties. It is evident that general and addiction psychiatrists are among some of the leading eligible clinicians with complex patients. APA also supports use of the proposed "complex condition" tool, the HCC indicator, to identify medical complexity and assign a per-patient score. That score will be based on age, sex, Medicaid eligibility, qualification for Medicare (if disabled), residence in an institution, and previous diagnoses. Each MIPS eligible clinician will receive a score, from averaging their beneficiaries' individual HCC scores.

Although this first indicator considers only Medicaid eligibility, we further support the use of the separate dual eligibility of Medicaid status per patent. Dual eligibility is determined by the ratio of MIPS participants' beneficiaries who are either eligible or engaged in full or partial Medicaid enrollment. The increased frequency of patients with behavioral health needs (i.e., psychiatric and substance use disorder treatment needs) assigned to this patient category, and the limited number of psychiatrists' who currently treat this patient population. APA supports CMS's effort to increase patient access to care, for this vulnerable population. **We are encouraged that psychiatrists who treat this population may qualify for this bonus, which may also serve to encourage psychiatrists to remain enrolled in Medicare.** While this newly proposed bonus is only recommended for the 2018 MIPS performance year, pending data findings and programmatic success, we hope to see the bonus remain for future reporting years, as we anticipate it will increase patient access to care.

Small Practice Bonus

We applaud CMS for proposing the small practice bonus as it is likely to increase access to quality care and we expect it to benefit psychiatrists participating in MIPS. Many psychiatrists treat Medicare patients in small practice settings, and do not always have the infrastructure or resources (staff, systems, or financial) to develop the necessary infrastructure to fully participate in the MIPS performance categories. This capped five-point bonus for "small practice" eligible clinicians, is a method that will help prevent many participating psychiatrists from receiving a negative payment adjustment and possibly encourage some to remain enrolled in Medicare. We understand that this bonus is currently proposed as a short-term opportunity for small practices, and is not for rural practices that do not meet the CMS description of a small practice, and we appreciate that CMS will continue to study data submitted by rural psychiatric practices. **We hope that in future reporting years this bonus will**

also apply to rural practices, including psychiatrists in rural areas. Rural practices suffer many of the same MIPS participation hindrances as small practices, and some additional challenges, when compared to MIPS eligible clinicians and practices in non-rural areas.

PHYSICIAN COMPARE

APA understands the importance of providing health care consumers an opportunity to make sound decisions when choosing their care providers. The Physician Compare website aims to meet the needs of Medicare Part B beneficiaries by providing a variety of information to allow consumers to make an educated decision on who best meets their health care needs. As described in the proposed rule, many details that appeared in Physician Compare during the Physician Quality Reporting System (PQRS) and Meaningful Use quality reporting would carry over to MIPS quality performance reporting. We are pleased to see information on quality program participation on the Physician Compare homepage and links to greater detail on Medicare Part B providers' individual profile pages. **APA applauds these changes to the Physician Compare website. However, we do have concerns about the usefulness of several of the proposals within the rule.**

CMS proposes that Physician Compare would continue to include a uniform symbol to designate quality program participation by provider, to permit consumers to identify the health care providers who participate in CMS quality programs, their performance rates, and the scores earned in each MIPS category or APM quality activities. While we support the inclusion of this information, and the descriptive information on the quality programs and their scores, we have concerns that consumers could misconstrue a provider's lack of participation in CMS quality programs. We are concerned that regardless of why those clinicians did not participate — whether it was due to meeting the low-volume threshold, an inability to financially afford the infrastructure required to participate in MIPS, or previously participating in minimal activity allowed by the 2017 “Pick Your Pace” options — consumers would assume that the absence of quality information was caused by the poor provision of care.

Public Reporting of MIPS Data on Physician Compare

MIPS Quality Performance: We request more information about how MIPS quality data would be shared on Physician Compare. CMS should use multi-stakeholder feedback and focus groups to choose the format for presenting this information. **Because recommendations on how to present this information in a user-friendly format are not being proposed now, APA is unable to support public reporting of this information.** We do not see the benefit of publicly sharing information intended for consumer utilization that could potentially mislead users.

MIPS Cost Performance: The plans are uncertain for publicly reporting information for all participants in the cost performance category. It is unlikely data from the 2017 and 2018 performance period would be available for publication. CMS acknowledges the density of the data extracted from administrative claims for use in the cost measures. Instead they propose to publish a subset of cost measure data, so as not to confuse consumers. APA requests to review this subset before providing support of its utilization.

MIPS Improvement Activity Performance: **We support the proposed delay in publicly reporting data collected from the IA performance category.** Since this is a new category for participation, it is important to test the concept and website before publicly sharing this information. This process would

provide consumer understanding and promote fair representation of eligible clinician participation in this performance category.

MIPS Advancing Care Information Performance: CMS reports that when surveyed, consumers give positive ratings to health care providers who use EHRs. CMS reports positive influence and impact from publishing the EHR-specific symbol on each Physician Compare health care provider profile page who uses an EHR. CMS would continue to provide eligible clinician data in the "public use files" found on www.cms.org. Physician Compare would continue to include the EHR-specific symbol on eligible clinician profile pages, if they are "successful" participants in the MIPS ACI performance category. **APA requests clarification on what would be considered "successful" participation in this category; would "successful" mean *at least* the base score, and if that is not achieved, the clinician receives a zero score for ACI?** Additionally, considering the high cost of CEHRT, and the potential for a product to lose certification, it is possible that an eligible clinician who had the EHR-specific symbol presented on their profile page reflecting activity from the previous performance period, might not qualify during the current performance year or beyond. How would this be addressed on Physician Compare? Also, some eligible clinicians do not influence EHR selection for the facility or practice in which they work. APA requests clarification of how this would be designated on Physician Compare, if this prevents their "success" in the ACI performance category. **APA also requests that CMS detail whether Physician Compare will demarcate the "successful use of EHR" variable regarding whether 2014 and 2015 CEHRT was used.**

Public Reporting Standards: **APA strongly opposes publicly reporting MIPS data until after it has reviewed potential changes to the website's design.** We cannot support publishing this data until we know it is being shared in a way that educates consumers, rather than misleads them. APA agrees that measure data published on Physician Compare must meet high reliability standards, so it would not be appropriate to publicly report the data collected in the first year of a new MIPS measure. CMS cites different standards of reliability that measures meet as they apply to scoring and public reporting. Presumably, CMS would not finalize measures that do not meet rigorous reliability, feasibility, and validity standards. Therefore, we would expect that MIPS measures, even following their first year of use, should be appropriate for public reporting. If CMS has concerns with posting this information, then closer attention to measure validity, reliability, and feasibility is required at the time of MIPS measure finalization. If CMS expects a more stringent reliability standard for publicly reporting measures than it does for scoring measures, how can MIPS eligible clinicians be confident in the scoring results and related MIPS payment adjustments? Alternatively, if CMS finalizes the decision to wait one year to assure public reporting measure reliability before publishing first-year measure scores, we recommend identifying, on their profile pages, the eligible clinicians who submitted data on first-year measures. Even though the performance rates for these new measures are not shared, eligible clinicians should receive acknowledgement of this effort on their profile page, particularly if they are limited with their measure choices.

Million Hearts: Physician Compare shares eligible clinician success in unique national campaigns aimed at improving gaps in quality care for specific health conditions, like the Million Hearts campaign. This national initiative set a goal to prevent 1 million heart attacks and strokes by 2017, and successful participation is reported on Physician Compare. While APA supports participation in this program, most psychiatrists do not regularly have use for quality measures that indicate participation in this program, and consumers may misunderstand their receipt of a low rating. Those psychiatrists who receive high

ratings in this program are generally part of a multispecialty group. Consumers comparing health care providers on this website may expect all providers to participate in this campaign, which could cause bias regarding health care provider selection, particularly when single-specialty individual or group psychiatrists are compared to psychiatrists who practice in a multispecialty group.

Physician Compare Benchmark and Appeals Process

The Achievable Benchmark of Care (ABC$^{TM)}$ is used to compare eligible clinicians on Physician Compare using a five-star rating system. Since psychiatrists are limited by measures they find "meaningful" or "appropriate" for their practice, but they are publicly rated on measures that meet the CMS public reporting reliability standard, the likelihood for achieving a desirable star-rating is tenuous. We understand that the ABC is a statistically appropriate way to compare eligible clinicians at the measure-level. However, we do not think it is a reliable way to compare clinicians at the practice-type and/or specialty-level. We propose a visible designation for this on the Physician Compare website, as well as on multispecialty or single specialty group practice pages.

In the past, the PQRS, Meaningful Use, and Value-Based Modifier programs included a 30-day review and appeal process when CMS inaccurately captured actual quality reporting. This appeals process, intended to correct data errors bound for CMS public reporting and negatively impacting eligible clinician payment, was limited. Unfortunately, clinicians often received inaccurate information or instructions, which led to rejection of their request for an appeal. This was disheartening and discouraging to already overburdened clinicians making an honest effort to participate in these programs. **APA recommends that CMS enact multiple improvements to streamline this process, including: providing additional training to customer service representatives to ensure they consistently disseminate accurate information; publishing information about the documentation required on the QPP and CMS websites; and providing an option for eligible clinicians to engage in the appeal process on their own via email or fax.**

INCENTIVES FOR ADVANCED ALTERNATIVE PAYMENT MODELS

APA supports the development of Advanced Alternative Payment Models (APMs) and other new models of care that will improve access, quality of care, and patient outcomes for the millions of individuals with mental health and substance use disorders (MH/SUDs). However, we believe that the prevailing policies and requirements for Advanced APMs must be improved to improve access and quality of care for patients with MH/SUDs and support participation by psychiatrists and other mental health providers. Psychiatrists account for the largest percentage (42%) of physicians in clinical practice that have formally opted out of Medicare, and since 2006, less than half of the available geriatric psychiatry fellowships have been filled.[1] CMS's Advanced APM policies could be an important tool to encourage and support the ability of psychiatrists to participate in Medicare, continue to see their current Medicare patients, and accept new patients.

[1] Boccuti, C. et al. December 2013. "Issue Brief: Medicare Patients' Access to Physicians: A Synthesis of the Evidence." *Kaiser Family Foundation*.

The following policies would encourage the creation of Advanced APMs for mental health and substance use disorders, as well as encourage participation in Advanced APMs by psychiatrists, other mental health professionals, and patients with MH/SUDs.

Simplification and Streamlining of Policies

APA supports the simplification and streamlining of CMS policies for Advanced APMs—and the inclusion of Medicaid APMs—to encourage psychiatrists, providers, and clinicians (particularly those in small practices and rural areas) to become more involved in creating and participating in Advanced APMs. The current and proposed requirements for Advanced APMs are unnecessarily complex, with too many variations and technical details. These policies are too daunting for many clinicians and providers, other than large integrated health systems with teams of experts and extensive resources. They were certainly not designed to attract small and rural providers. These requirements need to be simplified overall. They should also harmonize, whenever possible, the requirements and policies between Medicare and All-Payor Advanced APMs, including having one performance period. We urge CMS to employ consistent policies and eliminate unnecessary variations.

APA also fully supports CMS's proposal to expand All-Payor Advanced APMs to include those for Medicaid. Many patients with MH/SUDs receive services through Medicaid, and several state Medicaid programs have implemented APMs for behavioral health. We strongly advocate for CMS to allow psychiatrists and other professionals who participate in these Medicaid models to receive credit for that participation toward earning incentives for participating in Advanced APMs.

Supporting Collaborative Care Services

CMS should encourage and offer incentives for all Advanced APMs to offer Collaborative Care Model services. CMS is encouraging the Transforming Clinical Practice Initiative (TCPI) practice networks throughout the country to integrate behavioral health into primary care, increase the integration of health care services to optimize benefits for patients, and streamline the work of health care providers. As mentioned earlier, as a TCPI Support and Alignment Network, APA offers psychiatrists and primary care providers free training in the Collaborative Care Model. We also connect psychiatrists with Practice Transformation Networks that can provide quality improvement, workflow redesign, data collection, and optimization of electronic health records—to assist in the transition to new models of care. APA, with the Academy of Psychosomatic Medicine, wrote a report entitled *Dissemination of Integrated Care within Adult Primary Care Settings: The Collaborative Care Model,* which includes principles for evidence-based integrated care and highlights the importance of primary care integration through the Collaborative Care Model.[2]

In 2014, about 18 percent, or 43.6 million, of American adults had a mental illness. Yet only 40 percent of adults with a *diagnosed* mental illness received treatment. Moreover, only 59 percent of those with a *serious* mental illness received treatment.[3] Individuals with mental illness often have extensive non-

[2] American Psychiatric Association, Academy of Psychosomatic Medicine. "Dissemination of Integrated Care Within Adult Primary Care Settings: The Collaborative Care Model. 2016. Available at: https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/collaborative-care-model.

[3] National Institute of Mental Health. "Use of Mental Health Services and Treatment Among Adults." http://www.nimh.nih.gov/health/statistics/prevalence/use-of-mental-health-services-and-treatment-among-adults.shtml. "Use

psychiatric medical needs. Depression, anxiety, substance use disorders, and other common psychiatric disorders frequently are comorbid with cardiovascular disease, diabetes, obesity, pain disorders, and other costly and potentially disabling physical conditions.[4] Indeed, the rate of mortality among persons with mental disorders in comparison to those without is startlingly high.[5] Many chronic medical conditions require a self-care regimen in order to manage symptoms and prevent further disease progression, which may be hampered by comorbid mental conditions. A recent study found that 68 percent of adults who have a mental disorder also suffer from a medical comorbidity.[6]

Furthermore, most early mortality in patients with mental disorders is associated with chronic comorbid conditions, which are exacerbated by mental illness. A meta-analysis of worldwide mortality estimates found that the risk of mortality for individuals with psychiatric disorders was 2.2 times higher than for persons without mental disorders.[7] A majority (67%) of deaths was attributed to natural causes such as cardiovascular disease, lung disease, and diabetes and the reduction in life expectancy ranged widely from 1.4 to 32 years. Co-occurring mental disorders in persons with medical conditions also contribute to unemployment, absence from work, and decreased productivity at work.[8]

Increasing patient access and quality of care for individuals with MH/SUDs can often lead to savings over the long-term, particularly through improvements in overall health. But capturing those savings requires looking at the whole health of an individual, over a period of years. Most APMs are required to demonstrate savings during a snapshot period (typically a year). The bar is often raised each year due to shifting benchmarks. CMS often places limitations on what costs can be considered in that equation, for example, only comparing savings in Part B. If behavioral health APMs are subjected to this approach, most (if not all) are doomed to failure.

Patients with MH/SUDs can also benefit greatly from receiving support and assistance in areas that impact their health, but are not typically reimbursed by payors. For example, SAMHSA has provided

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of Mental Health Services and Treatment Among Children." http://www.nimh.nih.gov/health/statistics/prevalence/use-of-mental-health-services-and-treatment-among-children.shtml.

[4] Druss, B.G., Walker, E.R. 2011. "Mental disorders and medical comorbidity." *The Synthesis Project Research Synthesis Report* 21: 1-26. http://www.rwjf.org/en/library/research/2011/02/mental-disorders-and-medical-comorbidity.html.

[5] Demyttenaere, K., et al. 2004. "WHO World Mental Health Survey Consortium: Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys." *Journal of American Medical Association* 291: 2581-2590. Thornicroft, G. 2011. "Physical health disparities and mental illness: the scandal of premature mortality." *British Journal of Psychiatry* 199: 441-442. Wahlbeck, K., et al. 2011. "Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders." *British Journal of Psychiatry* 199: 453-458.

[6] Robert Wood Johnson Foundation. 2011. "Mental disorders and medical comorbidity." www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf69438.

[7] Walker, E.R., McGee, R.E., Druss, B.G. 2015. "Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis." *JAMA Psychiatry* 72: 334-341.

[8] Wang, P.S., et al. 2008. "Making the Business Case for Enhanced Depression Care: The National Institute of Mental Health-Harvard Work Outcomes Research and Cost-effectiveness Study." *Journal of Occupational & Environmental Medicine* 50: 468-472. Katon, W. 2009. "The impact of depression on workplace functioning and disability costs." *American Journal of Managed Care* 15: 322-327.

grants to support health improvement interventions such as smoking cessation, weight reduction, exercise classes, cooking advice, appointment reminders, etc. These can greatly improve clinical care and patient outcomes.[9]

Ensuring Adequate Reimbursement for Psychiatrists

Behavioral Health Advanced APMs must ensure adequate reimbursement of psychiatrists' services and should have flexibility in meeting nominal risk standards. CMS's current and proposed policies for Advanced APMs pose a potentially insurmountable barrier for the creation of Advanced APMs for the treatment of MH/SUDs. We urge CMS to adopt policies to address this issue, including the elimination of the nominal risk requirement for "mental health medical homes," and lowering the nominal risk standard for other Behavioral Health Advanced APMs to 5 percent of Medicare Parts A and B revenue. Advanced APMs largely address primary care, to incentivize primary care providers to serve as gatekeeper and care coordinator to decrease unnecessary procedures and hospitalizations. Proposals for new Advanced APMs are generally built around very costly procedures or conditions. The primary goal is often to reduce the overall costs for the entire course of care for such patients. The circumstances are very different for patients with mental illness, including substance use, and the psychiatrists who treat them—if those patients are even able to see a psychiatrist. Unlike the overwhelming preponderance of physical health issues, mental health issues are generally regarded to be under-treated, with persistent disparities in treatment for substance use disorders, as well as racial and ethnic disparities.

A fundamental obstacle to creating Behavioral Health Advanced APMs involving psychiatrists is the general requirement that an APM must generate savings, in comparison with fee-for-service. While psychiatric care can lead to cost savings for patients overall, there is a widespread view within psychiatry that the prevailing Medicare fee-for-service rates are insufficient. This contributes to the high percentage of psychiatrists who opt of Medicare. It also poses a major obstacle for creating APMs that would require demonstrated savings based solely on the reimbursement of psychiatrists.

To achieve successful and widespread acceptance and adoption, any Behavioral Health Advanced APM must be built upon a framework of adequate reimbursement for psychiatrists and other health providers. Unfortunately, reimbursement for psychiatrists has simply not kept pace with the rising costs of delivering care. Many psychiatrists in small and solo practices would like to be able to hire clinical staff and invest in electronic health record (EHR) systems, but they simply cannot afford it. As a result, many psychiatrists have left clinical practice for more lucrative opportunities, and this contributes to the shortage of psychiatrists in this country. Even the recently issued Medicare reimbursement rates for collaborative care services may not be sufficient to cover the costs of primary care providers contracting with psychiatric consultants. While APA strongly supports the inclusion of the Collaborative Care Model in APMs, that endorsement comes with the caveat that those models must ensure adequate reimbursement for the consulting psychiatrist's services—either by allowing separate billing for collaborative care services (under the Physician Fee Schedule) or by refraining from requiring savings generated from "ratcheting down" those rates.

[9] Institute of Medicine. 2012. "The mental health and substance use workforce for older adults: In whose hands?" Washington, DC: *The National Academies Press*.

CMS should also rethink its approach in having unfettered ability and limitless time to reopen, revise, and recoup Advanced APM payments "made in error." MACRA already requires most Advanced APMs to accept more than nominal financial risk, and simply creating an APM requires a substantial investment of time and resources (which is generally not acknowledged or for which credit is given). It is unreasonable to impose this potential financial vulnerability on Advanced APM entities. Moreover, this is inconsistent with the general tenets of commercial practices and commercial law, which circumvent the ability of commercial payments to be recouped in instances of errors.

CEHRT Requirements

Behavioral Health Advanced APMs will have unique challenges in satisfying CEHRT standards and should be offered alternative ways to meet his requirement, including a hardship exemption. APA realizes that the MACRA requires Advanced APMs to employ Certified Electronic Health Record Technology (CEHRT), which CMS has interpreted this as requiring that at least half their participants use CEHRT. APA understands that the need for greater integration and use of EHRs within health care delivery is paramount toward the goal of improving health outcomes of individuals and of the population. However, the general standard CMS is employing for Advanced APMs will pose an unsurmountable barrier for the development of Advanced APMs for MH/SUDs. Psychiatrists have struggled to meet the CEHRT requirements of the Meaningful Use program. Very few psychiatrists have been successful in meeting these standards. This may pose a significant barrier in the widespread adoption of behavioral health APMs for psychiatrists, unless allowances are made.

Many psychiatrists have been slow to adopt EHRs into their practice, particularly those who have their own small or solo practices. This is due to multiple reasons, including cost, a lack of high quality EHRs tailored to the practice of psychiatry, and concerns regarding the safety and security of highly sensitive data about individual patient's MH/SUDs. Despite the proliferation of EHR systems over the past decade, including some that purport to cater to mental health specialists, these generally do not have psychiatry-specific outcome measures integrated into their systems. Systems must be custom-built into the base EHR design, at the clinician's expense. This further increases the financial burden that solo practitioners and small-group practices already shoulder when bringing an EHR online in their practice.

Some APA members, especially those practicing in solo or small group settings, have also indicated that the adoption and maintenance of a complete EHR system has resulted in decreased efficiency for their practices. Even more disturbing, some say it has shifted their focus away from the patient, and poses a serious obstacle in the therapeutic relationship central to the psychotherapeutic process. Because of this, many psychiatrists have elected not to integrate an EHR system into their practice. Another issue is that many consulting psychiatrists who care for patients in hospitals and other facility settings do not have access to the hospital EHRs for those patients, or their own practice's EHR system is not compatible with the systems for those facilities. This prevents them from using EHRs to keep comprehensive data on those patients.

Encouraging and Rewarding the Use of Telepsychiatry

All Advanced APMs should be encouraged and receive incentives to offer the delivery of services via telepsychiatry. APA is a strong proponent of telehealth as practiced by psychiatrists, known as "telepsychiatry," and has developed a "Telepsychiatry Toolkit" with videos and other materials to

educate psychiatrists on this treatment option.[10] Telepsychiatry services, particularly in rural and remote areas, can make a real difference in the ability of patients with MH/SUDs to access the care they need, both long-term for those with chronic conditions and short-term for those facing a crisis. Telepsychiatry has been employed in therapeutic settings since the 1950s. Recent advances in video technology coupled with widespread, broadband internet access have resulted in a rapid expansion in the number of psychiatrists who regularly engage in telepsychiatry. Early and more recent research indicates that psychiatry, as a medical discipline, appears to be an ideal fit with video conferencing as a treatment modality. Many psychiatric treatments can be translated to telepsychiatry. Furthermore, case studies and empirical data have revealed no known absolute exclusion criteria, nor contraindications for any specific psychiatric diagnoses, treatments, or populations.[11]

Given the current shortage of psychiatrists practicing in the United States, the use of telepsychiatry is a helpful tool that can increase access to care for an already vulnerable mental health population.[11] Patients with acute and chronic mental health problems are at increased risk for suicide, homicide, and accidents. The risk of suicide is especially pronounced within rural populations, which typically demonstrate higher suicide rates, particularly for men, when compared with urban populations. Telepsychiatry is increasing access to critical services to patients within rural, remote, and isolated settings, and has the potential to address these public health concerns.[12] Medicare currently reimburses telepsychiatry services only in rural or designated underserved areas. Incentivizing Advanced APMs to employ telepsychiatry would allow expansion of those services.

Conclusion

Thank you for your review and consideration of these comments. If you have any questions or would like to discuss any of these comments, please contact Debra Lansey, M.P.A., APA Associate Director for Payment Policy, at DLansey@psych.org or (703) 907-7848.

Sincerely,

Saul Levin, M.D., M.P.A.
CEO and Medical Director

[10] APA Telepsychiatry Toolkit is available at https://www.psychiatry.org/psychiatrists/practice/telepsychiatry.

[11] Hyler, S., Gangure, D., Batchelder, S. Can telepsychiatry replace in-person psychiatric assessments? A review and meta-analysis of comparison studies. *CNS Spectrums* 2005; 10:403-413. De Las Cuevas, C., et al. Randomized clinical trial of telepsychiatry through videoconference versus face-to-face conventional psychiatric treatment. *Telemedicine Journal and E-Health* 2006; 12:341-350.

[12] Shore, J. et al. A resident, rural telepsychiatry service: training and improving care for rural populations. *Academic Psychiatry* 2011; 35: 252-255. Yellowlees, P., et al. Using e-health to enable culturally appropriate mental healthcare in rural areas. *Telemedicine Journal and E-Health* 2008; 14:486-492. Yellowlees, P., Shore, J., Roberts, L. American Telemedicine Association: Practice guidelines for videoconferencing-based telemental health: October 2009. *Telemedicine Journal and E-Health* 2010; 16: 1074-1089.