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Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-5517-P

P.O. Box 8013

Baltimore, MD 21244-8013

Re: Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule (81 Fed. Reg. 28162, May 9, 2016)

Dear Administrator Slavitt:

The American Psychiatric Association (APA), the national medical specialty representing over 36,500 psychiatric physicians and their patients, is pleased to provide comments to the Centers for Medicare and Medicaid Services (CMS) regarding the proposed rule establishing the Merit-Based Incentive Payment System (MIPS) and incentives for “advanced” alternative payment models (APMs).

THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015 (MACRA)

Essential Goals of the MACRA: Achieving High Quality of Care, Controlling Costs, Streamlining Quality Reporting & Easing Administrative Burden

For years, psychiatrists and other clinicians have struggled with quality reporting programs that require too much effort for too little reward, without actually enhancing patient care. The APA is pleased that CMS officials have made a commitment to ease physicians’ administrative burden, provide ongoing opportunities for their input, and maintain flexibility within the MIPS and APM programs. We highly encourage agency officials and staff to hold true to this commitment as they undertake spelling out the numerous details necessary to implement these programs. We hope that this MACRA rule represents a sea change in CMS working with and supporting physicians in participating in quality reporting and new payment models.

In addition to permanently repealing the SGR (sustainable growth rate) formula, the MACRA created an entirely new Medicare framework designed to reward physicians and other clinicians for achieving a high quality of care while also controlling their costs. Congress designed the new MIPS program and the incentives for APM participation with three fundamental, crucial goals in mind: 1) ensure that Medicare patients have access to a high standard of care, by offering incentives for clinicians who achieve certain quality metrics; 2) encourage and incentivize the efficiency of care, by rewarding participation in more efficient payment and delivery models, and providing care that leads to lower costs overall; and 3) streamline current reporting requirements,

with input from clinicians, to avoid unnecessarily burdensome reporting which does not contribute to the quality of care.

It is extremely important to keep these fundamental goals in mind as new policies are developed to implement these MACRA programs. Congress clearly intended for this new payment scheme to streamline quality reporting, while easing the considerable administrative burden posed by current programs. This is evident from the numerous provisions of the MACRA that grant the Secretary of Health and Human Services (HHS) a substantial degree of flexibility in, for example, weighting the MIPS categories for individual clinicians, allowing credit for MIPS improvement as well as achievement, defining “qualifying” APM participation with respect to patients as well as revenue, and including APMs from other payers in future years.

Another key feature of the MACRA calls for increased emphasis on measuring patient outcomes. As CMS moves forward with developing new policies to implement these programs, the agency should apply its own “outcome” analysis to MACRA policies. The “outcomes” of such policies – for patients as well as for clinicians and the health care system as a whole – should be part of their initial consideration. Each new policy should be subjected to questions such as the following:

- Does this policy actually improve or hinder patients’ access to high quality care?
- Does this policy actually encourage the efficient use of resources, without sacrificing quality of care and the patient’s ability to choose among treatments and providers?
- Is the burden on clinicians of meeting this requirement appropriate for the projected benefit?
- Does this policy maintain the flexibility inherent in the MACRA?

Whenever feasible, we would encourage CMS to widely publicize future opportunities for physicians and other clinicians to provide input into the process, at a minimum through *CMS Provider News* and other widely distributed communications vehicles, if not through announcements in the *Federal Register*. We believe these are more likely to generate input representative of the broad array of clinicians who will be subject to these programs, rather than small focus groups of individually selected clinicians.

The MACRA Will Have a Unique Impact upon Psychiatrists and Patients with Mental Illness

The general rationale behind implementation of the MACRA does not apply to patients with mental illness. Much of the impetus for the MACRA, as for current quality reporting programs, comes from the growing recognition that the American health care system spends an inordinate amount of funds per patient without achieving better results. As the largest health payment system in the country, Medicare avoids wide price variations by paying a consistent amount for each service or supply and has strict rules regarding which services are covered and when. However, like private payers, Medicare is susceptible to unnecessary expenditures for duplicative, ineffective, or overly costly testing, treatments and procedures — often due to a lack of care coordination. Given the fundamental right of Medicare patients to choose their providers and to be involved in directing their course of treatment, Medicare faces an uphill battle to decrease unnecessary or costly treatments. The circumstances are very different for patients with mental illness, including substance use, and the psychiatrists who treat them – if those patients are even able to see a psychiatrist. Unlike the overwhelming preponderance of physical health issues, mental health issues are generally regarded to be under-treated, with persistent disparities in treatment for substance use disorders, as well as racial and ethnic disparities.

Individuals with mental illness often have extensive non-psychiatric medical needs. Depression, anxiety, substance use disorders, and other common psychiatric disorders frequently are comorbid with

cardiovascular disease, diabetes, obesity, pain disorders, and other costly and potentially disabling physical conditions.¹ Indeed, the rate of mortality among persons with mental disorders in comparison to those without is startlingly high.² Many chronic medical conditions require a self-care regimen in order to manage symptoms and prevent further disease progression, which may be hampered by comorbid mental conditions. A recent study found that 68% of adults who have a mental disorder also suffer from a medical comorbidity.³ Furthermore, most early mortality in patients with mental disorders is associated with chronic comorbid conditions, which are exacerbated by mental illness. A meta-analysis of worldwide mortality estimates found that the risk of mortality for individuals with psychiatric disorders was 2.2 times higher than for persons without mental disorders.⁴ A majority (67%) of deaths was attributed to natural causes such as cardiovascular disease, lung disease, and diabetes and the reduction in life expectancy ranged widely from 1.4 to 32 years. Co-occurring mental disorders in persons with medical conditions also contribute to unemployment, absence from work, and decreased productivity at work.⁵

Many patients with mental health issues face major barriers to accessing care, and they often suffer from other health needs that may go untreated. **There is a severe shortage of psychiatrists in the United States, and psychiatrists account for the largest percentage (42%) of physicians in clinical practice that have formally opted out of Medicare.**⁶ Since 2006, less than half of the available geriatric psychiatry fellowships have been filled.⁷ Overly complex Medicare regulations disproportionately disadvantage psychiatrists and their patients, and further discourage physicians from selecting geriatric psychiatry as a subspecialty. Yet the need for psychiatric physicians' expertise is acute. According to recent studies, the percentage of adults receiving mental health treatment increased from 12.6% in 2004 to 14.6% in 2013. But less than 2% of adults received substance use disorder treatment over the period, with insurance coverage of that treatment increasing only slightly, from 45% to 46%.⁸ Mental health treatment rates continued to increase in 2014, but racial and ethnic disparities in access to mental health services persist. Despite gains in health coverage across multiple racial/ethnic groups, treatment rates for substance use disorders did not increase. "This suggests that gains in insurance coverage alone are not likely to push forward meaningful reductions in mental health treatment

¹ Druss, B.G., Walker, E.R. 2011. "Mental disorders and medical comorbidity." *Synth Proj Res Synth Rep.* 21: 1-26. <http://www.rwjf.org/en/library/research/2011/02/mental-disorders-and-medical-comorbidity.html>.

² Demyttenaere, K., et al. 2004. "WHO World Mental Health Survey Consortium: Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys." *JAMA* 291: 2581-2590. Thornicroft, G. 2011. "Physical health disparities and mental illness: the scandal of premature mortality." *Br J Psychiatry* 199: 441-442. Wahlbeck, K., et al. 2011. "Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders." *Br J Psychiatry* 199: 453-458.

³ Robert Wood Johnson Foundation. 2011. "Mental disorders and medical comorbidity." www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf69438.

⁴ Walker, E.R., McGee, R.E., Druss, B.G. 2015. "Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis." *JAMA Psychiatry* 72: 334-341.

⁵ Wang, P.S., et al. 2008. "Making the Business Case for Enhanced Depression Care: The National Institute of Mental Health-Harvard Work Outcomes Research and Cost-effectiveness Study." *J Occ Environ Med/ Am Coll Occ Environ Med.* 50: 468-472. Katon, W. 2009. "The impact of depression on workplace functioning and disability costs." *Am J Manag Care* 15: 322-327.

⁶ Boccuti, C., et al. December 2013. "Issue Brief: Medicare Patients' Access to Physicians: A Synthesis of the Evidence." *Kaiser Family Foundation*.

⁷ IOM (Institute of Medicine). 2012. "The mental health and substance use workforce for older adults: In whose hands?" Washington, DC: *The National Academies Press*.

⁸ Mark, T. L., et al. June 2016. "Insurance Financing Increased For Mental Health Conditions But Not For Substance Use Disorders, 1986–2014." *Health Affairs* 35 (6): 958-965.

disparities or increase consistently low overall substance use treatment rates.”⁹ **Medicare policies need to encourage and support the ability of psychiatrists to participate in Medicare, continue to see their current Medicare patients, and accept new patients.** Medicare quality programs also need to provide incentives that are truly attainable, in order to encourage psychiatrists to participate in those programs.

Many patients rely on their primary care providers to manage their mental health care, and they may rely upon non-physician clinicians such as psychologists, clinical social workers, nurse practitioners, etc. for therapy. However, psychiatrists are uniquely positioned to determine appropriate medications and other treatments for individual patients, particularly those with comorbid medical conditions and several mental illness. Psychiatrists have years of training in the biological, psychological, and social aspects of mental health and substance use disorders. Decisions regarding diagnosis and treatment require extensive knowledge and experience regarding the pharmacological effects of particular medications, as well as how they interact with the patient’s own particular mental health and other conditions. Some of these medications can have permanent side effects. And some can actually exacerbate the patient’s symptoms, particularly in the case of children and adolescents. In addition, receiving therapy and medications from the same provider ensures continuity of care. And while the Medicare population as a whole is generally not considered the key population affected by substance use disorders, the current opioid crisis has caught Medicare patients in its web.

As a profession, psychiatrists are also uniquely situated in how they practice medicine, which poses particular challenges for participating in MIPS or APMs. While some psychiatrists are employed full-time by major medical centers, most psychiatrists work in solo or smaller group practice settings. Even among “small” physician practices, psychiatric practices generally have far fewer clinicians and staff than other physicians groups.

Psychiatrists also commonly work in more than one setting. These include academic health centers, hospitals, clinics, nursing homes, and private practices. Psychiatrists who have been working in private fee-for-service practices – off the grid from Medicare, Medicaid, and private insurance – have been encouraged to work part-time in accountable care organizations, in collaborative care settings, or as consultants under arrangements supported by private or public funding. Many psychiatrists also do telemedicine, either solo or in a group. **This makes it difficult for psychiatrists to capture all the work they do, because of the combination of settings that utilize multiple, and potentially differing reporting programs and methods.** Additionally, many psychiatrists adjust from year to year their relationships with various sites and the amount of time they spend at each, so that subsequent feedback on their quality performance may no longer be relevant to their current practice model.

Psychiatrists also have limited time and resources to devote to Medicare quality reporting. Except for geriatric psychiatrists, only a small portion of their patients may be in Medicare. Psychiatrists’ average annual salaries generally hover near those for primary care physicians. While primary care physicians have incentives to form large groups that can create economies of scale, this often is not the case for psychiatrists unless they are located in large, urban areas. Thus, relatively few psychiatrists who practice outside of large medical centers have enough resources to purchase their own electronic health record (EHR) system. **Psychiatrists also have limited choices in outcome quality measures.**

⁹ Creedon, T. B. and Le Cook, B. June 2016. “Access to Mental Health Care Increased But Not For Substance Use, While Disparities Remain.” *Health Affairs* 35 (6): 1017-1021.

Medicare Covers “Mental Health” and Substance Use Disorders

Throughout the proposed rule, particularly in the MIPS Quality and CPIA categories, CMS employs the terms “behavioral health,” “mental health,” or both, to refer to elements of the program that address mental illness and substance use disorders. We recommend using precise language that recognizes and reinforces the fact that mental health and substance use disorders are biological, brain diseases, rather than the broad term “behavioral health.” The more clinically appropriate, meaningful, and comprehensive term is “mental health” rather than “behavioral health.” Whichever term is used, it is imperative to make absolutely clear that it includes treatment for both mental illness and substance use disorders.

THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

The MACRA replaces current Medicare quality reporting programs with a new “Merit-Based Incentive Payment System” (MIPS) which completely transforms these programs. The MIPS program consolidates aspects of the current Medicare quality programs and offers the first substantial rewards for achieving high quality of care. The MIPS will replace the Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VM), and Meaningful Use (MU) of electronic health records.

MIPS payment adjustments begin in January 2019. Each “eligible clinician” (or group) will receive a “composite performance score” from comparing their performance in four categories with the average of all MIPS clinicians. Those categories are quality, resource use, accessing clinical information, and clinical practice improvement activities. The clinicians who score above average receive a bonus, and those scoring below average receive a penalty. MIPS bonuses and penalties will be up to 4% in 2019, 5% in 2020, 7% in 2021, and 9% starting in 2022. Those payment adjustments are budget neutral. There is an additional \$500 million per year for bonuses of up to 10% for “exceptional” MIPS performers, from 2019 through 2024. Clinicians who do not report at all under MIPS will receive the highest penalty for that year, unless they qualify for an exemption.

The MIPS “Low-Volume Threshold”

Under the definition of the “low-volume threshold” in the proposed rule, psychiatrists, other eligible clinicians, and groups who have no more than 100 Medicare patients and \$10,000 in Medicare billings during the reporting year would fall under the “low-volume threshold.” They would be exempt from MIPS reporting and MIPS payment adjustments. Clinicians would also be exempt from the MIPS program if they have enrolled in Medicare for the first time during the reporting year, have formally opted out of Medicare, only provide Medicare services through Medicare Advantage, or meet the definition of a “qualifying” or “partially qualifying” participant in an “advanced” APM.

Given the serious shortage of psychiatrists and the barriers that many patients face in finding mental health and substance use treatment, the APA urges CMS to adjust the definition of the MIPS “low-volume threshold.” Based upon APA analysis, we believe that psychiatrists typically do not see more than 150 Medicare patients per year.

APA members have also advised us that \$10,000 per year is far too low a figure to trigger the requirement for MIPS reporting. And some see the MIPS reporting requirements as so burdensome that they are considering no longer accepting Medicare patients. **Given the serious gaps in care for mental**

health treatment among Medicare patients, MACRA policies should focus on incentivizing clinicians to participate in the program rather than driving them away.

The APA offers three recommendations for defining the “low-volume threshold” to encourage psychiatrists and other clinicians to continue to serve Medicare patients. First, we highly recommend that the threshold be calculated at the individual clinician level, even for clinicians who are reporting as part of a group practice, “virtual group,” etc. Second, we would support a higher threshold of 150 patients per individual eligible clinician, and we believe that the maximum annual billings for Medicare patients should be raised to \$30,000. And third, as an alternative, CMS could drop the dollar figure altogether, so that the threshold is only defined as a maximum patient count of 150 per year, per individual clinician.

These changes would allow many of the psychiatrists in small or solo practices to continue to take Medicare patients with mental health and substance use disorders. This would also demonstrate that CMS is committed to preserving patient access and to helping small practices continue to thrive despite an increasingly hostile health care environment. **We also urge CMS to consider additional new mechanisms to entice psychiatrists and other clinicians who are not currently seeing Medicare patients to begin to do so.**

The MIPS Reporting Period

CMS is proposing that the initial MIPS reporting period would be calendar year 2017. Under the proposed rule, MIPS reporting would begin on January 1, 2017. Thus, MIPS reporting would begin a mere two months after November 1, 2016, the statutory deadline for issuing the final rule which will establish the new policies and procedures for that reporting.

This is not enough time for psychiatrists and other eligible clinicians to prepare for these massive changes. MIPS reporting will require substantial, fundamental adjustments – as well as additional resources – for most physicians and their practices. Considering the infrastructure adjustments clinicians will have to integrate into their practices (solo, group, or other settings) to participate in this program, **we recommend that the first year reporting period begin in July 2017 and end in December 2017.** It is unreasonable to expect that participants, especially small and solo practices, can be ready to successfully engage in MIPS reporting starting in January 2017, with only two months to digest the new policies and procedures from the November 2016 rule.

Starting in 2018, the APA would support the MIPS reporting period extending to a full calendar year. We believe this would be beneficial as psychiatrists would then have a wider window in which to capture data for their Medicare patients, who are often a small subset of their practice.

We also support the availability of a “portal” for clinicians to be able to have a “first glimpse” or initial snapshot of what their MIPS performance assessment is likely to be. This ability to preview one’s performance may be an important selling point to encourage more clinicians to participate in the program.

MIPS Reporting as a “Virtual Group”

The MACRA offers small practices (of up to 10 clinicians) the option of forming “virtual groups” for the purpose of MIPS reporting. Those practices can report together, and be assessed together, at the level

of their “virtual group.” This allows small practices with limited resources to pool their resources and share the reporting burden, and it may allow them to hire administrative staff to assist with quality reporting.

This is a very attractive option for the large number of psychiatrists who are in small or solo practices, many of whom have little or no administrative support. It is not unusual for psychiatrists to spend a significant amount of time doing their own paperwork, including documentation and billing, since they have no one to assist them. And since few of them have their own EHR system, much of this is actually done on paper.

However, we were very disappointed to see that CMS did not plan to offer this as an option until the 2018 reporting period. **Therefore, we urge CMS to allow “virtual group” reporting from the very start of the MIPS program.**

We understand that it may take CMS some time to create this process. But we are concerned that many psychiatrists and other eligible clinicians will need to “lock in” how they do MIPS reporting, and if this is not available from the start, it will not be seen as a viable option. CMS will have additional time to prepare for this mechanism, if it delays the start of MIPS reporting until July 2017.

MIPS Reporting Mechanisms and Feedback

We also would like to point out that the MACRA explicitly requires CMS to “make available timely (such as quarterly) confidential feedback to MIPS eligible professionals” regarding their performance in the MIPS categories of quality and resource use, in the provision entitled “Feedback and Information to Improve Performance.” **We urge CMS to make quarterly feedback the standard for all MIPS performance categories, to allow clinicians to truly “improve their performance” consistent with Congressional intent.**

The APA commends CMS for preserving all of the current reporting options for the MIPS that are now available under the existing quality programs. As noted above, few psychiatrists have their own EHR system. Even among the psychiatrists who do have an EHR system, few meet the standards for certified electronic health record technology. Consequently, psychiatrists must rely on alternative reporting methods to participate in the MIPS program.

The APA is also very supportive of the number of provisions in the proposed rule that encourage and give credit for MIPS reporting through a qualified clinical data registry. We are beginning to develop a mental health clinical quality data registry for use by psychiatrists in quality reporting.

Weighting of the MIPS Performance Categories

We strongly urge CMS to be flexible in exercising the discretion that Congress granted under the MACRA to weight the four MIPS performance categories differently from the standard percentages for each category. The MACRA allows CMS to score the MIPS categories differently, even ignoring a category altogether, if there are not enough measures or activities available or applicable to that type of clinician. Psychiatrists will be at a particular disadvantage in meeting the standards of the “advancing care information” (ACI) performance category, as we discuss in greater detail below, largely because of circumstances beyond their control. A lack of adequate and appropriate objectives and related measures is clearly a basic disadvantage for psychiatrists. Therefore, **CMS should automatically bring the weight of the ACI category to zero for those psychiatrists and practices that are unable to meet**

the base score ACI standards. We believe this approach will serve Medicare patients by supporting their access to psychiatrists and actually encourage more psychiatrists to invest resources in EHR systems that will help them streamline their practices and coordinate care for their patients.

MIPS PERFORMANCE CATEGORIES

MIPS Quality Performance

The MIPS quality performance category will generally count 30% toward each psychiatrist's MIPS composite score, which in turn determines whether they will receive a penalty or bonus. However, the quality performance category counts even more in the first two years of MIPS adjustments – 50% in 2019, 45% in 2020, and then 30% starting in 2021. The quality reporting requirements and measures are based largely on the Physician Quality Reporting System (PQRS). The MIPS will continue most valid PQRS quality measures, add measures to fill particular gaps, and allow the addition of measures from private payers and different setting.

MIPS Quality Measures

Under the proposed rule, psychiatrists will no longer be required to report nine quality measures across three National Quality Strategy “domains.” They will instead be required to report six quality measures, including one cross-cutting measure. They must also report one outcome measure, if one is available. If no outcome measure is available, they are to report one measure of appropriate use, patient safety, efficiency, patient experience, or care coordination. CMS has also proposed a “Mental/Behavioral Health” measure set with 12 measures relevant to psychiatrists.

We applaud CMS' proposal to no longer require the reporting of nine quality measures across three National Quality Strategy domains. These requirements have been widely regarded as overly stringent. They have particularly disadvantaged psychiatrists, who have limited choices in quality measures and for whom certain domains were simply not applicable.

While the APA commends CMS for its effort to decrease the quality reporting burden under the MIPS program, most psychiatrists may still not have six relevant quality measures to report for their Medicare patients. We appreciate CMS acknowledging that even within specialty-specific measure sets, not all measures would apply to each clinician in that specialty. Relevance would depend on their patient mix, and we anticipate that for many psychiatrists, six measures may still be too many. The minimum number of quality measures should be determined not only at the level of each specialty or subspecialty, but also take into account individual psychiatrist's patient mix, to ensure that available measures are truly applicable to their practice. As noted in the “CMS Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs),” mental health and substance use is one of the specialties with a limited number of applicable measures. **We therefore recommend that CMS start in the first reporting year with the expectation that psychiatrists will only be reporting one or two quality measures in mental health. These requirements should only expand as new measures become available that are meaningful and relevant to psychiatrists and their patients.** Otherwise, psychiatrists will simply be padding their quality reporting with additional measures which are neither clinically useful nor meaningful, requiring substantial time and effort with little or no benefit to patients.

While we appreciate CMS' inclusion of a measure set dedicated to Mental/Behavioral Health, it is unlikely that the measures recommended in this set will apply to the majority of psychiatrists reporting on the quality section of the MIPS. We commend CMS for maintaining the Dementia measure set, and for recognizing the valuable gap it fills. However, these measures make up the bulk of the 12 measures included in the Mental/Behavioral Health set. While the majority of individuals in this country who have dementia are likely to be Medicare patients, many times patients with dementia see specialists other than psychiatrists to treat their dementia symptoms (such as neurologists, geriatricians, primary care physicians) and some psychiatrists do not treat patients with dementia at all. As a result, these measures do not apply to many psychiatrists.

Even when a psychiatrist or a practice has access to an EHR and to electronic clinical quality measures, this does not mean there are six quality measures that are meaningful for that patient encounter. For example, discussion of an influenza vaccine is counter-productive to meaningful psychotherapy for person experiencing a major depressive episode. This places psychiatry at a disadvantage compared with many other specialties. Other specialties have numerous potential measures to choose from that address the wide array of patients' physical issues and particular circumstances, while psychiatrists require quality measures that focus solely on the patients' mental health. Other specialties' measures draw on the vast amount of existing data related to physical health, and address a wide array of issues such as laboratory and other diagnostic tests (including vital signs), diagnoses, treatment options, procedures, avoiding complications, patient engagement and satisfaction, care coordination, and collaboration with other providers. In psychiatry, most of these measures are either not applicable or not meaningful, or don't really pertain to psychiatry. For example, psychiatrists typically do not employ mental health screening tools, so such measures may not be appropriate for psychiatrists. They are designed for providers without specialized psychiatric training. Therefore, mental health screening measures should not be considered appropriate for psychiatry. **In light of these challenges we applaud CMS for identifying mental health and substance use as a priority area as part of its Measure Development Plan. Additional resources are required to more closely identify and develop meaningful quality measures for psychiatry, and there is a particular need for patient-reported outcomes.**

We appreciate the requirement to report on at least one outcome measure, where available, or one high priority measure. **But it should be highlighted that 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 how that illness affects their ability to function. For example, a patient facing "mild" depression for the first time may find it intolerable, particularly if it impairs their job and their relationships. Conversely, improving another patient's longstanding severe, intractable depression to a "mild" level could be seen as a positive outcome. Furthermore, some 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 and vary among patients. In addition, the testing of outcome measures for mental health and substance use conditions is complicated by the need for ongoing vigilance and necessary adjustments in treatments for individual patients. Each patient with mental illness and/or substance use disorder has a unique constellation of symptoms and life circumstances, and different patients often respond very differently to the same treatment modality. Treatment protocols must have sufficient flexibility to allow for individual modification in order to prevent serious side effects, including fatalities. This complicates the ability to ethically perform research that can support development of practice guidelines of general applicability by diagnosis, which in turn are often at the heart of individual quality measures.

Addressing Gaps in MIPS Quality Measures

We urge CMS to devote resources toward supporting the development of additional mental health quality measures, including electronic clinical quality measures (eCQMs). We believe this would be consistent with the priorities detailed in CMS' Measure Development Plan. It is critically important to acknowledge that the EHR Incentive Program did not support the development of EHR systems that serve mental health, nor did it support the adoption of such systems by mental health providers. Resources are badly needed for mental health settings to create quality measurement via innovative EHRs.

As we addressed in comments on the Draft CMS Measure Development Plan, this is 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 the APA's and CMS' gap analysis development would be more effective than only providing feedback downstream during formal comment periods (such as this one), where APA input and collaboration could arguably be too late. This would also reinforce the identification of measures or measure gaps that are meaningful for participants intended to utilize them.

The "MAV" Process under the MIPS

Currently, in the PQRS program the Measures-Applicability Validation (MAV) process is applied to clinicians who fail to meet the requirement of reporting nine quality measures. The MAV process involves a retroactive look at administrative claims to identify codes submitted for payment during the reporting year to determine if there were measures a clinician should have reported, but did not. Unfortunately, this process serves little purpose other than to explain to a clinician why they failed to avoid the penalty. While the proposed rule does not outline an alternative process, it does state that a "validation process to review and validate a MIPS eligible clinician's inability to report on the quality performance requirements" will be developed.

This review process should provide ample time to notify clinicians of their errors and include a realistic amount of time for those clinicians to develop and submit additional data on the newly identified measures. Reporting clinicians devote substantial time and resources to quality reporting. This review process should include a time frame allowing them to make a good faith effort to comply with the MIPS quality requirements, once they have been notified of their errors. These clinicians should not be subject to a perfunctory process with such a short time frame that there is simply no time or opportunity to make amends for choosing the wrong measures. They should not be subject to what amounts to an automatic penalty. Furthermore, there should be an appeals process if the clinician finds that completing such identified measures on their patients would be inappropriate, such as being outside the scope of the measure's exception.

Other MIPS Quality Issues

The American Psychiatric Association is the steward for a number of PQRS quality measures, including five measures which were attributed incorrectly to the American Psychological Association in the proposed rule. **We request that this be corrected in the final rule.** These measures are:

- PQRS 282: Dementia: Functional Status Assessment
- PQRS 283: Dementia: Neuropsychiatric Symptom Assessment
- PQRS 284: Dementia: Management of Neuropsychiatric Symptoms
- PQRS 286: Dementia: Counseling Regarding Safety Concerns
- PQRS 288: Dementia: Caregiver Education and Support

Finally, as discussed above, the “Mental/Behavioral Health” Measures set title should simply say “Mental Health” to comport with correct clinical terminology. Moreover, it should also be made explicit that this category includes substance use disorders.

MIPS Resource Use

CMS plans to apply the Value-Based Payment Modifier (VM) to all physicians, regardless of practice size, in 2017 and 2018. Current VM payment adjustments range up to 4%, although few practices have earned a VM bonus. In 2019, MIPS resource use will replace the VM. Resource use will generally count 10% in 2019, 15% in 2020, and then 30% starting in 2021. CMS will calculate MIPS resource use, with no reporting required. Starting in 2018, all Medicare claims will include special codes to identify the care episode, patient condition, and physician’s relationship to the patient. These codes will assist with linking patients to the appropriate clinicians for measuring resource use.

The APA has a number of concerns about psychiatrists being subject to the VM payment adjustments in 2017 and 2018. We understand that the VM is plagued with a host of problems. Many physicians and payment experts have found the Quality and Resource Use Reports (QRURs) incomprehensible. Moreover, the methodology and process for determining the VM for individual practices has lacked transparency, making it extremely difficult for stakeholders to provide meaningful input. As a result, physicians can neither predict whether they would be subject to a VM adjustment (either up or down), nor develop an understanding of the VM metrics to guide them in what to do differently. The VM process has also lacked appropriate risk adjustment, so the physicians receiving penalties are often those with the sickest and poorest patients.

While the MACRA calls for major changes in the calculation of resource use under the MIPS program, we remain concerned that flaws of the VM may be carried into the MIPS program. We urge CMS to start fresh with measuring MIPS resource use. The MIPS resource use methodology and standards must be transparent and comprehensible. Moreover, individual physicians should be able to comprehend those standards, as well as how and why they received a particular score in this area. This would allow them to undertake changes in how they practice to improve their performance in this category.

It will be essential for CMS to develop clear pathways for accurately attributing particular resource use by individual Medicare patients to the appropriate clinicians. Psychiatrists treat mental health and substance use disorders, while most Medicare patients suffer from a number of comorbid, often chronic, medical conditions – some of which can lead to very costly treatments, including costly surgical procedures with long inpatient admissions. Yet many psychiatrists play a very circumscribed role by focusing on the treatment of mental health and substance use disorders. It would not be appropriate, for example, for individual psychiatrists to be held responsible for the costs of their patients’ hip replacements, hospitalizations for cardiac or pulmonary issues, or other conditions or costs that are unrelated to mental health and beyond their control. We look forward to hearing more from CMS about how it plans to attribute such costs to individual clinicians.

If MIPS resource use measures are truly inapplicable to psychiatrists, or CMS is unable to carve out mental health services in measuring psychiatrists' resource use, then CMS should exempt psychiatrists from this category altogether, and increase the weight of the quality and CPIA categories. **The APA is working with member experts to recommend appropriate psychiatric conditions, episodes of care, and relationship groupers and plans to offer suggestions in August in response to CMS' request for comments.**

MIPS “Advancing Care Information”

Advancing care information (ACI), which assesses the use of EHRs, will generally count 25% toward each clinician's MIPS composite score. Under the proposed rule, half of the ACI score will be from a “base” score and half will be from a “performance” score. The ACI category continues some of the measures from the “Meaningful Use” program, and eliminates others. The MACRA also grants CMS authority to decrease the weight of this category to as low as 15% in years where there is a high percentage (at least 75%) of “Meaningful Use” adoption by eligible clinicians. Other provisions of the law set a goal of achieving interoperability of EHR systems in 2018, with possible repercussions if this goal is not met, and require a study to assist physicians in comparing and selecting among certified EHR products.

The use of EHRs within medicine—while more widespread in recent years—is not ubiquitous across the health care landscape. Unfortunately, for a variety of reasons – including cost, a lack of high-quality EHRs tailored to the practice of psychiatry, and concerns regarding the safety/security of highly sensitive mental health/substance use disorder data – many, if not most, psychiatrists have been slow to adopt EHRs into their practice. This is particularly true for the many psychiatrists who have their own small or solo practices. **While the APA supports CMS' general goal of using certified EHRs and other technology to improve the coordination, safety, and quality of care for patients, we believe that the requirements outlined within the ACI section place undue financial and workflow burdens on psychiatrists.**

The APA understands that the need for greater integration and use of EHRs within health care delivery is paramount toward the goal of improving health outcomes of individuals and of the population as a whole. However, in its current incarnation, the ACI category would not create a reporting environment favorable to those goals. Specifically, psychiatrists have already struggled to meet highly similar requirements previously part of the EHR Meaningful Use (MU) Incentive Program. Unfortunately, very few psychiatrists have been successful in meeting these standards. And we anticipate that multiple facets of ACI will pose similar challenges toward EHR adoption. This has the potential to actually discourage psychiatrists from participating in Medicare, thereby resulting in fewer clinicians serving an already under-resourced population within mental health.

The proposed scoring methodology for ACI, with both a “base” and a “performance” score, will make it extremely difficult for psychiatrists to receive any of the 25 percentage points under this category. This holds true even with the “Base Score Alternate Proposal,” which provides some flexibility but still requires active engagement with the EHR measures differently, but still prohibitively, as described below. In order to receive any points toward the “base” score, the eligible provider must a) use Certified Electronic Health Record Technology (CEHRT), which is essentially the definition of being a “meaningful user” and b) meet the two measures that comprise the “base” score, specifically conducting a Security Risk Analysis and e-prescribing.

The APA has received testimony from many member psychiatrists—especially those practicing in solo or small group settings—that the adoption and maintenance of a complete EHR system has resulted in

decreased efficiency for their practices. Even more disturbing, it has also resulted in a shift away from focusing on the patient, and poses a serious obstacle in the therapeutic alliance which is central to the psychotherapeutic process. Because of this, many psychiatrists have opted-out of integrating an EHR into their practice. This would therefore make them ineligible for the “base” score and, by extension per the proposed rule’s scoring methodology, also ineligible for the “performance” score, resulting in an ACI score of 0%.

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

Finally, the APA appreciates that the proposed rule takes into consideration that many clinicians may be practicing in multiple facilities and settings where they generally do not have control over the availability or usability of EHRs. This is particularly true for long-term and post-acute care settings. In cases where a clinician’s patient load in such settings meets or exceeds 50% of the clinician’s total reporting base, according to the proposed rule, the ACI category is reweighted to zero. **The APA supports this proposal, but we also recognize there are situations where a clinician’s patient load for such settings may be lower than 50%, but still significant enough to place the clinician at a disadvantage with respect to reporting on the ACI measures. In those cases, the APA recommends that patients from these settings be removed from the denominator of ACI measures, which would still allow the clinician to report on ACI while avoiding unjust penalties.**

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

The APA also provides the following detailed comments regarding specific ACI objectives and their corresponding measures:

MIPS ACI “Protect Patient Health Information” Objective

Security Risk Analysis Measure: “Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified EHR technology in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the MIPS eligible clinician’s risk management process.”

The APA appreciates the importance of safeguarding the sensitive and confidential nature of psychiatrists’ patients’ health information. We however seek clarification: 1) if this Measure is

duplicative of the intent of the Health Insurance Portability and Accountability Act (HIPAA) Security Rule and the Federal Regulations identified in the Measure, and 2) it therefore may place an additional burden on providers who are already constrained by time and limited technical expertise to meet these aforementioned requirements.

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

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

Electronic Prescribing (ePrescribing) Measure: “At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using certified EHR technology.”

The measure of “one” is a welcome change from the Stage 3 Meaningful Use measure (i.e., down from 80%) criteria. While this may be easily fulfilled by psychiatrists who have already adopted electronic prescribing into their practice, the APA would like to underscore that the degree to which providers utilize electronic prescribing is highly dependent upon the extent to which pharmacies are able to receive these prescriptions. And this in turn is greatly influenced by whether State laws mandate the use of e-prescribing.

In the proposed rule, the exclusionary criterion that was a part of Stage 3 for Meaningful Use has been eliminated. CMS qualifies this removal by stating that the proposed \$10,000 reimbursement ceiling or 100 patient threshold accomplishes the same purpose as the original Stage 3 exclusionary criteria. Although this remains to be seen, the agency does not address other potential barriers to e-prescribing, such as the geographic availability of pharmacies that accept electronic prescriptions. While many pharmacies do—and with more onboarding the technology to make e-prescribing possible—a patient should not have to select a pharmacy based on this single criterion for the sake of the clinician’s need to meet the requirements of this measure. This would likely have a severe negative impact on psychiatrists practicing in rural or remote areas of the United States. **The APA recommends that an exception be placed in the final rule allowing for the electronic prescribing measure to be given a weight of zero for clinicians practicing in locations where the majority of pharmacies within 10 miles do not accept electronic prescriptions.**

MIPS ACI “Patient Electronic Access” Objective

Patient Access Measure: “At least one patient seen by the MIPS eligible clinician during the performance period is provided timely access to view online, download, and transmit to a third party their health information subject to the MIPS eligible clinician’s discretion to withhold certain information.”

The APA acknowledges the fundamental importance of patients’ rights to receive their medical information in a timely and appropriate manner. **The APA also appreciates CMS’ understanding that this should be subject to the clinician’s discretion.** This is a very helpful stipulation in the proposed rule from the perspective of psychiatry, which is a practice setting where highly sensitive patient information might have adverse effects on the patient if the patient were to view the data while experiencing symptoms of psychopathology or other prohibitive issues—i.e., lack of internet access or relevant technology; minimal technological sophistication; cognitive limitations; severe psychosis or mood disturbance.

However, it remains a concern that this overall objective and its measures—like many in the proposed rule—are contingent upon the behavior of the patient. The clinician has no control over a patient’s behavior and whether they log into a patient portal (a feature that many EHRs lack) and engage with their record. **The APA recommends clarification as to whether a clinician satisfies this measure’s criteria simply by ensuring that the record is user-facing and available, rather than requiring that a patient log in to the record itself.**

This is especially pertinent, as the ability to meet these measures and objectives is based on the patient population that the psychiatrist serves. For example, some psychiatrists who provide services to children and adolescents and attempted to attest to Meaningful Use Stage 1 on similar measures were unable to enroll patients between the ages of ten and seventeen into a patient portal due to concerns about parental access and state-based confidentiality regulations. The minor patients still remained in the denominator for measures related to patient portal use but were unable to be counted for the numerator, which resulted in the providers being unable to meet the percentage reporting threshold.

Patient-Specific Education Measure: “The MIPS eligible clinician must use clinically relevant information from certified EHR technology to identify patient-specific educational resources and provide electronic access to those materials to at least one unique patient seen by the MIPS eligible clinician.”

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

MIPS ACI “Coordination of Care Through Patient Engagement” Objective

Secure Messaging Measure: “For at least one unique patient seen by the MIPS eligible clinician during the performance period, a secure message was sent using the electronic messaging function of certified

EHR technology to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative)."

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

The *type* of content that is conveyed during secured messaging should also be considered for this measure, as it may affect the numerator. Specifically, messaging appointment reminders may be fairly benign and easily completed. However, questions about the confirmation of diagnosis and care plan goals or even information about patient progress may contain highly sensitive material and psychiatrists might avoid engaging in this type of messaging. Therefore, **the APA recommends that future rulemaking take this into consideration and not create additional stipulations requiring the type/content of messaging and instead leave this to the discretion of the clinician.**

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

The MIPS “Clinical Practice Improvement Activity” Performance Category

We greatly appreciate that the inventory of clinical practice improvement activities (CPIAs) recognizes a broad range of practice improvement activities, which physicians regularly engage in to ensure the delivery of high-quality health care. In particular, **we commend the inclusion of activities that focus on the importance of mental health as part of comprehensive health care delivery.** Many activities, even those that do not specifically highlight mental health, align with APA-supported recommendations related to practice guidelines, patient safety goals and educational activities. We also laud CMS for proposing modified requirements for small practices and practices in rural areas and geographic Health Professional Shortage Areas (HPSAs). While psychiatrists in these practice settings routinely engage in activities to improve their care delivery, providing full credit for a fewer number of activities, supports physicians who face resource constraints due to their practice size and/or location.

The APA strongly supports the evidence-based Collaborative Care Model (CoCM), which raises the quality of care for patients who receive mental health care through primary care providers, through ongoing involvement of a behavioral health care manager, and regular case review by a psychiatrist. We are therefore very pleased to see that CMS has included some CPIA activities that would recognize the value of integrating mental health services with primary care and other clinical care settings and services. The CoCM is the ONLY integrated health model with a clear evidence base.

We are also extremely pleased with the inclusion of the high weighted activity “Participation in the CMS Transforming Clinical Practice Initiative.” As we discuss in more detail in the Alternative Payment Models

Section of this letter, the APA is actively promoting practice transformation for psychiatrists through participation in the TCPI.

Specialty Involvement in CPIA Activity Recognition

We recommend that in the final rule and/or sub-regulatory guidance, CMS establish a process for determining how specific individual activities will be recognized as qualifying as a CPIA activity. This process should involve collaboration with relevant specialty societies, drawing on their clinical expertise and understanding of their physician members' practices. Partnering with specialty societies will ensure relevancy to practitioners within that specialty. Societies could then communicate to their members ahead of each reporting year a list of activities that are pre-approved to meet the CPIA requirement, providing an easily understandable pathway for participation in the CPIA category. We note, however, that such a list would not be exhaustive, because we anticipate that there may be some other activities for which physicians ought to receive credit, which may not necessarily be identified on a specialty society list.

Consideration of Time/Work Intensity in Weighting Determination

We understand that CMS proposed weighting activities as “high” based on the extent to which they align with activities that support the patient-centered medical home (PCMH), CMS priorities for transforming clinical practice, and activities that require performance of multiple actions. We believe that CMS ought to include a criterion for high weighting that recognizes activities that are time and resource intensive. For example, implementation of fall screening and assessment programs to identify patients at risk (e.g. because of benzodiazepines use) requires substantial, initial and continued engagement of the care team members, as well as potential modifications to EHR systems to introduce clinical decision support tools. Additionally, there may be instances in which such high time/resource use practices meet two different CPIA goals and should therefore be allowed to count across both activities.

CPIA Subcategories and Activities

Integrated Behavioral and Mental Health: We greatly appreciate inclusion of this CPIA category as tacit recognition that, despite the widespread prevalence of mental illness, including substance use disorders, only 25% of patients receive effective care, including in primary care settings, where the majority of patients receive their usual care. Incentivizing better care delivery through the integration of mental health care with other medical care is an important component to addressing this gap. In particular, **we appreciate the inclusion of components of the CoCM, such as regular case review and the use of a registry to support active care management and outreach to patients in treatment.** In support of this important category and to accurately reflect current clinical best practices and terminology, the APA requests the following clarifications and edits.

We request that CMS amend the category title to “Integrated Mental Health and Primary Care/Non-Primary Care” and replace the term “behavioral health” with “mental health” throughout the remainder of the section, as well as specifically clarify that the category includes substance use disorders. CMS has acknowledged there is significant room for improvement in access to and quality of care for mental health and substance use disorders. It should be clear from the category title that the listed activities focus on the interaction of mental health with other medical care in both primary care and specialty care settings. Most importantly, there should be explicit recognition that mental health care includes

treatment of substance use disorders. Likewise, references to “behavioral or mental health conditions” should be changed to “mental health conditions.”

The activity entitled “Offer integrated behavioral health services to support patients with behavioral health needs, dementia, and poorly controlled chronic conditions [emphasis added]” could be interpreted in an overly restrictive manner as requiring patients to have all three of the listed conditions and needs, in order to earn credit as a CPIA. Such overly restrictive patient criteria would fail to recognize the benefit of offering integrated services to any patient with mental health needs. For example, the CoCM has been shown to be effective for a range of mental health conditions. Therefore, we recommend changing “and” to “and/or.”

While regular, proactive outcome monitoring and treatment to a specific outcomes target using standardized outcome measures/rating scales is integral to the CoCM, we disagree with the specification of use of “certified health information technology” (CEHRT). Requiring CEHRT is too proscriptive and does not necessarily lead to optimizing clinical outcomes.

The medium-weighted activity “Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic medication” should be broadened to recognize the importance of diabetes screening for all persons using an antipsychotic medication, regardless of indication. Antipsychotics carrying the FDA-required warnings about diabetes and metabolic syndrome are approved for treatment of major depression and other conditions beyond bipolar and schizophrenia disorders. Clinical practice guidelines reflect this; e.g. the APA’s “Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients With Dementia” recommends “monitoring [...] fasting glucose [...] at baseline for individuals receiving antipsychotic medication, with additional [...] fasting plasma glucose at 12 weeks and annually [...].”¹⁰

Both primary care providers and psychiatrists engage in and partner on prevention and treatment interventions for the four activity areas listed on tobacco use, unhealthy alcohol use, depression screening, and major depressive disorder treatment. It should be made explicit that for these CPIA activities, both the provider doing the screening and the provider engaging in the follow-up and management of care qualify for credit.

Care Coordination: The APA has concerns regarding the CPIA activity entitled “Performance of regular practices that include providing specialist reports back to the referring MIPS eligible clinician or group to close the referral loop or where the referring MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the certified EHR technology.” **We recommend clarification that specialists are able to receive credit for closing the referral loop through note transmission, even if not done through an EHR.** Psychiatrists and other specialists face particular ongoing challenges related to interoperability of EHR systems, which are completely beyond their control.

Beneficiary Engagement: The APA is pleased with CMS’ inclusion of activities related to recognition of collecting and acting on patient experience data. Psychiatrists, as part of their Maintenance of Certification (MOC), participate in activities that meet “Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan.” The

¹⁰ The American Psychiatric Association, Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients With Dementia, May, 2016. <http://dx.doi.org/10.1176/appi.books.9780890426807>.

MOC Part IV feedback module focused on patient feedback is a quality improvement exercise designed to identify and implement areas for improvement based on feedback from patients via a questionnaire/survey. The feedback module covers six general competencies, which are reviewed on the feedback forms: interpersonal and communications skills, medical knowledge, patient care, practice-based learning and improvement, professionalism, and system-based practices. Based on results from the feedback, psychiatrists identify opportunities for improvement to the effectiveness and/or efficiency in their practice, and take steps to implement improvements as needed. Within 24 months of initial assessment, the physicians then collect data from another set of the same or different patients and use the same feedback option for the initial assessment and reassessment steps.

Patient Safety and Practice Assessment: It is unclear in the proposed CPIA activity regarding “Participation in Maintenance of Certification Part IV for improving professional practice [. . .]” what is meant by “including participation in a local, regional or national outcomes registry or quality assessment program” and whether this would be a requirement to receive credit. Such a possible requirement may have the effect of eliminating activities that qualify under the American Board of Psychiatry and Neurology (ABPN) MOC Part IV. **CMS should defer to the expertise of the medical specialty boards in defining which activities warrant recognition for MOC Part IV’s Improvement in Medical Practice.**

We support modified inclusion of the activity “For eligible professionals not participating in Maintenance of Certification (MOC) Part IV, new engagement for MOC Part IV, such as IHI Training/Forum Event; National Academy of Medicine, AHRQ Team STEPPS.®” We read this to allow non-MOC participating providers to participate in MOC Part IV activities and receive credit under the CPIA, and request additional language clarifying this. While patient safety courses provided by IHI are a worthwhile activity and should count as a CPIA, they are not classified by the ABPN as a MOC Part IV activity. Consequently, we request that this activity be listed separately from any mention of MOC Part IV.

We request modifying the CPIA “Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities” so that recognition should not be limited solely to “adoption.” Any eligible professional participating in activities affiliated with such a model should receive credit under the CPIA performance category, recognizing that successful deployment of these models is predicated on physician involvement at all levels.

Population Management: In discussing vulnerable populations in this section of the CPIA, we urge that CMS explicitly mention individuals with mental health and substance use disorders. It is important to recognize the historical lack of access to high quality care for such individuals and the role that such illnesses play in other chronic diseases—for which new evidence emerges on an ongoing basis.

MACRA ALTERNATIVE PAYMENT MODELS

The MACRA provides another pathway for psychiatrists and other physicians to earn incentives for participating in new models of care. From 2019 through 2024, “qualifying” physicians who furnish a substantial percentage of services through “advanced” alternative payment models (APMs) will receive an annual bonus of 5% and be exempt from MIPS reporting. Their total APM services would have to be at least 25% of all of their Medicare payments in 2019 and 2020, at least 50% in 2021 and 2022, and at least 75% starting in 2023. Those with slightly lower percentages could be considered “partially qualifying” participants and would not be eligible for bonuses, but could choose not to report in the MIPS program. Also, starting in 2021, there is some flexibility to calculate these percentages with respect to all payments, regardless of payer. The MACRA also created a new Physician-Focused

Payment Model Technical Advisory Committee to advise and support physicians in developing new payment models.

The APA has serious concerns about the ability of psychiatrists to participate in, and develop, new models of care that would meet the standards of “advanced APMs.” The MACRA statutory requirements already set the bar quite high. First, these new models of care must either be in the Medicare Shared Savings Program (MSSP), approved by the Centers for Medicare and Medicaid Innovation (CMMI), or required by federal law. Second, they must use certified electronic health record technology. Third, they must assume “more than nominal” risk, except for patient-centered medical homes. And fourth, they must tie payment to quality measures similar to those for the MIPS program.

Unfortunately, the proposed rule further restricts the ability of physicians to develop new models that may qualify as “advanced” APMs. CMS has proposed that the first year, these would include only: Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs) in Tracks 2 and 3, Next Generation ACOs, the Comprehensive Primary Care Plus (CPC+) program, and two specific models for end-stage renal disease and oncology care. Contrary to the clear intent of the MACRA, some patient centered medical homes would have to assume more than nominal risk. We do, however, support CMS’ interpretation that a certain percentage of an advanced APM’s participants would have to use CEHRT, and we think that the proposed level of 50% is quite fair.

New payment models are evolving to address mental health. While most Medicare models target primary care, physical conditions, or procedures, Medicaid and private insurers are leading the way in developing new models that focus on mental health. For example, the state of Minnesota developed the first Medicaid ACO, which has emphasized improving mental health care. **The MACRA pathway for new models of care should support the development of models for mental health and substance use disorders treatment, and should reward psychiatrists for participating in those models.** There are no current APMs for mental health that would seem to meet the MACRA “advanced” APM criteria. The APA will be working with APA member experts to explore new opportunities for psychiatrists to possibly develop and participate in “advanced” APMs, including possible approval for the Collaborative Care Model. But it will be very difficult for new APMs that focus on mental health to meet the proposed “advanced” APM criteria, particularly the stringent requirements around the definition of “more than nominal risk” as well as the extremely complicated benchmarking definitions and methodology.

The APA strongly supports the Collaborative Care Model (CoCM), which raises the quality of care for patients who receive mental health care through primary care providers, through ongoing involvement of a care manager, and regular case review by a psychiatric consultant. The CoCM was developed by psychiatrists at the AIMS Center at the University of Washington. In this model, primary care practices employ a behavioral health care manager who manages care for their patients with mental health and substance use disorders, and a psychiatrist consults with the practice to review the patient’s progress and make recommendations for adjusting their treatment. This model has been demonstrated to raise quality and be more cost-effective than care as usual, in some cases even saving money, in over 80 random clinical trials.¹¹ We are pleased that elements of this model are included in the MIPS as CPIAs. However, we are concerned that the proposed criteria for “advanced” APMs may not allow the

¹¹ Archer, J.P., et al. 2012. “Collaborative Care for Depression and Anxiety Programs (Review).” *Cochrane Database Syst Rev*, no 10. Unutzer, J., et al. “A Web-Based Data Management System to Improve Care for Depression in a Multicenter Clinical Trial.” *Psychiatric Services (Washington, DC)*. 53 (6): 671-73, 678. <http://www.ncbi.nlm.nih.gov/pubmed/12045303>.

development of this and other models that address mental health and substance use disorders, further widening gaps in care.

The APA is involved in a number of activities that encourage psychiatrists to participate in the CoCM and to transition to new models of care and delivery. CMS' "Transforming Clinical Practice Initiative" (TCPI) aims to improve patient outcomes, reduce costs, and transition 75% of clinician practices to alternative payment models. As a TCPI Support and Alignment Network, the APA offers psychiatrists the opportunity to receive free training in the CoCM. The APA also connects psychiatrists with Practice Transformation Networks that can provide quality improvement, workflow redesign, data collection, and optimization of electronic health records – to assist in the transition to new models of care. Finally, the APA is also co-author, with the Academy of Psychosomatic Medicine, of a recent report entitled *Dissemination of Integrated Care within Adult Primary Care Settings: The Collaborative Care Model*. The report includes a working set of principles defining evidence-based integrated care implementation and highlights the importance of primary care integration through the Collaborative Care Model.

We also urge CMS to give psychiatrists the credit they deserve for caring for patients who are part of ACOs and other "advanced" APMs. Many psychiatrists are seeing patients who are part of ACOs and other APMs. This is particularly true for psychiatrists who work with integrated health systems or large, multi-specialty practices. Some ACOs even have a psychiatrist as their medical director, or in a similar leadership position. A number of psychiatrists are now seeing a significant percentage of patients—or have a significant level of revenue – tied to the MSSP Track 2 or 3 ACOs, CPC+, or other "advanced" APMs.

Physician attribution to these APMs particularly needs to account for psychiatrists who provide services pursuant to consulting or case review arrangements such as those provided under the CoCM. Those psychiatrists are making essential contributions to the delivery of high-quality, evidence-based care, and providing services that are integral to meeting the quality and cost-control benchmarks of those APMs. The methods for attributing providers as an APM participant need to recognize such psychiatrists, who advise on and deliver such care to patients in these settings. CMS contemplates limiting recognition to some combination of APM participant lists or affiliated practitioner list. CMS may need to look beyond those two methods in order to accurately capture all "qualifying" and "partially qualifying" APM participants.

We also urge CMS to make it a priority to identify and give credit to all specialists who provide services to "advanced" APMs, as well as other ACOs and models of care. We believe it would be extremely helpful, as medical specialty societies move forward in their consideration of developing new models of care, for CMS to publish specialty-specific data on the number of physicians in each specialty who are providing services to Medicare patients in these models.

Conclusion

Thank you for your review and consideration of these comments. If you have any questions or would like to discuss any of these comments further, please contact Eileen Shannon Carlson, RN, JD, APA Director of Reimbursement Policy, at ecarlson@psych.org or (703) 907-8590.

Sincerely,

A handwritten signature in black ink that reads "Saul Levin, M.D., M.P.A." in a cursive style.

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