



March 1, 2016

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Centers for Medicare & Medicaid Services (CMS)

Department of Health and Human Services

Baltimore, MD 21244-8016

Re: DRAFT CMS Quality Measure Development Plan (MDP) Supporting the Transition to the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)

Dear Mr. Slavitt:

On behalf of the American Psychiatric Association (APA), the national medical specialty society representing over 36,000 psychiatric physicians and their patients, I am pleased to share the APA's comments on the DRAFT CMS Quality MPD Plan ("the Draft Plan"). Effective implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is critical for ensuring psychiatrists' ability to meaningfully participate in Medicare and ensuring patients' access to needed, high-quality psychiatric care.

The APA overall supports the approach outlined in the Draft Plan, including prioritizing funding for measure development by specialties with too few field-specific measures. We do, however, have several concerns about how specific strategies outlined in the Plan will be implemented. In particular we:

- Ask CMS to collaborate with the APA to identify gaps in current psychiatric quality measures where more measures need to be developed;
- Strongly urge CMS to examine the quality measures currently available to psychiatry for mental health conditions separately from those available to neurologists for neurological conditions;
- Support the use by APMs of MIPS quality measures, when appropriate, so that physicians who do not meet the MACRA APM requirements may still potentially meet the MIPS quality requirements;
- Urge CMS to assure that measures are valid across settings, before applying measures specifically developed for one setting to a different or new setting;
- Support assistance for low-volume providers to engage in quality reporting;
- Strongly oppose requiring quality reporting to cover a specified number of National Quality Strategy (NQS) domains, which can force psychiatrists to report on clinically irrelevant measures; and
- Do not believe that electronic clinical quality measures (eCQMs) should be a priority for psychiatrists, as the currently available electronic health record (EHR) systems do not meet the unique and specific needs of their patient population and type of practice.

Gap Analysis

According to the “strategic approach” of the Gap Analysis (page 7): “CMS will conduct a comprehensive, systematic gap analysis of the existing measure portfolio to address gaps in measure domains [...] where there is demonstrable variation in performance by providers; gaps in types of measures applicable to medical specialties (see Appendix for a table of measure counts across medical specialties); measure gaps for clinicians in settings outside of traditional healthcare sites, including home care and telehealth; and gaps in measures applicable to people with certain healthcare conditions.”

The APA supports this approach, which actually parallels an effort initiated by the APA and the APA Committee on Performance Measurement (CoPM), which, like CMS, supports quality measure development using a multi-stakeholder group and collaborating across developers. The CoPM is in the process of conducting a gap analysis of psychiatric quality measures, as well as underlying treatments and clinical guidelines. This comprehensive effort is intended to be completed over the next year and will include consideration of psychiatric subpopulations, such as the elderly, adolescents, and individuals with severe mental illness. Therefore, consistent with the aims of the draft MDP, the CoPM will be identifying areas where there are gaps not only in measure development, but also the need for new measures that address gaps in care. **CMS’ proposed gap analysis presents an excellent opportunity for the APA, working in consultation with CMS, to assist in identifying the need for additional psychiatric measures, while reducing duplicative activities and further promoting alignment across stakeholders.** Working in partnership and collaboration with CMS early in APA’s and CMS’ gap analysis development would be more effective than only providing feedback downstream during formal comment periods, where APA input and collaboration could arguably be too late.

However, in review of the Appendix—Reportable Measures by Specialty (Table 1, page 54), the APA notes that psychiatry is listed together with neurology – so that the quality measures available to psychiatrists in diagnosing and treating psychiatric disorders are lumped together with the quality measures that relate to neurological disorders. **This results in a serious “over-counting” of the quality measures that are actually available to psychiatrists and which are relevant to the patients to whom they provide care. We strongly urge CMS to consider psychiatry separately from our colleagues in neurology, and we respectfully disagree with the applicable measure count of 37.**

In our review of the Physician Quality Reporting System (PQRS) measures currently available for reporting, we note that there are only 11 psychiatric-specific measures, plus one measures group (Dementia) that consists of 9 measures. This inaccurate assignment of 37 measures to psychiatry misrepresents the number of applicable measures for our specialty and masks the need for funding for psychiatric quality measure development. Psychiatrists already encounter a limited number of applicable specialty-specific measures. New quality measure reporting requirements under MACRA call for addressing additional priorities (such as outcomes) and areas of care (such as care coordination). In order to fulfill the new requirements, psychiatrists will require additional quality measures that are specifically tailored and directly relevant to improving the care of patients with psychiatric disorders. Funding is needed to support the development of additional psychiatric quality measures that allow psychiatrists to fully demonstrate the quality of the unique care they are providing, particularly in light of the new priorities identified in MACRA.

On page 20, the MDP discusses the recommendations of the 2015 Institute of Medicine Report “Vital Signs: Core Metrics for Health and Health Care Progress” and requests comment on how to incorporate

the recommendations into quality measurement for the MIPS and APMs. We appreciate the report's discussion of metrics related to Depression, Drug and Alcohol Dependence and Delay of Needed Care. However, pending the APA's own, dedicated aforementioned gap analysis, it is not the appropriate time to comment on how the IOM measures could be part of new models of care and payment.

Applicability of Measures Across Healthcare Settings

In considering the "Applicability of Measures across Healthcare Settings" (page 7), CMS states that, "MACRA requires the MDP to consider applicability across healthcare settings in developing the measure portfolio for MIPS and APMs and requires quality measures used in APMs to be comparable to the quality measures used in MIPS." We support the general idea of using the same measures across care and payment settings, where possible. It will be particularly important, for example, for CMS to encourage APMs to base their quality measures on MIPS quality measures, to the extent that is appropriate. This may potentially allow physicians to meet MIPS requirements, when they have not been successful in their efforts to qualify for participation in an eligible APM. However, we also note that there may be cases where important measures may only be appropriate for one setting.

We appreciate the "Strategic Approach" that CMS details in this section that, "CMS will consider recommendations from recent publications and gather stakeholder input related to measures that are applicable across settings of care and types of clinicians. Options may include adapting specifications for measures developed for a different setting or level of care and using measures that may not be specific to a care setting." **Our major concern however lies in the clinical validity of measures using this strategy. Will these measures be tested, if they are being manipulated for utilization into a different care setting or level of care? What guides will be in place to assist in determining where an additional setting may be reasonably safely applied?**

On page 37, CMS seeks comment regarding "measures in use in other healthcare settings" which "may be appropriate for modification at the physician or other health care professional level and what types of measures would be most appropriate for use across a health system that spans multiple settings of care." **Pending our gap analysis, it is too early to comment on this question. Additionally, any measure that may have potential application in a different setting, than for which it was originally developed, will first need to go through testing to evaluate its clinical validity and feasibility for a new setting.**

Evidence Base of Non-Endorsed Measures

On page 29, CMS proposes utilizing the National Quality Forum (NQF) criteria to evaluate non-endorsed measures for possible inclusion in the MIPS and APM programs. While we support the NQF criteria, there may be times when these criteria are overly stringent and rely too much on evidence based on randomized control trials. In the field of psychiatry, this type of information is not always available, due to ethical research considerations. There is precedence for this consideration, when CMS accepted the Dementia Performance Measurement Set into PQRS, despite the set not having met NQF's endorsement criteria. **We therefore urge CMS to recognize the need for exceptions to the general rule. CMS should build into its process the ability to allow exceptions to using the NQF criteria in the measure selection process, in order to accommodate cases where important, efficacious measures may not be able to meet the criteria, due to real-world research limitations.**

Low-Volume Providers

The issue of low volume providers (page 20), is also an area of APA concern and its member psychiatrists participating in Medicare. Challenges do not solely exist for rural psychiatrists, but any psychiatrist with a low volume of Medicare beneficiaries. While the Plan suggests “mitigation strategies such as reconsideration of exclusions for existing measures and development of new measures that are broadly applicable across rural providers, that use continuous rather than binary variables, and that have results expressed as ratios where the numerator is not part of the denominator,” we are concerned more generally about providers meeting the reporting demands, given the inherent costs associated with these activities. Instead of improving care, the costs related to quality measurement reporting may actually harm access to quality care, by causing earlier retirements, fewer providers moving to rural areas, or opting out of the Medicare program entirely. The APA does support lower-volume providers engaging in quality measurement reporting, but only if mitigation strategies are in place and support is available to address the practice burdens. **We recommend that CMS grant funds to these providers to support their adoption of reporting mechanisms that reduce the related time and financial burden created by reporting, perhaps from the technical assistance funds available under MACRA. The APA also anticipates that there may be a number of psychiatrists who may benefit from joining “virtual groups” for MIPS reporting.**

Quality Domains and Priorities

We strongly caution against requiring that MIPS and APM measures cover a specified number of National Quality Strategy (NQS) domains, which can force psychiatrists to report on clinically irrelevant measures. While the APA supports the goal of identifying measures in the NQS domains, including the need to ensure a balanced national scorecard for quality, it is sometimes challenging to develop and fit measures into these discrete boxes and ensure that specialties, such as psychiatry, have an adequate suite of measures to meaningfully participate. CMS should also allow a measure to satisfy multiple domains, where applicable. **Consequently, we recommend that CMS consider doing away with the domain requirement and instead use domains to simply guide achievement of the national quality goals.**

On page 31, CMS proposes adding a sixth quality domain of “efficiency and cost reduction.” The **APA is supportive of such a domain, but, as just discussed, is concerned about forcing measure development for the sole purpose of filling a domain requirement, rather than prioritizing measure development based on actual clinical gaps and needs.** Additionally, any development of measures in this domain would need to ensure robust risk-adjustment.

On pages 31-35, CMS solicits comments and suggestions for development of measures in the five domains identified by MACRA. **As we discussed in the above Gap Analysis section, we are undertaking a psychiatric care gap analysis to be completed over this year. As part of this work we will be identifying existing and needed measures which will apply to some or all of these domains and therefore look forward to collaborating with you on developing and implementing our findings going forward.**

Consideration of Electronic Specifications

The APA generally supports the increasing availability and use of electronic clinical quality measures (eCQMs) and the considerations and benefits discussed in this section of the MDP, however, prioritizing eCQM development over other quality measure development is premature. First, as previously

discussed, there are currently a limited number of psychiatry-applicable measures, so the first priority should be on filling that gap more generally, not solely on translating existing measures into eCQMs. Second, there is a major lack of Electronic Health Records (EHR) products applicable to psychiatric practices. EHR vendors typically design products and include quality measures with the greatest utility to physicians practicing in primary care (e.g., vaccination measures, etc.). This leaves psychiatrists with products of limited utility since they do not specifically address the clinical needs of their patient population. Even when measures germane to psychiatry *are* integrated into EHR systems, these measures are not ubiquitous across products, and—outside of total health measures like the PHQ-9 (Patient Health Questionnaire for Depression)—fail to capture the scope of psychiatric practice.

We understand that CMS and the Office of the National Coordinator for Health Information Technology (ONC) are considering ways to improve measure reporting via EHRs, and leveraging the certification process to promote development of EHR products which are geared toward specific specialties and which also possess a minimum amount of vetted, specialty-focused eCQMs that are also reflected in the current PQRS program. However, even if there are requirements for certification of a specialty-specific EHR, there is no guarantee that vendors will opt to seek certification in a given specialty. **We therefore request that the MDP acknowledge that for some specialties in the near future, the development of eCQMs should be less of a priority than quality measures development more generally.**

Identifying and Developing Meaningful Outcome Measures

We appreciate the discussion highlighting the challenges identifying meaningful outcomes measures and valid risk-adjustment models. This discussion is particularly relevant to psychiatry. Measuring quality in mental health can be exceptionally difficult. First, the definition of what constitutes a positive outcome may vary greatly, depending on the severity of a patient’s mental illness as well as socioeconomic factors which may impact the efficacy of their treatment. For example, some patients may be able to tolerate mild depression, and that may be a positive outcome for them. This may not be the case for other patients. Other psychiatric conditions, including schizophrenia, are not considered “curable” in the strictest sense. “Management” of such conditions is the ultimate treatment goal, and the best outcome. And the definition of acceptable “management” can change over time, as well as varying among different patients. In addition, for many individuals with mental health conditions, such as those who are suicidal and children with mental illness, it is not ethical to subject them to clinical trials that are the gold standard for comparing the outcomes of different treatment modalities, including the option of “doing nothing.”

Thank you again for the opportunity to comment on this important Draft Plan. We look forward to working with CMS to ensure successful implementation of MACRA. If you have any questions, or if we can be of further assistance, please contact Samantha Shugarman, M.S., Deputy Director for Quality at sshugarman@psych.org.

Sincerely,



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