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Department of Health and Human Services
Attention: CMS-1690-P
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Dear Administrator Verma:

The American Psychiatric Association (APA), the national medical specialty society representing over 37,800 psychiatric physicians and their patients, would like to take the opportunity to comment on the 2019 proposed rule for the Medicare Physician Fee Schedule and Quality Payment Program. Our comments focus specifically on issues that affect the care of patients with mental health and substance use disorders (MH/SUDs).

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In general, our comments proceed in the order issues were discussed in the Proposed Rule. The following areas are our priorities:

- Care for Management of Counseling Treatment for Substance Use Disorders
- Evaluation and Management Documentation and Reimbursement
- Promoting Interoperability Request for Information, and
- Quality Measures

**Assembly
2018-2019**

James (Bob) R. Batterson, M.D.
Speaker
Paul J. O'Leary, M.D.
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Seeth Vivek, M.D.
Recorder

Determination of Malpractice Relative Value Units

CMS's has continued their policy to crosswalk non-physician practitioner (NPP) malpractice costs to the specialty with the lowest physician risk factor specialty (Allergy/Immunology) which results in a risk factor that is too high for some NPP specialties. **We urge CMS to either update the premium data or use the most recent data they have from the 2006 AMA Physician Practice Information (PPI) survey.**

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

Modernizing Medicare Physician Payment by Recognizing Communication Technology Based Services

Brief Communication Technology-Based Service and Interprofessional Internet Codes

APA supports CMS’s proposal to adopt coverage for the following non-face-to-face services that employ technology for the benefit of the patient:

GVC11, Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion.

99446, Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a verbal and written report to the patient’s treating/requesting physician or other qualified healthcare professional; 5–10 minutes of medical consultative discussion and review.

99447, Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a verbal and written report to the patient’s treating/requesting physician or other qualified healthcare professional; 11–20 minutes of medical consultative discussion and review.

99448, Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a verbal and written report to the patient’s treating/requesting physician or other qualified healthcare professional; 21–30 minutes of medical consultative discussion and review.

99449, Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a verbal and written report to the patient’s treating/requesting physician or other qualified healthcare professional; 31 minutes or more of medical consultative discussion and review.

994X0, Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes.

994X6, Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient’s treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time.

In addition, APA supports requiring verbal consent (with documentation in the record) from the beneficiary prior to the initiation of any of these services to ensure the patient is aware of the applicable cost-sharing.

Comment Solicitation on Creating a Bundled Episode of Care for Management and Counseling Treatment for Substance Use Disorders

As an organization representing front-line physicians who treat patients with substance use disorders, APA commends CMS for their interest in providing coverage for treatment of patients suffering from substance use disorders, including opioid addiction. According to 2016 data from Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Survey on Drug Use and Health (NSDUH), 19.9 million adults in the United States needed substance use disorder (SUD) treatment, yet only 2.1

million actually received the specialty care they needed. One of the primary reasons for this “treatment gap” is that many individuals lack health care coverage and therefore cannot afford treatment. To make productive gains in combating this public health crisis, the APA urges CMS to advance solutions that will improve access to effective evidence-based treatment, reduce the stigma associated with substance use disorders, and protect safety net programs that offer valuable coverage for individuals and families in need of treatment.

This is even more important given there are over 11 million Americans who misused prescription opioids, nearly 1 million used heroin, and 2.1 million had an opioid use disorder (OUD) due to prescription opioids or heroin. Opioid misuse among older adults has become especially concerning. An analysis of Medicare Part D data by the Office of the Inspector General revealed that more than 500,000 Medicare Part D beneficiaries received high amounts of opioids in 2016, with the average dose far exceeding the manufacturer’s recommended amount.¹ Data indicate that in 2012 there were an average of six reported treatment admissions each day of individuals aged 65 or older for heroin or other opiates. On an average day in 2011, there were 118 drug-related emergency department visits by adults aged 65 or older involving prescription or nonprescription pain relievers, 80 of which involved narcotic pain relievers specified by name (e.g., hydrocodone, oxycodone).²

As with other medical conditions, treatment for substance use disorders should be individualized and comprehensive based on patient need and severity of illness. It should include assessment and treatment as indicated for co-occurring mental health disorders or other physical health conditions. Patients may benefit from different levels of care at different points in their recovery, for example outpatient counseling, intensive outpatient treatment, or inpatient treatment; for some this is a chronic illness that will require varying levels of care throughout the course of their life.

Patients should have access to FDA approved medication in these settings with the three most commonly used being Methadone, Buprenorphine, and Naltrexone/Vivitrol. Studies have demonstrated the effectiveness of medication for OUD, especially when combined with counseling and other psychosocial therapies.^{3,4,5} Thus, Medication Assisted Treatment (MAT) should be prescribed as part of a comprehensive treatment plan that includes counseling and participation in social supports.

Given that Medicare has no comprehensive SUD treatment benefit, including reimbursement for services delivered or drugs dispensed by an Opioid Treatment Programs (OTP), we urge CMS to:

- **Work with OTPs to establish appropriate payment for MAT-related services in Opioid Treatment Programs (OTP). CMS should evaluate the services reimbursed within three years to ensure adequate reimbursement rates and effective treatment services are included to meet the individual needs of patients and improve quality.**
- **Review models of care in place in state Medicaid programs such as Vermont’s “Hub and Spoke” model and Massachusetts Nurse Care Manager Model as potential templates for implementing similar reforms in Medicare to better address the needs of those with OUD.**⁶ The Vermont model relies on a network of nine regional “hubs” that provide intensive MAT services and serve as a resource to the 75+ community-based “spoke” sites that provide outpatient maintenance MAT.⁷ According to a recent study by the Vermont Department of Health, this model led to a 96 percent decrease in opioid use, while saving costs both in terms of a 90 percent decrease in arrests for opioid use and an 89 percent reduction in emergency room visits for opioid-related overdoses.⁸ The

Massachusetts model reimburses nurse care managers in federally qualified health centers who are supporting physicians in the provision of buprenorphine or naltrexone for OUD treatment. A pilot study of 408 patients enrolled in this program reported that 51 percent had received buprenorphine treatment at 1 year, and 91 percent of those retained on a regimen of buprenorphine at 12 months had urine toxicology screens that were negative for opioids.⁹ Encourage implementation of the collaborative care model which incorporates key elements of effective treatment of substance use disorders and for which there is an existing reimbursement mechanism.¹⁰

- **Evaluate existing bundled payments or emerging alternative payment models such as those in state Medicaid programs (such as Maryland and Massachusetts) as well as those developed by private payers, as to their effectiveness to provide appropriate payment for evidence-based services.** Evidence-based services such as those included in the “Substance Abuse and Mental Health Services Administration’s Treatment Improvement Protocol 63: Medications for Opioid Use Disorder”¹¹ and the “VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders”.¹²
- **Consider the development of a demonstration project(s) designed to evaluate such as the impact of cost-sharing on a patient’s ability or willingness to engage in treatment and/or ways to incentivize physicians to care for patients including increasing the number of patients they are willing to treat.**

APA also encourages CMS to take steps to minimize barriers to MAT by easing prior authorization requirements and making available (via coverage and reimbursement) all FDA-approved medications for treating substance use disorders, including long-acting buprenorphine formulations that reduce the risk of relapse and improve adherence. The APA also supports CMS’s efforts that any proposed benefit plan that would implicitly or explicitly discourage enrollment by beneficiaries in need of these therapies will not be approved. It is imperative to ensure that Medicare beneficiaries have appropriate access to MAT, and we continue to expect Part D sponsors to include products in preferred formulary tiers, and to avoid placing generic drugs indicated for MAT in brand tiers. As CMS has noted via guidance documents, the agency will closely scrutinize formulary and benefit submissions with respect to formulary inclusion, utilization management criteria, and cost-sharing for Part D drugs indicated for MAT.

Valuation of Specific Codes

CMS has made several proposals regarding the valuation of specific services.

(59) Interprofessional Internet Consultation (CPT Codes 994X6, 994X0, 99446, 99447, 99448, 99449)

CMS proposes to reduce the AMA RUC recommended work value for 994X6 from 0.70 RVUs to 0.50 RVUs, citing that the work of that service is like that of 994X0. While the two services share the same intraservice time, the work of 994X6 (reviewing patient summary and developing treatment recommendations as a consulting physician with a written report to the treating physician) requires greater technical skill and judgement and involves more psychological stress than 994X0 (development of the patient summary to be reviewed by the consulting physician). **APA supports adoption of the RUC recommended values for both 994X0 and 994X6.**

(65) Structured Assessment, Brief Intervention, and Referral to Treatment for Substance Use Disorders (HCPCS Codes G0396, G0397, and G5BR1)

APA supports the CMS proposal to reduce the documentation requirements associated with the codes that describe assessment, brief intervention and referral to treatment for substance use disorders as well as the proposal to provide coverage for a third HCPCS code, GSB1 for work that falls between 5 and 14 minutes. We suggest that CMS continue to monitor utilization of these services to ensure the goal of increasing the provision of these services has been achieved.

(66) Prolonged Services (HCPCS GPRO1)

APA supports the CMS proposal to adopt an additional HCPCS code GPRO1 to describe prolonged evaluation and management or psychotherapy service(s) in the outpatient setting with direct patient contact beyond the usual service; 30 minutes. This change allows for appropriate payment for work performed. We encourage CMS to work with the AMA CPT Editorial Panel in the development of a similar CPT code.

Evaluation & Management (E/M) Visits

APA commends CMS for “Patients over Paperwork” initiative, including the proactive measures have undertaken over the past several months to ease the administrative burdens faced by physicians who provide direct patient care. We applaud CMS for crafting a proposal that makes a meaningful attempt to address the complexities of the current evaluation and management documentation guidelines and coding structure.

Psychiatrists are treating an increasing number of complex patients based on advances in population-based care and a diminishing psychiatric workforce. Approximately 1 in 5 adults (44.7 million in 2016) in the United States lives with mental illness, and of those, 10.4 million individuals suffer from serious mental illness.¹³ In 2016, nearly 45,000 Americans aged 10 and older died by suicide which is the 10th leading cause of death and is one of just three that are on the rise.¹⁴ Approximately one-half to two-thirds of those who committed suicide suffered from mood disorders.¹⁵ It is well-documented that opioid drug overdoses have continued to rise. The estimates in 2017 indicated that more than 72,000 individuals would die by overdose, representing an increase of about 10 percent from 2016.¹⁶ This death rate would surpass the peak-year death toll for HIV (over 40,000) and car crashes (over 54,000), and exceeds the average number (over 33,000) of individuals who die by firearm-related deaths in the U.S. each year. Therefore, access to psychiatric care is critically important for individuals whose healthcare is covered by Medicare either because of age or disability.

APA concurs with CMS’s proposal to meaningfully reduce the administrative burdens tied to documentation of the evaluation and management services; however, we have concerns that the proposed simplification of the fee structure could have unintended consequences that would negatively impact beneficiary access to care, especially for the most vulnerable and most medically complex. **We urge CMS not to finalize this proposal in its entirety and to work with key stakeholders to identify alternative ways to reduce documentation and related administrative burdens without jeopardizing access to care for our patients.**

We support many of the proposed documentation changes that would reduce both the overall administrative burden and the amount of unnecessary documentation. However, the proposal to simplify the fee structure is problematic and would require additional input prior to being implemented. While a simplified structure may appear to reduce the documentation requirements and the need for audits, it is difficult to determine the full impact of these changes based on the proposal as currently written.

Additional information about the criteria for code selection and corresponding documentation requirements is necessary before the full impact can be understood.

Although we have some concerns, we support many of the changes highlighted in the proposed rule. These include:

- Eliminating the prohibition on same-day E/M visits billed by physicians in the same group or specialty. This will save patients time and money by giving them an opportunity to schedule their medical appointments more efficiently.
- Eliminating the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or by the patient.
- Changing the required documentation of the patient's history to focus only on the interval history since the previous visit.
- Removing the need to justify providing a home visit instead of an office visit.

CMS has also proposed allowing physicians to choose from a range of options when documenting services. These options would initially be limited to services for new and established patients in the office or outpatient setting but could later be implemented for other settings covered by Medicare.

The options proposed by CMS are:

- Continuing to document on the basis of current 1995/1997 guidelines,
- Documenting on the basis of medical decision making, or
- Documenting on the basis of face-to-face time.

CMS has proposed to apply a minimum documentation standard equivalent to a Level 2 E/M service if the above were implemented. This proposal is being made in tandem with a proposal to simplify or conflate the payment amounts for Levels 2-5 to one fee, which would seem to eliminate the need to differentiate the work for billing purposes.

APA supports the suggestion to allow physicians the option of using Medical Decision Making (MDM) as the primary driver for medical necessity and code selection, while preserving the five levels of E/M service that currently exist. Consideration should be given to simplifying the current MDM documentation guidelines, with the emphasis on code selection based on risk and management options. Use of the CMS risk table from the 1995/1997 guidelines (modified and updated), in combination with the quantitative approach for documentation management options discussed in "Practical E/M Documentation and Coding Solutions for Quality Patient Care" by Stephen Levinson, MD¹⁷ would be a reasonable way to address medical necessity and code selection. With this approach, decision-making for what is needed for each level is simplified, which leads to more focused, clinically relevant documentation. With this change in emphasis on MDM, documentation of the history and examination will be only what is necessary to support the level of MDM. This would be administratively simpler and less prone to misuse through EHRs and other systems of checklists.

The concept of time as an option for code selection in situations beyond when counseling and coordination of care dominate should be thoroughly evaluated. Consideration should be given to how this impacts other services as well as to the various physician practice patterns. **We could not support the use of time as the sole way of documenting E/M services. Variability in time is not always a good proxy for the level of acuity of the visit.**

Changes such as those being proposed should not be made in a vacuum. The current documentation guidelines are used by both private and public payers. Electronic health records and other billing templates are designed to support the existing guidelines. Any change should be done in a manner that allows for a smooth transition to a different system, particularly if physicians are permitted to select from a range of options. In fact, the proposed reductions in documentation are essentially reductions to what is required for billing purposes. Physicians document for a variety of reasons, with billing being just one. A clear and concise record of the “when, what, and why” of the services provided to patients documents the basis for the medical necessity of the visit and the rationale for the treatment provided. It is necessary for continuity of care and it facilitates care coordination among providers. It is also essential if medical liability is being considered.

As to the second aspect of the CMS proposal – simplification of the fee structure – **APA has a number of concerns and recommends that CMS refrain from implementing this proposal but work with interested stakeholders, including the AMA, to explore other options.**

The melding of the current graduated fees into one fee, regardless of the level of work performed, creates a disincentive to treat patients who are sicker and more medically and socially complex. We are especially concerned about having only one level of payment for new patient visits (CPT codes 99202-99205). These first encounters with patients where an evaluation of the patient’s condition must be done can be highly variable. A patient may be seeing the physician for the first time for a simple problem or may be coming in with a very complex and potentially life-threatening disorder. The latter would likely be the case for those patients who generally avoid medical care until symptoms can no longer be ignored.

Over the last several years there has been a focus on early identification and treatment of mental health and substance use disorders, as well as a push toward more effective treatment in primary care settings through the implementation of models such as the psychiatric collaborative care model. The results are that patients are seeking care, care of the less complex patient is happening more often in the primary care setting, and psychiatrists are seeing a higher percentage of more complex patients. A shift away from a graduated fee structure based on patient complexity could result in fewer psychiatrists willing to treat more complicated patients and driving more psychiatrists to not accept Medicare patients. This would be further exacerbated when you factor in the diminishing psychiatric workforce, with some estimates projecting a shortage of 14,280 to 31,091 psychiatrists through 2024.¹⁸

Simplification of the fee structure could lead to practice patterns of brief, but more frequent, visits that limit the focus to one or two issues each visit, rather than addressing complex issues in one longer visit that would be appropriately paid for if based on the complexities addressed. This has the potential to adversely impact patient care and decrease patient convenience since it disincentivizes physicians to care for the sickest and most complicated patients. We have seen this in psychiatry in the past. Our specialty has only recently come out from under the burden of a flat fee for medication management (CPT code 90862) with no recognition of the patient’s complexity. This can be especially problematic for the Medicare population, whose members often have several chronic conditions that must be taken into account at every encounter.

CMS has proposed two add-on codes that appear to be meant to distinguish the work of specific groups:

- GPC1X (*Visit complexity inherent to evaluation and management associated with primary medical care services that as the continuing focal point for all needed health care services (add-on code list separately in addition to an evaluation and management visit), and*
- GCG0X (*Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology,*
- *allergy/immunology, otolaryngology, cardiology, or interventional pain management-centered care (Add-on code, list separately in addition to an evaluation and management visit))*

Both appear to be meant to supplement the work of the E/M service, with the former applied to evaluation and management services provided by primary care providers and the latter available to a select group of specialties to recognize work involved in caring for more complex patients.

CMS states that the add-on codes are meant to address stand-alone E/M visits where there are additional resources inherent in the E/M service. **CMS goes on to propose that psychiatry be excluded from using either add-on code “because psychiatrists may utilize CPT code 90785 to describe work that might otherwise be reported with a level 4 or level 5 E/M visit.”**

We appreciate that CMS recognizes that not all visits require the same amount of work despite the proposal to reimburse as if all visits were similar. However, we find the restricted nature of these add-on codes, which excludes some physicians who provide the same or similar work, problematic. **If CMS were to choose to adopt the proposed single complexity code, we would strongly encourage CMS to clearly define the service, permit psychiatrists to use the GCG0X add-on code, and develop clear parameters as to when this code can be used.** We must fault the reasoning behind the proposal that suggests psychiatrists already have access to a different code (90785) that can describe this work. CMS proposes to exclude psychiatry on the basis of what appears to be a misunderstanding of how CPT code 90785, Interactive Complexity, is intended to be used.^{19,20} **This code does not describe medical work nor can it be used in conjunction with an E/M service.²¹ It was developed to account for communication problems that intensify the therapeutic portion of the work in a psychotherapy session and has nothing to do with the complexity of the patient’s medical condition, which is captured in the E/M portion of the visit. The new proposed single complexity code (GCG0X) is very different as it does address increased clinical work and would be just as appropriate for psychiatrists to use as would any other physician.**

Changes of the magnitude proposed have far reaching ramifications. The immediate implementation of this proposal would likely mean physicians would be documenting E/M services differently depending on the payer. Contracts between payers and physicians, and physicians and employers may need to be renegotiated. The relativity of services within the RBRVS system would be impacted. It would also require an educational effort for physicians, payers, and others such as coders and auditors to ensure all of the changes are well understood.

In summary, we recommend CMS finalize the following documentation changes, which can be implemented in January 2019, while maintaining the 5 levels of E/M services:

- **Eliminating the prohibition on same-day E/M visits billed by physicians in the same group or specialty. This will save patients time and money by giving them an opportunity to schedule**

their medical appointments more efficiently.

- **Eliminating the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or by the patient.**
- **Changing the required documentation of the patient's history to focus only on the interval history since the previous visit (for established patients).**
- **Removing the need to justify providing a home visit instead of an office visit.**

We also recommend that in lieu of finalizing the remaining proposals within the E/M section, CMS work with APA and other interested stakeholders (including the AMA) to further explore what has been proposed as well as to identify additional ways that offer a reduction to administrative burden while ensuring access to appropriate care. It is important to thoroughly understand the impact major changes such as those proposed will have on the entire system, including identifying any unintended consequences prior to implementation, and particularly if CMS is considering an expansion of the model to other settings.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Payment for Care Management Coding

The CMS proposal would expand the number of billable HCPCS/CPT codes for use by rural health clinics (RHCs) and federally qualified health centers (FQHCs). Currently, these settings use two codes for reporting collaborative care management (CoCM), chronic care management (CCM), and general behavioral health integration services (BHI).

- *G0511 qualified CCM or general BHI services, at least 20 minutes each calendar month*
- *G0512 initial psychiatric CoCM services, at least 70 minutes each calendar month, or subsequent psychiatric CoCM, at least 60 minutes each calendar month*

In 2019, CMS would add code 994X7 (chronic care management, 30 minutes or more) to the fee schedule, as a similar service to 99487 and 99490. RHCs and FQHCs would see new code 994X7 added as a code for general care management. Its relative value would also be added to the calculation of G0511, such that the payment value of G0511 becomes the average of non-facility values for 99490, 99487, 99484, and 994X7.

APA strongly supports this proposal. Reimbursement for these services would improve beneficiary access to mental health and integrated care services provided at FQHCS and RHCS at a time when the nation is fighting an opioid and substance use public health emergency.

APA commends CMS for their ongoing support for providing care management services in RHCs and FQHCs. Coverage proposals over the last year have provided an opportunity for the implementation of evidence-based models of care that have improved patient care and response to treatment. These models of care can only be sustained if there is appropriate funding to cover the associated costs.^{22,23,24}

CMS approved payment for psychiatric collaborative care services beginning in January 2018, assigning HCPCS code G0512, and creating a payment amount that was the average of two of the three existing CMS approved CPT codes (99492 and 99493). Unlike the CPT codes which allowed for the application of

the CPT time rule when calculating the time required to bill the service, CMS mandated that minimum time required (70 minutes for the first month, and 60 minutes for subsequent months) must be met prior to billing the service. As a result, RHCs and FQHCs must spend additional time beyond that spent under the traditional Medicare benefit prior to billing the service. We have heard from several centers that this has resulted in an inability to bill for the services being provided. While they can bill the other care management code, G0511, the payment amount is insufficient to cover the additional costs associated with the collaborative care model. It has had a negative impact on their ability to successfully implement what has been shown to be an effective model of care. **APA requests that CMS reconsider and allow for the application of the CPT time rule in the billing of collaborative care services in RHCs and FQHCs which would enable centers to bill the services at 36 and 31 minutes, respectively.**

Communication Technology-Based Services and Remote Evaluations

To parallel the new communication technology-based services that are proposed for the fee schedule, CMS would similarly allow RHCs and FQHCs to separately bill an as-yet-unspecified G-code for a virtual check-in of 5 to 10 minutes, to assess whether a patient's condition requires a face-to-face visit. The code would be billable only when the medical discussion was not related to an E/M visit during the previous 7 days and did not result in a face-to-face visit in the following 24 hours or next available appointment. CMS would allow RHCs and FQHCs to bill the unspecified code separately in cases where the physician/clinician determines that an in-person visit is not necessary. This is a departure from current policy that considers all services related to a specific office visit to be included in that visit's all-inclusive per diem reimbursement. This new Virtual Communications G-code would be reimbursed at the average of payments for GVC11 (communication technology-based services) and GRAS1 (remote evaluation services). Coinsurance would apply in the FQHC; the beneficiary's coinsurance plus deductible would apply in the RHC. **APA is pleased that a new code for services provided using communications-based technology is proposed for the RHC and FQHC settings. We support this proposal which we expect will increase beneficiary access to mental health services.**

Promoting Interoperability

APA acknowledges the success of the Health Information Technology for Economic and Clinical Health (HITECH) Act and the original Meaningful Use program in incentivizing the adoption of electronic health record (EHR) systems into practice, especially among hospitals. APA also appreciates CMS's commitment to reducing administrative burdens associated with EHR adoption and utilization with respect to the MIPS program and supports CMS's commitment to do so for eligible clinicians in the 2019 reporting year Quality Payment Program proposed rule.

As APA has detailed extensively in previous letters, the focus on true interoperability—rather than on arbitrary, measure reporting thresholds with respect to EHR use—should remain the cornerstone of the Medicare EHR Incentive Program. **Accordingly, APA appreciates the current proposed rule's emphasis on using EHRs to promote interoperability, the overall reduction of mandatory reporting thresholds, and the elimination of many burdensome, patient-driven measures, all of which represents progress toward implementing the aims of the Office of the National Coordinator for Health Information Technology (ONC) MyHealthEData initiative.**

First, APA supports the performance-based approach to determining eligible clinicians' scores on the Promoting Interoperability performance category.

While questions remain about the direct correspondence of these activities to improved patient outcomes, the proposed scoring methodology would allow eligible clinicians to select the measures that best meet their strengths with a focus on health-data exchange, patients' access to their records, and open APIs to facilitate the movement of patient data across systems.

Unfortunately, there are still too few Certified Electronic Health Record Technology CEHRT options specifically tailored for behavioral health, and psychiatry specifically, that will allow for successful participation of psychiatrists in MIPS through EHRs alone (although psychiatrists are reporting successfully for MIPS by connecting their EHR system to our PsychPRO registry for the Quality performance category). While there are general CEHRT options that psychiatrists *could* use to participate in the Quality Payment Program, these often do not directly mirror psychiatric care workflows. That said, the APA is hopeful that the performance approach in the 2019 reporting year proposed rule will offer psychiatrists some degree of leniency in selecting those measures most germane to their practice.

Second, APA also appreciates the efforts of CMS in this proposed rule to reduce administrative burdens within the EHR Incentive Program that have been time-consuming or not truly aligned with the meaningful use of EHR systems in general. The removal of patient-driven measures that proved particularly challenging for psychiatrists (e.g., Patient-Specific Education, Secure Messaging, Patient-Generated Health Data, View, Download, or Transmit) and the consolidation of others (e.g., Request/Accept Summary of Care, Clinical Information Reconciliation) is especially appreciated, given the administrative burden endured by clinicians in adopting these activities into workflows and subsequently tracking successful incidences of their use. Additionally, successful reporting on these measures is based on whether psychiatric patients use specific features of their record—such as secure messaging--something beyond the control of clinicians, especially given the unique nature of certain psychiatric diagnoses.

The APA anticipates that psychiatrists will continue to experience challenges on the new measures that consolidate the features of some of those removed (e.g., Support Electronic Referral Loops—Receiving and Incorporating Health Information). While APA is committed to empowering innovation in psychiatric practice as a way to mitigate some of these challenges (e.g., by reporting through our PsychPRO Registry), many of our members may still continue to struggle to integrate measures around EHRs into their workflows because a) they work with specific patient populations whose diagnoses make it extremely difficult to regularly and meaningfully engage with the EHR in the interest of their own care coordination, or b) because they work in solo or small group practices and often have little administrative support to integrate EHRs into their practice.

We have heard from members who indicate that the two renamed/re-envisioned measures (e.g., Supporting Electronic Referral Loops by Sending Health Information; Provide Patients Electronic Access to their Health Information) will be challenging to successfully report due to the unique nature of psychiatric workflows. APA appreciates the proposed rule's elimination of many of the arbitrary thresholds and administrative burdens associated with these types of reporting activities required under the current reporting program. However, attaining the maximum combined 60 points under the proposed performance score methodology for the "Provider to Patient Exchange" and "Health Information Exchange" Promoting Interoperability measures may still prove challenging for many psychiatrists due to the unique nature of psychiatric workflows and the limited capacity for some psychiatric patients to engage with their electronic record.

The APA recommends that the final rule follow previous rulemaking in allowing “one permissible...” activity to count toward full participation in the various measures under the Promoting Interoperability category (e.g., “at least one permissible prescription written by an eligible clinician...”).

Health Information Exchange Across the Care Continuum (Health Information Exchange Objective): This measure, if introduced into the Promoting Interoperability performance category, has the potential to “close the referral loop,” which would be beneficial for psychiatrists and their patients. **The APA recommends that this not become a required measure for reporting year 2019, but instead be introduced as a potential bonus of up to 5 percent for the Improving Interoperability performance category.**

Transition to Sole Use of 2015 CEHRT

In the current proposal, CMS states that it will require eligible professionals to use 2015 Edition CEHRT by the 2019 reporting year. APA understands the drive toward 2015 CEHRT will maximize the potential for interoperability between systems and that including 2014 CEHRT results in several drawbacks due to retro-adaptations.

With respect to the CEHRT program overall, psychiatrists continue to experience challenges in adopting CEHRT into their practices compared to other care providers for the reasons stated in the previous sections. Regardless of the CEHRT edition, it is in the interest of Medicare to promote greater engagement of independent and small group psychiatrist eligible clinicians with larger hospital systems and limiting the type of EHR system that can support this engagement precludes these efforts. The MyHealthEData initiative’s focus on interoperability and this proposed rule’s use of APIs to connect patients and providers may eventually bridge this gap; unfortunately, the business case for smaller, psychiatry-focused EHR vendors to adopt CEHRT simply does not exist, often because many solo and small group providers have opted-out of Medicare due to the increasing demands of reporting requirements.

While many larger vendors certified to the 2015 Edition can and do support psychiatry, there is often an added cost in adapting the software to fit psychiatric workflows, including integrating relevant electronic clinical quality measures into the platform. Providers must also then bear the cost of hiring administrative support staff to aid in adhering to the quality reporting programs. The APA has had success in helping psychiatrists with reporting for MIPS, but those who wish to use their EHR alone still find that they have limited options when seeking psychiatry-specific systems in the ONC’s Certified Health IT Product List (CHPL).

The APA recommends that CMS allow for a one-time exception for the Improving Interoperability for eligible clinicians for the 2019 reporting year who used CEHRT for the 2018 Quality Payment Program reporting year to ease the transition for those who must purchase and implement new technology.

New Opioid Measures: Query of Prescription Drug Monitoring Program (PDMP); Verify Opioid Treatment Agreement

APA appreciates CMS efforts in addressing the opioid epidemic. While the addition of two new measures under the e-prescribing objective may prove helpful in this endeavor, APA has some questions regarding their implementation.

Query of Prescription Drug Monitoring Program (PDMP): First, APA supports the Query of PDMP measure as a tool to address opioid abuse and diversion. However, PDMP integration is not currently in widespread

use for CEHRT, and many eligible clinicians would potentially need to change workflows at the point of care before they can meet this measure without experiencing a significant burden.

For example, APA has heard from many members regarding how work flows are already burdensome when using PDMPs in practice. This is because it takes a significant amount of time to query PDMPs due to additional steps of logging into systems, entering patient data for querying purposes, and using two-factor authentication. Requiring that physicians engage in these practices to meet measure thresholds would add to this burden. However, better integration of PDMPs into CEHRT would help to mitigate these issues and APA is supportive of CMS or the ONC in developing standards around resolving this issue if CMS were to accept feedback on proposed standards during additional rulemaking.

Verify Opioid Treatment Agreement: While opioid treatment agreements have demonstrated some benefit to patients and providers, APA urges caution in the widespread adoption of this measure into Promoting Interoperability framework. A lack of consensus on how an opioid treatment agreement is defined; the potential for the introduction of mistrust into the therapeutic alliance; and the potential for providers to discontinue treating patients due to systemic errors in the technology related to integrating this measure broadly into a patchwork of EHR systems may result in more negative than positive outcomes.

CY 2019 Updates to the Quality Payment Program

MIPS Performance Category Measures and Activities

Performance Category Measures and Reporting

Collection Types, Submission Types and Submitter Types

APA supports CMS's proposed update to the following terminology associated with MIPS quality measurement data collection and submission:

- **Collection type** describes the measure specifications method of capturing data (e.g., Medicare Part B claims; electronic clinical quality measure (eCQM); MIPS clinical quality measure (MIPS CQMs); and CMS Web Interface). Quality measures may have multiple collection-types.
- **Submitter type** is the entity that submits the measure data. This can be an individual eligible clinician (EC), representative of a group, or third party (e.g., QCDRs or CMS Web Interface).
- **Submission type** describes the mechanism by which data is transmitted to CMS. The different mechanisms are direct (i.e., end-to-end electronic submission), log-in and upload (i.e., submit data through CMS specified format requiring authenticated credentials), log-in and attest (i.e., attest data through CMS specified format requiring authenticated credentials), Medicare Part B claims (data transmitted at the time of billing), and the CMS Web Interface, and CAHPS for MIPS survey.

If CMS finalizes these terminology updates, we request that educational information become available on the QPP website so that ECs will understand and appropriately apply these terms.

CMS proposes the following data completeness criteria for each measure collection type:

- Medicare Part B Claims should be submitted for 60 percent of individual MIPS ECs' or groups' Medicare Part B patients for the 2019 performance period.
- QCDR measures, MIPS CQMs, and eCQMs should be submitted for 60 percent of individual MIPS ECs' or groups' patients across all payers for the 2019 performance period.
- CMS Web Interface is applied to the first 248 consecutively ranked and assigned Medicare beneficiaries in the order in which they appear in the groups' sample for each measure. If there are

fewer than 248 assigned beneficiaries, then the group would report on 100 percent of their assigned beneficiaries.

- CAHPS for MIPS survey per CAHPS for MIPS sampling requirements.

APA supports the proposed data completeness criteria assigned to each measure collection type; they closely match the data completeness criteria of prior program years. APA also supports CMS's proposal to update quality performance category benchmarks, by individual quality measure and according to their collection types. We agree this update would maintain consistency when migrating between current MIPS terminology to proposed MIPS terminology, if finalized (i.e., moving from benchmarks based on measure submission mechanisms like EHR or registry, to measure collection types like eQMs or Medicare Part B claims).

APA supports the proposed update to the CMS Web Interface submission type to include groups of 16 or more ECs, instead of the current allowance of 25 or more ECs. We think that reducing the number required for EC-groups to participate in the Web Interface would promote an overall increase of EC participation in MIPS.

We understand that the requirements to submit measure data through the CMS Web Interface hinge on groups of 16 or more ECs meeting the data completeness requirements set forth for EC-groups of 25 or more. This means that measures must be applied to 248 sampled beneficiaries (or 100 percent of the assigned beneficiaries if there are fewer than 248 beneficiaries assigned to a measure) with the measures having a case minimum of 20 beneficiaries. We question the likelihood of EC-groups of 16 or more clinicians meeting the 20-case per measure criterion. **If there is a discrepancy between case minimum for most groups of 16 or more ECs, compared to groups of 25 or more, APA recommends that CMS maintain the current EC eligibility criteria of groups of 25 or more participating via CMS Web Interface submission type.**

APA supports the proposed allowance for third-party intermediaries to submit CMS interface measure data on behalf of groups participating in the quality performance category under this submission type. This not only allows groups already involved in a QCDR (for other quality improvement initiatives) to utilize this data submission process and reduce their data submission burden, but also could increase the likelihood that QCDRs could submit to become CAHPS for MIPS CMS approved vendors.

Virtual Groups

Virtual Group Election Process and Virtual Group Eligibility Determinations

APA supports the alignment of the virtual-group eligibility determination period with the MIPS determination period. For ECs to decide whether they would participate in MIPS through a virtual group, it is important that they are notified of their eligibility with time to work with CMS to find other ECs interested in participating within a virtual group, to finalize the virtual-group participation agreement, and to submit the required election materials to CMS before the close of the calendar year.

APA supports the CMS proposal to have ECs contact the QPP Service Center and work with a QPP representative to confirm their virtual-group-eligibility status. CMS confirms that the current claims data that QPP representatives' access to determine virtual-group-eligibility status is 100 percent reliable. The proposed action is intended to improve on the current and less reliable method of using TIN status. **We recommend that CMS devise, as part of the QPP portal, a direct way for ECs to confirm their virtual-**

group-eligibility status with 100 percent reliability, and to eliminate the potential human errors when using a QPP representative as an intermediary.

APA appreciates CMS’s proposed update to the virtual-group election process, which now requires virtual-group representatives to make the election through the QPP web-based portal. This process is intended to reduce the burden and eliminate potential e-mail address errors in the current method of separately identifying the appropriate e-mail address for submitting the election, and for virtual-group representatives to enter e-mail addresses into the election process. The error would later impact virtual groups that, as a result, would not receive notification of their approval to participate under this method.

Continuation of Support for Small and Rural Practices

CMS has proposed a reinvigoration of Medicare Part B claims measures for use by small practices. Considering CMS’s prior multi-year initiative to phase-out Medicare Part B claims measures and to drive the adoption of EHRs and electronically specified quality measures, **APA is concerned about how small and rural practices that have made the financial investment into certified EHR technology (CEHRT) would react to this proposed update that now promotes Medicare Part B claims measurement as a submission type.**

This proposed update sends an inconsistent message to those small and rural psychiatric practices that made the financial investment to adopt CEHRT.

APA appreciates CMS’s proposed effort to support small and rural practices’ participation in MIPS. We urge CMS to provide greater detail about whether:

- new Medicare Part B claims measures would be accepted for inclusion in the rulemaking process, or if only the current Medicare Part B claims quality measures would be continued for use by small and rural practices.
- small and rural practices who report their performance solely through Medicare Part B claims measures would be afforded the opportunity to submit fewer than the 6-measure criteria (including one outcome or high priority measure) required.
- there is value in the data submitted through the claims measure collection type, given the reduced number of clinically appropriate and applicable measures under Medicare Part B claims measures, particularly considering data that is collected from claims forms t containing minimal clinical information.

Due to the variation in the data quality of among eCQMs, MIPS CQMs, and Medicare Part B claims measures, **APA is particularly concerned by CMS’s public reporting of provider-level quality data on Physician Compare.** Our apprehension arises from the variation in performance rates between small and/or rural practices and larger and/or non-rural practices, because the larger and/or non-rural practices have greater chances of presenting quality data on that represent meaningful care (outcomes focused eCQMs or MIPS CQMs).

Application of Facility-Based Measures

We would support the definition of a facility-based EC—if it were to include psychiatrists—as one who “furnishes 75 percent or more of their covered professional services in sites of service identified by the place of service (POS) codes used in the HIPAA standard transaction as an inpatient hospital, on-campus outpatient hospital, or emergency room setting based on claims for a 12-month segment beginning on October 1 of the calendar year 2 years prior to the applicable performance period and ending on

September 30 of the calendar year preceding the applicable performance period with a 30-days claims run out.”

APA is interested in obtaining more information about the concept of ECs earning quality and cost performance category scores through the facility-based measurement option.

We urge CMS to work with behavioral health stakeholders to make comprehensive updates to the CMS Inpatient Psychiatric Facility Quality Reporting Program (IPFQRP). The needed updates would improve quality provided at the inpatient psychiatric facility care setting and would also support psychiatrists' future participation under the facility-based measurement option. Given some concerns APA has with the current IPFQRP, we would not advocate to psychiatrists that participation in this measurement option would allow them to use data that illustrates true quality care. This would place psychiatrists and other behavioral health MIPS ECs at a disadvantage not experienced by other ECs who are eligible to participate in facility-based measurement.

Stated in the proposed rule, CMS would not know until the second segment of the 12-month determination period whether ECs meet the facility-based qualification criteria. This would be problematic because ECs run the risk of assuming that they meet criteria based on unreliable preliminary information provided by CMS's web-based look-up tool only to learn later, when the final determination information is confirmed, that they are not eligible for MIPS facility-based measurement. This hinders ECs' potential success in the quality performance category because they did not participate in MIPS' traditional quality measurement. The inability for potential ECs to confirm this participation until the second 12-month segment creates redundancy because the only method non-confirmed facility-based ECs must ensure MIPS success is through collecting quality performance category data.

Before fully supporting this MIPS measurement option, APA requests that CMS detail the following issues:

- What percentage of MIPS ECs does CMS anticipate successfully participating in facility-based measurement?
- What percentage of MIPS ECs does CMS anticipate inaccurately assume that they meet facility-based measurement eligibility?
- Of those ECs who inaccurately assume that they meet facility-based measurement eligibility, what percentage would fail participation in the quality performance category?
- Has CMS developed a plan for ECs who fail to meet the facility-based measurement eligibility and who still aim to be successful in MIPS?

Medicare Shared Savings Program (MSSP)

Like MIPS, MSSP is a value-based payment (VBP) program that incentivizes the delivery of high quality care and positive health outcomes at low cost for accountable care organizations (ACOs). And like Alternative Payment Models APMs, ACOs take on a percentage of risk as it relates to the cost of care for the patients they treat. ACOs share in both savings and losses. Given the similarities between these VBP programs, as well as the similarities with how the quality measurement data are collected, **APA supports increased alignment between the MSSP and the QPP.** We are pleased by the CMS decision to streamline quality measures, reduce burden, and expand upon innovative data collection and reporting opportunities afforded by electronic health records (EHR) within the MSSP.

Quality Measurement

We also support the decision to update the MSSP measure set (ACO measures) to reduce reporting burden and to include outcome measures that provide greater meaning to the providers who use them, and to patients. Three of CMS's seven measure-removal criteria were used to update the MSSP measure set. These factors included removing analogous, inferior, and obsolete measures (unsubstantiated by current evidence). The MSSP set of ACO measures are reported through the CMS Web Interface, as are several MIPS quality measures that assess the same care gap, but at varying measurement-levels (ACO: system-level measurement, MIPS: provider-level measurement). **We recommend that CMS include quality measures in programs only where they have been tested.**

Like CMS, APA supports the use of evidence-based quality measures. According to the proposed rule, measure **ACO-15/NQF# 43 (lapsed)/Quality ID # 1111: Pneumonia Vaccination Status for Older Adults** is no longer supported by current clinical evidence. As such, we agree that it should be retired from use within the MSSP and the MIPS quality performance category. However, we question the proposal to remove it from the CMS Web-Interface for MIPS and MSSP, but not from use under the MIPS quality performance category through alternative data collection-types (Medicare Part B claim and MIPS CQM specifications). If CMS were to finalize this measure as part of the MIPS quality performance category until an evidence-based measure becomes available to address this topic, the current measure should at least be flagged within the CMS QPP MIPS Measure Database as representing data collection lacking the support of evidence and therefore burdensome and outdated. **We also request CMS provide details on available alternate quality measures that could help MIPS ECs meet the required measure criteria, instead of using NQF# 43 (lapsed)/Quality ID # 1111.**

APA supports the proposed replacement of NQF# 101/ACO-13/Quality ID # 318: Falls: Screening for Future Fall Risk. This measure captures an important care component, but with limited efficiency. APA's opinion is that screening and assessment quality measures should include follow-up processes that link to improved care and positive health outcome. **We support the concept of replacing the original measure with NQF #101/ACO-47/Quality ID# TBD: Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls.** As described within the proposed rule, NQF# 101/ACO-13/Quality ID # 318 has undergone such substantial changes that it is subject to the rulemaking process. If finalized as proposed, it would be identified as ACO-47 and with a new to-be-determined (TBD) MIPS quality identification number. ACO-47/Quality ID# TBD, the new measure proposed to replace ACO-13/Quality ID # 318, captures data elements of three quality measures proposed for removal from MIPS (Quality ID # 154: Falls: Risk Assessment, Quality ID # 155: Falls: Plan of Care and, Quality ID # 318: Falls: Screening for Future Fall Risk). We agree that this significantly updated quality measure should be included within the MIPS quality performance category as a high priority quality measure. **We support the implementation of ACO-47 into MSSP since it promotes more comprehensive and less disjointed care delivery than ACO-13.**

APA is deeply concerned that two quality measures pertinent to psychiatrists and other healthcare providers are proposed with updates for continued inclusion within MIPS's quality performance category but are simultaneously proposed for removal from the CMS Web Interface for MIPS, and therefore are also recommended for removal from MSSP. Within the MSSP section of the rule it is unclear why both **ACO-41/NQF #55/Quality ID # 117: Diabetes: Eye Exam** and **ACO-16/NQF #421/Quality ID # 128: Body Mass Index (BMI) Screening and Follow-Up Plan** are proposed for removal. Closely examining Table Group D within Appendix 1 referenced as "MIPS Proposed Quality Measures," one sees an explanation for the reasons to update the measure collection-type to Medicare Part B claim, eCQM, and MIPS CQM specifications.

APA understands that by using the CMS Web Interface to participate in MIPS or MSSP, participants are subject to all quality measures included as part of this data collection and submission method. Because of the potential for the list of quality measures within the CMS Web Interface to become burdensome since it consists of a considerable number of measures (15 included in the 2018 performance year), **APA supports the concept of reducing measure clutter and user burden. However, we disagree with the proposed removal of these measures from MSSP's data submission, despite CMS's policy of streamlining the removal or inclusion of measures between the QPP and MSSP.**

MSSP's measure set is cross-cutting, and applicable to a broad swath of physicians. ACO-16: Body Mass Index (BMI) Screening and Follow-Up Plan is included within 17 of the 33 MIPS Quality Performance Category measure specialty sets. Therefore, we think it is an appropriate, applicable, and important metric to assess within the CMS Web Interface for MSSP. Since weight loss and gain are symptoms of some mental health disorders and patients with serious mental illness face increased risks for obesity and early death from medical comorbidities as a side-effect caused by psychotropic medications, psychiatrists and primary care clinicians continue to benefit from having access to this quality measure. **We recommend that CMS maintain this measure in the MSSP and MIPS Web Interface.**

Although fewer specialty sets propose including ACO-41/NQF #55/Quality ID # 117: Diabetes: Eye Exam, we are troubled by its potential removal and limited specialty set inclusion. This cross-cutting measure intends to close care gaps for those with diabetes who, because of this diagnosis, are at an increased risk for developing retinopathy and vision loss. Individuals with schizophrenia often develop diabetes independent of an antipsychotic medication regimen, and those on antipsychotics for psychotic disorders (e.g., schizoaffective disorder and delusional disorder) or mood disorders (e.g., bipolar disorders) are often diagnosed with diabetes as a side-effect of antipsychotic medications.²⁵ Unfortunately, individuals with these serious mental illnesses (SMI) often receive infrequent treatment on a regular basis by a PCP.²⁶ So, while they might be screened and diagnosed with diabetes, they often go unmonitored. This measure would benefit psychiatrists and others who treat those with SMIs for the continued monitoring of diabetes and related comorbidities. **APA recommends this measure for inclusion within the Mental/Behavioral Health Measure Specialty Set as reportable through all data collection types.**

For the purposes of program alignment and harmonization, APA supports the proposal to align the MSSP measure set with those measures collected by CMS Web-Interface for MIPS. CMS has a process to unidirectionally streamline measure data collection between the programs. Updates to measures used in the CMS Web Interface for MIPS are reflected in ACO quality measures, reducing measurement clutter and reporting burden. However, we caution the overuse of this update process. We recommend that measurement and this type of reporting updates be made on a case-by-case basis and meet the needs of the program and its participants.

Calendar Year 2019 MIPS Updates

APA supports CMS's decision to propose some refinements to MIPS eligibility criteria, clinician participation categories, and performance categories. We recognize the adoption of the Meaningful Measurement Initiative as imperative to meeting the needs of individual ECs and groups. Since the transition from CMS's legacy programs (i.e., Physician Quality Reporting System, Value-Based Modifier, and Electronic Health Record Incentive Program for Meaningful Use) to MIPS, some qualifying MIPS participants have been able to take advantage of different exemption criteria or bonuses. We are concerned by the discontinuous policies that define ECs and the impact of excluding more providers from MIPS. This has great impact on those ECs who make large financial commitments and organizational

infrastructure modifications to obtain designation as exceptional performers, which rewards them with the exceptional performer bonus payment. However, **by promoting opportunities to exempt more participants under the low-volume threshold criteria, the percentage rate awarded to exceptional performers is reduced and negatively effects the investment the exceptional performers made to their MIPS participation.**

APA recommends that CMS delay the proposed increase to the exceptional performer points threshold. Until stakeholders receive and review feedback on the success rates of MIPS ECs. APA recommends that CMS make available the rates that EC-psychiatrists exceeded the exceptional performance points threshold during the 2017 MIPS performance year.

Selection of MIPS Quality Measures for Individual MIPS Eligible Clinicians and Groups Under the Annual List of Quality Measures Available for MIPS Assessment

Background and Policies for the Call for Measures and Measure Selection Process

APA agrees that to address the opioid crisis, quality measures addressing various aspects of the epidemic must be developed and implemented. We support the proposal to include quality measures addressing the opioid epidemic but urge CMS not to include it as its own high priority measure domain. Because the opioid epidemic is multifaceted, APA recommends that the care gaps that contribute to the crisis may be addressed by impactful measures that fit under the established high priority measure domains. Identifying a certain clinical subject like opioids as a high priority area would increase the potential to silo the measures used and incentivize measure developers to develop an excess of opioid quality measures including concepts addressed by other general population quality measures, but with the additional opioid-specification. Instead, **APA recommends a more impactful approach that includes CMS presenting stakeholders with an environmental scan of opioid measures** (including those finalized in rulemaking and others), assign the measures to MIPS quality performance category “high priority” domains so that stakeholders (including developers) can see what exists on this topic and see where gaps in care and measurement remain, and determine a strategy to address these gaps.

We are also concerned that measures addressing this high priority area would be used by those providers who already meet the numerator actions and achieve high performance rates, thereby not eliciting a greater frequency of improved outcomes or process changes. As such, **APA requests that CMS work with other appropriate agencies and stakeholders and use existing resources, like the National Quality Forum-convened National Quality Partnership Opioid Action Team’s Playbook, to develop a strategy to significantly change the quality of care regarding patient outcomes and the various components related to the opioid epidemic.**

APA supports CMS’s solution to the concerns voiced by Medicare’s Payment Advisory Commission (MedPAC), including efforts targeted at reporting burden and reducing barriers to interoperability. We agree that MIPS administrators should prioritize implementing patient-centered provider-level quality measures, while also reducing the inflated number of ineffective process measures. However, contrary to our recommendation to remove process measures, we advise CMS and MIPS to adopt better-specified evidence-based process measures that address the occurrence of procedures proven to promote positive health outcomes, rather than continuing to implement narrowly specified quality measures that omit otherwise appropriate patients.

As quality measure developers, approvers, and implementers, CMS should bear the responsibility of ensuring that quality performance measures are specified in way that equitably and sufficiently assesses the quality of provided care, and addresses care variation and gaps for as broad a population as possible. They should not encumber ECs with focusing on the quality measures each patient encounter would or would not meet. **CMS must insist that the measures implemented, even if they are not patient-reported, meet the needs of all patients, not just Medicare Part B beneficiaries.**

The Mental/Behavioral Health Specialty Measure Set too narrowly defines the measures' denominator populations. This type of highly detailed specification inappropriately limits the users' abilities to apply otherwise applicable and useful measures to a larger percentage of patients.

We appreciate that the APA-stewarded measure Quality ID# 325: Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions is proposed for continued inclusion in the Mental/Behavioral Specialty Measure Set for the 2019 MIPS performance year. We interpret the lack of the "Individual Measures List" proposed within the rule to mean that CMS solely supports quality measures as part of specialty measure sets, and we conclude that ECs would be required to select measures from one of the 33 specialty sets to meet the 6-measure (including one outcome or high priority measure) criteria.

Even with Quality ID#325 continuing in the quality performance category, we are concerned that requiring ECs to select their measures only from a discreet specialty set puts patients at risk for receiving more fragmented and reduced care quality. For example, EC-psychiatrists treat patients with serious mental illnesses (SMIs) like schizophrenia and other psychotic disorders, major depressive disorder, and bipolar disorders. Rates of medical illness in patients with SMI exceed those of the general population in every disease category.^{27,28} Those with SMI experience higher standardized mortality ratios compared to the general population for cardiovascular, respiratory, and infectious diseases.

Patients with SMI engage in modifiable risk behaviors, including tobacco use, other substance use, poor diet, lack of physical activity, and lack of adherence to treatments at higher rates than the general population, placing them at risk for chronic medical conditions and poorer outcomes. In addition to adverse social determinants of health (e.g., the effects of economic disadvantage and chronic stress), side effects of medications prescribed for patients with SMI also contribute significantly, with weight gain and glucose dysregulation being noted most prominently with antipsychotic medications.²⁹ In addition to this, those with mental illness are at risk for receiving poor-quality medical care.

SMI patients underuse primary care services and overuse emergency and medical inpatient care,³⁰ resulting in fragmented and irregular services and lower rates of preventive care.³¹ Individuals with SMI are also less likely to receive adequate, standard of care treatment for medical conditions when compared to age-matched controls, which likely contributes to premature mortality.³²

Considering the frequency of medical comorbidity diagnoses and the fragmented health care delivery for SMI patients, **we request that CMS include more cross-cutting measures that address commonly diagnosed medical comorbidities among patients with SMI into the Mental/Behavioral Health Specialty Measure Set.** Due to the nature of the encounter, the EC-psychiatrist might not utilize otherwise-appropriate measures because it might be therapeutically inappropriate. The decision to employ a quality measure for all specialties must be made on a case-by-case basis.

We do not think that new measures must be developed to specifically address patients with mental or substance use disorders and medical comorbidities. Measures that already exist for the general population would be adequate to use to monitor these conditions. We recommend that the following measures be included:

- Quality ID: 126 – Diabetic Foot and Ankle Care, Peripheral Neuropathy, Neurological Evaluation;
- Quality ID: 127 – Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention, Evaluation of Footwear;
- Quality ID: 117 – Diabetes: Eye Exam;
- Quality ID: 163 – Diabetes: Foot Exam;
- Quality ID: 001 – Diabetes: Hemoglobin A_{1c} (HbA_{1c}) Poor Control (>9 percent);
- Quality ID: 119 – Diabetes: Medical Attention for Nephropathy;
- Quality ID: 0047 – Care Plan; and
- Quality ID: 236 – Controlling High Blood Pressure.

APA is concerned by CMS's broadly applied contrary opinion of process measures. We agree that implementing outcome measures as part of routine care is the epitome to providing high quality health care. These measures present meaning to patients and healthcare providers and support the implementation of evidence-based treatment interventions that suffer care gaps and variation. However, **we caution CMS not to automatically propose measures for removal or to reject new and updated measures simply because they are process-based.**

Psychiatrists have gradually adopted measurement-based care (MBC) and treatment-to-target, as well as medication assisted therapy (MAT) in the treatment of substance use disorders. Because of the expansion of integrated care and the increased frequency with which behavioral health treatment occurs in the primary care setting, we think measures regarding assessing the frequency of MBC and treatment-to-target are necessary. This process is not yet part of the standard workflow for specialty behavioral health and primary care settings. Process measures assessing the occurrence of MAT for the treatment of particular substance use disorders (alcohol and opioid use disorders), would help ECs develop this treatment component into their workflow and yield more positive health outcomes.

Table Group B (B.17 Mental/Behavioral Specialty Measure Set)

NQF #104/Quality ID #107: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment assesses an inherent symptom of multiple mental illnesses. Due to the threat this symptom imposes on patients' and their family members' lives, assessing for suicidality and measuring the assessment rate is especially important. This is particularly true for primary care physicians and other healthcare providers who do not possess expertise in the assessment, management, and treatment of suicidality and other symptoms associated with mental illness.

APA is concerned by limitations imposed by the measure's denominator. As currently specified, the denominator limits screening for suicide to patients with new onset or recurrent episodes of Major Depressive Disorder (MDD), instead of applying it to patients with mood disorders, as supported by the measure's rationale and evidence to measure (part of the National Quality Forum's 2018 Spring Behavioral Health Measure Endorsement Cycle). Current evidence supports suicide risk assessments for an even broader population, like patients with other mental illnesses who present an increased safety risk.³³ Examples include anxiety, posttraumatic stress, and substance use disorders. Other conditions that pose an increased suicide risk are schizophrenia and other psychotic disorders; eating disorders and Borderline

Personality Disorder. This measure would be better specified by including patients with comorbid-multiple psychiatric illnesses paired with increased substance use and medical conditions (i.e., chronic pain).

We request CMS work with the measure’s developers to also provide a definition of the term “assessment.” Also, while we do not wish to have a proscribed list of required assessment tools, so users may earn performance points for this measure, to avoid issues with the measure’s reliability and to provide clarity to those ECs who do not possess expertise in suicide risk assessments, a basic definition of what consists of this evaluation or “assessment” is necessary. **We recommend that the measure include references on the use of validated rating scales designed for suicide screening and assessment should be considered.**

APA recommends removing NQF #105/Quality ID #009: Anti-Depressant Medication Management from use in Physician Compare, including the Five Star Ratings System and other consumer accessible quality performance information. Given that test data included in the submission package for NQF’s 2018 Spring Behavioral Health Measure Endorsement Cycle consisted only of results on the measure’s use at the health plan-level, CMS is unable confirm the quality of the data collected at the provider-level. If a measure is not tested at the provider-level, it is unknown whether the data collected in the MIPS quality performance category is valid or reliable among users at this measurement level. This means that the data posted on Physician Compare could inaccurately report physician performance of this measure’s numerator. If the data collected under this measure inaccurately illustrated provider administered care, patients and practices would be negatively impacted.

We request that CMS have the developers test this measure at the provider-level before considering its continued use in MIPS.

Quality ID #105 also consists of a limited denominator. Antidepressants may be prescribed to individuals who do not meet criteria for an MDD diagnosis. According to current evidence, various mental illnesses may be treated with antidepressants; as such, adherence to antidepressants result in more positive health outcomes for those for whom they are appropriately prescribed. Therefore, we request that CMS engage with the measure’s developers and discuss widening the measure’s population to consist of anyone prescribed antidepressants as guided by current evidence. Given this measurement update, and the requirement that substantive measure updates are subject to rulemaking, **we request that this measure not be considered for use in the MIPS quality performance category until it is tested and demonstrates valid and reliable measurement characteristics.**

Currently, APA does not support the proposed removal of Quality ID #367: Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use. We are pleased that the quality performance category includes Quality ID # 431: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling, but we urge CMS to continue to include Quality ID #367. Based on the measures proposed in the Mental/Behavioral Specialty Measure Set, should CMS remove Quality ID #367, the specialty measure set would lack measures that address unhealthy substance use. Per CMS’s measure removal criteria, we agree that it is appropriate and necessary to replace measures that are duplicative or are inferior to other quality measures. We view Quality ID #431 as neither -duplicative nor superior to Quality ID #367; removing Quality ID #367 would not align with the CMS measure removal criteria.

We agree that Quality ID #367 is crudely specified. If the developers were to update the denominator to include the general population and the numerator to include data capture of the follow-up actions related to the appraisal, this measure would be more useful in MIPS than is Quality ID #431. However, in the absence of a quality measure that tracks unhealthy substance use for the general population within the Mental/Behavioral Specialty Measure Set, and because individuals with Bipolar Disorder or MDD have high rates of co-morbid substance abuse which lead to worse outcomes (e.g., increased symptoms, greater suicide attempts, and longer episodes and lower quality of life) we think this measure should be included in the Mental/Behavioral Specialty Measure Set, until a more superior measure becomes available to take its place.

Table Group D: Measures with Substantive Changes Proposed for the 2021 MIPS Payment Year and Future Years

The quality measures listed in “Table Group D: Measures with Substantive Changes Proposed for the 2021 MIPS Payment Year and Future Years” have undergone considerable changes, making them subject to rulemaking.

When the substantive changes include new or updated eQMs, CMS advises ECs to communicate with their CEHRT vendor if their EHR system does not adequately capture data defined within the new or updated eQMs. However, APA understands this is a challenge for psychiatrists because individual and group EC-psychiatrists do not have that level of influence over EHR vendors. Because psychiatric practices tend to earn less revenue than other medical specialty practices, they purchase less expensive CEHRT systems that may not meet their functionality needs. Cited in the US Government Accountability Office’s (GAO) 2018 “Medicare Report on Small and Rural Practices’ Experiences in Previous Programs and Expected Performance in the Merit-based Incentive Payment,” challenges related to CEHRT and data collection updates regarding eQM specifications also apply to larger and nonrural practices. Some examples include the lack of qualified staff available to perform necessary EHR maintenance tasks, which impedes interoperability between CMS or other data-recipients (e.g., QCDRs), therefore practices are unable to submit MIPS required measurement data; they rely more heavily on vendors’ technical assistance to provide services that financially-able practices employ qualified staff to provide. However, the problem arises when vendors may be less willing or unable to fully provide the level of support required by one of these less financially-able psychiatric practices. **We urge CMS to work with the ONC on provisions of the 21st Century Cures Act around interoperability and information blocking to give ECs more options in selecting their CEHRT vendors.**

Scoring Measures That Do Not Meet Case Minimum, Data Completeness, and Benchmarks Requirements

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 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 60 percent of their eligible practice and to include at least one outcome or high priority measure. 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, psychiatrists must use more cross-cutting quality measures than do other eligible clinicians. However, the cross-cutting measures that psychiatrists *can* use often do not

equate to measures they *should* use. **APA recommends that MIPS administrators work with the multi-specialty clinical experts to revise and improve their definition of measure “appropriateness “and “applicability.”**

We urge CMS to work with the specialty societies and clinical experts to refine the measure validation process. As proposed, CMS would apply the measure validation process to MIPS CQMs and Medicare Part B claims measures. Given that ECs who submit Medicare Part B claims measures and MIPS CQMs already face barriers to meeting the 6-measure criteria to earn scores that reflect care quality, we recommend that CMS include an opportunity for ECs to appeal the CMS validation process determination. **We recommend that the appeal process include an opportunity for deliberation among clinical experts who engage with the EC over the clinical appropriateness and applicability of the EC’s decision to omit the measures CMS determined “appropriate” and “applicable.”**

APA is also concerned with eCQMs and EC- psychiatrists’ reduced influence over EHR system changes. We recognize that eCQMs are not proposed for inclusion in the MIPS measure validation process. **However, we request clarity regarding how CMS would determine the number of points in the quality performance category denominator if EC-psychiatrists use eCQMs to collect data and submit through the direct submission type (e.g., CEHRT), but are unable to meet the six-measure reporting criteria because the EHR system did not capture the data elements within some of the eCQMs included as part of the psychiatrists’ selected specialty measure set.**

Topped Out Quality Measures

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 EC attempts to achieve the six-quality measures criteria, “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 seven points allowed toward the ECs “total measure achievement points,” earned by reporting “topped out” measures, is a reasonable points assignment.

We are concerned by the proposed update to the “topped out” measure removal process that impacts quality measures and their users more rapidly than the four-year topped out measure removal cycle. As stated in the proposed rule, “once a measure has reached an extremely topped out status (for example, a measure with an average mean performance within the 98th to 100th percentile range), we may propose the measure for removal in the next rulemaking cycle, regardless of whether or not it is in the midst of the topped out measure lifecycle, due to the extremely high and unvarying performance where meaningful distinctions and improvement in performance can no longer be made, after taking into account any other relevant factors.” We support CMS’s effort to implement meaningful quality measures that are not maintained for measurement sake. However, recognizing a measure as meeting “an extremely topped out status” and then proposing its removal during the following rulemaking cycle is contrary to the standardization process CMS has developed and continues to refine.

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.

Categorizing Measures by Value

We are not yet able to comment on whether we support CMS's concept of quality measurement weight assignments proposed for future MIPS quality performance category years, given the limited information provided within the proposed rule. However, **we recommend CMS work with their clinical-expert partners (via professional societies) to determine quality-measure-weight values.** Since MIPS administrators do not possess clinical expertise in all medical specialties, it would not be appropriate to assign measurement weight values based solely on the measure-type (process or outcomes) and without consulting clinical subject-matter experts.

MIPS Final Score Methodology ***Achievement Point Assignments***

As we have since the 2017 MIPS Program Transition Year, **APA continues to support the assignment of three to 10 measure achievement points for each submitted measure** that can be reliably scored against a benchmark, which implies that the measure met case minimum and data completeness requirements.

Additional Policies for the CAHPS for MIPS Measure Score

APA supports the proposal that permits EC-groups to continue to voluntarily participate in the CAHPS for MIPS survey despite CMS's inability to confirm the beneficiary sampling criteria before the timeframe that CAHPS for MIPS data is collected. We appreciate that by reducing the denominator of the total quality performance category scoring algorithm by ten points, CMS is removing one measure from the anticipated total number of measures scored with the maximum 10 points.

APA urges CMS to better define and finalize the "topped out measure" criteria and measure removal process before considering how to apply it to, and score, CAHPS for MIPS Summary Survey Measures (SSM). However, considering that SSMs have been removed from MIPS scoring between performance years due to low reliability, duplication of the survey questions, and to promote alignment with other CMS quality programs, our suggestion would be to individually score all SSMs. Individually scoring each SSM and removing them based on the CMS removal criteria prevents CAHPS for MIPS from becoming "topped out," and supports the appropriate removal and potential inclusion of SSMs for MIPS scoring. ECs would still have the potential to measure their practices' performance in the SSM domains, but those measures would be void of earning quality performance category measure achievement points toward the full CAHPS for MIPS survey measure achievement points score.

Small Practice Bonus

APA agrees with CMS's proposal to award small practices with three bonus points, given these ECs submit data to MIPS on at least one quality measure. By adding the three bonus points to the quality performance category numerator, MIPS scores include data reflective of performance, rather than their ability and infrastructure to support quality performance category data submission.

Incentives to Report High-Priority Measures

APA supports the update that removes the award of bonus points to groups who participate in the quality performance category through the CMS Web Interface. Given that the CMS Web Interface assigns beneficiaries for data collection and prepopulates the measures with data, groups who use this option for MIPS show better performance rates than groups who use alternative data collection types, have an increased probability of earning higher quality performance category, and overall higher MIPS

scores. Moreover, those groups who collect and submit data through the CMS Web Interface are also at an increased likelihood of utilizing the CAHPS for MIPS survey, which is being retained for group utilization and still applicable for earning bonus points as a high priority measure.

APA requests that CMS provide more information about the potential future proposal to remove high-priority measure bonus points from the quality performance category. Furthermore, we request CMS strongly consider how the (potential) removal of low-value process-based quality measures from specialty measure sets would present disparities between the ECs whose specialties have access to a greater number of high-value measures, compared to those ECs whose specialties have access to fewer high-value measures.

We are concerned about the potential for these concepts to create unintended consequences including further impeding health equity for patients who are already subject to healthcare disparities.

Exceptional Performer and Incentives to Use CEHRT to Support Quality Performance Category Submissions

APA supports the intent of the exceptional performer and electronic end-to-end reporting bonuses as incentives to adopt an EHR system into practice. And given that the Proposed Rule states that CMS has future plans to discontinue the end-to-end bonus award because of the anticipated shift toward full MIPS program implementation, **we recommend CMS review and update the determination period for the exceptional performer bonus payment rate so that ECs may make a fully informed decision on adopting CEHRT, while being completely aware of the exceptional performer bonus award rate for the given performance year (prior to the start of that year).**

We are concerned by the delay between the time that CMS announces the exceptional performer bonus points payment adjustment rate and the time required for individual and group ECs to deploy an EHR system. We understand that there are some MIPS EC-psychiatric practices capable of devoting financial resources to purchase and regularly maintain an EHR system that suits their practice. However, there are many EC-psychiatrists who are either unable to make such an investment and choose not to adopt CEHRT into their practices, or who invest in inferior EHR products with the intent of capitalizing on benefits presented by the new EHR systems, but soon experience the barriers and negative impact of these lesser functioning products.

According to the proposed rule, CMS would not define the exceptional performer bonus payment adjustment rate until the close of the applicable performance year and the regulations stipulate that the scale may range from +0.5 percent at the lower end of MIPS final composite scores (i.e., final score is 70 points/or as proposed: 80 points) and would max out at +10 percent at the higher end of MIPS final composite scores (i.e., final score is 100 points).

Some practices committed to adopting expensive CEHRT systems as a strategy not only to earn more money under Medicare Part B, but also to meet the MIPS exceptional performer bonus requirements which would offset the costs dedicated to the CEHRT system. Fortunately, there are psychiatrists earning the exceptional performer 2019 bonus payment, but because of the post-performance year sliding scale determination announced long after the financial and human capital investments have been made, these individual and group ECs are finding that the award is inadequate to neutralize their practices' budgets. Rather, they are paying to participate in the program under the premise of earning rewards to increase

the practice's revenue, but instead are now responsible for the using the rewards to pay for the long-term maintenance of EHR systems that were instituted to help earn those rewards.

Future Approaches to Quality Performance Category Scoring

We support CMS's initiative to simplify the quality performance category scoring and in effect, streamline this category's participation requirements. We appreciate the opportunity to review and comment on the scenarios that could be operationalized because of this simplification effort.

- **Option 1:** Assign ECs predetermined quality performance category denominators, but not require ECs to submit a specific number of quality measures. As part of this option CMS would categorize MIPS and QCDR measures by value (designations representing each measure's level of meaning and burden). As described in the Proposed Rule, this option could result in awarding achievement points ranging from 15 to 20 points for high-value measures; up to 10 points for mid-value measures; and up to five points for low-value measures. Given this points-assignment method, participating in, and scoring the quality performance category would reflect the structure of the improvement activities performance category, whereby clinicians who chose more heavily weighted measures are not responsible to submit as many measures to MIPS. APA agrees with CMS's preference for the submission of higher value measures.
- **Option 2:** Under this scenario, CMS proposes maintaining the current 6-measure criteria with every measure worth up to 10 measure-achievement points in the denominator. But like Option 1, would assign measures to a value-level (i.e., high-, mid-, and low-value) and assign a minimum number of measure achievement points to each of these value-levels. As described in the proposed rule for this option, high-value measures could qualify for high-priority bonus points and/or have a higher floor, while low-valued measures would have a lower floor. In other words, ECs who used high-value measures could earn five bonus points and up to 10 measure achievement points, while the low-value measures could earn at least one measure achievement point.

CMS states that for whichever of the two options is finalized, they plan to eliminate the measure validation process. Because assigning the measures value and developing criteria that define ECs' eligibility to use each measure, the validation process is no longer needed to elucidate which measures are "available and appropriate" for EC use. **APA remains concerned that CMS does not recognize the definition of "appropriate" quality measurement for EC-psychiatrists.**

Many APA members who plan to participate in MIPS are frustrated by the expectation to meet the current six-quality-measure reporting criteria under the current MIPS policy. **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, from the current MIPS program, 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 those available quality measures. **APA recommends that MIPS administrators work with various behavioral health stakeholders, and especially psychiatrists, to develop the criteria they plan to use when defining measure “applicability” and “appropriateness.”** Although it might be appropriate at times to ask patients about medical history including vaccines, the determination of each quality measure’s “applicability” and “appropriateness” for EC use, should not only be made by applying CMS’s criteria, but also reviewed on a case-by-case basis with the potential for a determination process including deliberation, rather than strict code review or attributes assigned as part of CMS’s “applicability” and “appropriateness” criteria.

APA’s mental health registry, PsychPRO, currently supports about 400 EC-psychiatrists. Thanks to this newly accessible data, PsychPRO can become a tool that informs on quality measure conceptualization, specification, and testing. For instance, as applicants to the CMS-administered MACRA Measure Development Funding Opportunity, APA submitted fully formed measure statements that, once PsychPRO is fully developed, will capture meaningful data. Until these measures become available (under the Funding Opportunity or some other financial source), **APA requests that CMS reject applying a standard set of criteria (broad or specialty-specific) to determine “applicability” and “appropriateness” of all MIPS quality measures for psychiatrist or other EC use.**

Because the Proposed rule offers limited details on determining the value-level of the quality measures, and because APA is uncertain how many value-level measures would be available to psychiatrists, we neither support nor reject either option presented as potential quality performance category updates. **We request more detail about the proposal to streamline and simplify the quality performance category before CMS finalizes this proposed update.**

Calculating the Final Score

Complex Patient Bonus and Accounting for Risk Adjustment

APA supports CMS’s proposal to continue the complex patient bonus for the 2021 MIPS payment year. Given current limitations in accessing behavioral health care, we agree that accounting for risk factors, including social risks, when applying the MIPS program scoring methodology is important.

We support the National Quality Forum, the Office of the Assistant Secretary for Planning and Evaluation (ASPE), and the National Academy of Medicine in their ongoing studies, focused on the influence of social risk factors in cost and clinical quality measurement and those found in CMS’s value-based purchasing programs. Considering that through the utilization of cost and quality measurement, value-based purchasing programs aim to reward clinicians who achieve high levels of quality care while spending less money to yield positive health outcomes, it is important to elucidate the factors that contribute to poor health outcomes. **Understanding that risk adjustment methodologies remove factors from analyses to equalize the metrics, we recommend that CMS stratify the diagnostic risk factors for analysis, rather than eliminating them.** If this were not done, we would be concerned that diagnoses like mental and substance use disorders would not be analyzed for contributing to care gaps.

Until ASPE/National Academy of Medicine and NQF release their findings, we support CMS's proposal to award a five-point, capped bonus toward ECs' total MIPS score to acknowledge the provision of high quality treatment for complex patients. **Because of the proposed alignment of the MIPS and complex patient determination periods, APA agrees that CMS should appropriately identify and award ECs with no more than five bonus points for treating these high risk and complex patients.**

Final Score Performance Category Weights

APA agrees with the *original concept* behind reweighting MIPS performance category scores and understands it as form of forgiveness for those ECs who are unable to participate in a specific performance category. However, as we have stated throughout our comments, APA is concerned with CMS's definitions and process when determining "appropriate and applicable" quality performance category participation. Since CMS reweights performance category scores based on MIPS administrators' determination of "appropriate" and "applicable" participation within a given performance category, we are hesitant to support the method that is used to reweight the quality performance category scores, such that the other categories would carry greater weight towards the final MIPS score.

Reweighting the quality performance category has the potential to inaccurately apply positive, neutral, or negative payment adjustments to ECs who did not truly deserve their respective payment adjustment. For the 2019 performance year, the proposed quality performance category is the heaviest weighted of all MIPS performance categories, making up 45 percent of the total MIPS score.

ECs may have their MIPS performance category scores reweighted based on CMS's decision over what is "appropriate" performance category participation. This could result in ECs who effortfully participate given their intention to submit measure data that best apply to their practice, but for whom this proves ineffectual because the MIPS measure validation process identified quality measures that the EC did not submit as being "appropriate" or "applicable" for the EC's practice. Because that the EC did not complete those measures, this not only negatively effects the EC's quality performance score, but also the EC is not considered to meet criteria for category reweighting and would earn a MIPS score that illustrates poor care, even though a high level of quality care was provided. **APA strongly urges CMS to refine the definitions of, and process involved with, determining "appropriate" and "applicable" performance category participation.**

QCDRs Seeking Permission from Another QCDR to Use an Existing, Approved QCDR Measure

As a QCDR measure developer and steward, APA appreciates the value that QCDR-developed and -implemented measures provide. This type of measure is integral when assessing the degree of quality care administered by PsychPRO users. We agree with CMS and support multiple QCDRs reporting on the same QCDR measure, as that provides a larger cohort of users to report on a specific measure, establishing more reliable benchmarks and providing opportunities for a better chance to obtain a higher score on a particular measure. However, we do not support CMS finalizing the proposed condition that QCDR measures approved for use in MIPS must require QCDR measure owners to enter into a license agreement with CMS that would permit any approved QCDR to submit data on the QCDR measure (without modification). The development of quality measures, including QCDR measures, requires a significant investment of time, expertise, and money. It would be inequitable for a QCDR to spend the time, money, and other resources necessary to develop a measure only to then allow others (including competitors) to use that work product without any compensation for the measure developer. This applies particularly to both commercial entities and to associations and nonprofits who typically charge a fee for QCDR registration participation.

We caution against CMS finalizing the proposal to automatically reject QCDR measures if the stewards refuse to enter into such a license agreement. We recommend that CMS work with QCDR measure stewards to support ongoing communication and information-sharing among QCDR measure developers during the measure conceptualization and specification phases to promote measure harmonization and alignment. Additionally, we recommend that through rulemaking, CMS propose guidance on license agreements executed between QCDR measure developers and stewards, including a cost-based algorithm that would be used to determine a specific QCDR measure fee. This would allow CMS to protect organizations that could not afford the development of a quality measure or that were not able to develop a measure because a similar measure exists. It also prevents QCDR measure developers from assigning an unreasonable fee to their measures. Further, an algorithm that includes the cost of developing a measure as a variable supports the ongoing investment in QCDR measure development, harmonization, and alignment. We recommend that CMS continue to support networking and information exchange among QCDR measure developers and registry stewards.

APM Entities and Low-Volume Threshold Opt-in

For APM entities in MIPS APMs, CMS proposes the choice for them to opt-in if they meet one or two of the low-volume threshold elements for MIPS reporting. If the APM entity makes that choice, they would be able to participate in MIPS and be scored under the APM scoring standard. Eligible clinicians (in APM entities inside MIPS APMs) that opt in would be subject to the MIPS payment adjust factor.” If the MIPS APM entity does not exceed the low-volume threshold, it becomes eligible for the MIPS reporting opt-in – but an eligible clinician in that APM’s TIN or virtual group is not automatically opted in.

APM Scoring Standard for MIPS-Eligible Clinicians Participating in MIPS APMs

Since 2017, the rule for MIPS eligible clinicians is that they are scored at the APM entity group level and that each MIPS eligible clinician receive the APM Entity’s final MIPS score. In this proposed rule, CMS would change the regulation to state that if the APM Entity group is excluded from MIPS, all the eligible clinicians within that APM Entity group would also be excluded from MIPS. **APA welcomes this proposed change to make the participation rules less complicated and more appropriately aligned across eligible entities.**

The 2017 rule also contains a sentence that has caused confusion for MIPS APM participants, and appears to discourage entities from reducing the costs of care and/or utilization. A new proposal would revise §414.137(b) from “the APM bases payment incentives on performance (either at the APM entity or eligible clinic level) on cost/utilization and quality measures” to state “the APM bases payment incentives on performance (either at the APM entity or eligible clinic level) on quality measures and cost/utilization.” In this way, the program regulations emphasize the importance of using model design features—not just the direct cost/utilization measures—to address cost/utilization. **APA appreciates these proposed clarifications, which may serve to promote greater participation in MIPS.**

Cost Performance Category

In this proposed rule, CMS reminds the public that in last year’s rule, the cost category was scheduled to be weighted at 15 percent for MIPS payment year CY 2021, up from the ten percent in payment year 2020. The agency views this 15 percent as a moderate increase. MACRA requires the cost category weight to be 30 percent by performance year 2021, and the Act gives the Secretary latitude to delay the target weights if the Secretary determines that there are not enough cost measures available for reporting.

For performance year 2019, CMS says that it considered maintaining the weight at 10 percent. However, it acknowledges that the cost measures are still in the early development stage and that clinicians would not be as familiar with the cost measures as they are with the quality measures.

To expand the cost category for next year (performance year 2019), CMS proposes to add eight new, procedure-focused, episode-based cost measures for performance year 2019. Of the eight measures, none are directly applicable to psychiatric services. If finalized, it would mean that psychiatrists would continue to be assessed on only their performance on the Medicare Spending Per Beneficiary and Total Cost Per Beneficiary Cost measures, as they were last year (when the cost category weight was zero percent).

After the formal notification of finalized measures, it is proposed that the cost measure information (those in use, those in development and their timeframes, potential future measures topics, etc.) would be posted on the CMS website no later than December 31st each year, beginning with 2018.

APA supports the effort to develop more cost measures including episode-based measures, and it has nominated two psychiatrists to participate in the contractor-led episode development project.

However, the association is concerned with the slow development of said measures. **APA disagrees with the proposal to increase the weight of the 2019 cost category, when there are no directly relevant episode-based measures for our psychiatrists.** A continued ramp-up of the category weight without a significant addition of meaningful measures for all clinicians (especially those in nonsurgical specialties) is inequitable. It could also prove to discourage participation in MIPS and Medicare, and eventually decrease beneficiary access to care.

The APA urges the Secretary to exercise regulatory latitude and we recommend that the cost category weight be maintained at 10 percent for at least another year, or until all MIPS eligible clinicians have episode-based measures available to them. Alternatively, CMS should consider setting the category weight to 10 percent for any specialty during the first performance year in which it has meaningful episode-based measures.

Improvement Activities Performance Category

CMS believes that the public nomination process for improvement activities (IAs) should include emphasizing the importance of attention to public health emergencies. For performance year 2019, CMS proposes to add “Include a Public Health Emergency as Determined by the Secretary” to the criteria for nominating new improvement activities to the inventory. **APA supports this proposal.**

APA also supports CMS’s proposal to add new improvement activities including:

1. IA_BMH_XX Completion of Collaborative Care Management Training Program (medium weight). CMS references the collaborative care management (CoCM) training developed by the American Psychiatric Association through the Transforming Clinical Practice Initiative
2. IA_BE_XX Financial Navigation (medium weight)
3. IA_CC_XX Relationship-Centered Communication (medium weight)
4. IA_PSPA_XX Patient Medication Risk Education (high weight)

5. IA_PSPA_XX Use of CDC Guideline for Clinical Decision Support to Prescribe Opioids for Chronic Pain Via Clinical Decision Support (high weight)

We also support the modifications proposed to existing improvement activities:

1. IA_CC_10 Care Transition Documentation Practice Improvement (medium weight)
The proposed change would add examples of how the care plan could be documented: "...real time communication between PCP and consulting clinicians; PCP included on specialist follow-up or transition communications"
2. IA_PM_13 Chronic Care and Preventive Care Management for Empaneled Patients (medium weight)
The proposed change would add examples of evidence based, condition-specific pathways that could be used for the care of chronic conditions: "These might include, but are not limited to, the NCQA Diabetes Recognition Program (DRP) and the NCQA Heart/Stroke Recognition Program (HSRP)."
3. IA_PSPA_2 Participation in Maintenance of Certification (MOC) Part IV (medium weight)
The proposed change would Add two examples of ways a that MIPS eligible clinician could participate in Maintenance MOC Part IV: participation in "specialty-specific activities including Safety Certification in Outpatient Practice Excellence (SCOPE)" and "American Psychiatric Association (APA) Performance in Practice modules"
4. IA_PSPA_8 Use of Patient Safety Tools (medium weight)
The proposed change would add an example/category of an action that could meet the activity requirements: "opiate risk tool (ORT), or other similar tools."
5. IA_PSPA_17 Implementation of Analytic Capabilities to Manage Total Cost of Care for Practice Population (medium weight)
The proposed change would add an example platform that uses available data to analyze opportunities to reduce cost through improved care. Improvement Activities Performance Category

Conclusion

Thank you for the opportunity for APA to review this proposed rule and for the 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 (202) 609-7123.

Sincerely,



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

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