September 2, 2014

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Proposed Rule for Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2015

Dear Administrator Tavenner:

The American Psychiatric Association (APA), a national medical specialty society comprised of over 35,000 psychiatric physicians, would like to submit comments in response to CMS’s Proposed Rule for Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2015.

APA appreciates the opportunity to comment on the number of important policy changes which CMS has proposed in the rule. We are encouraged to see that CMS has taken our comments into consideration on past proposed rules and we hope that the agency will do so again.

Malpractice Relative Value Units (RVUs)

CMS, which is charged with reviewing malpractice relative value units (RVUs) no less than every five years, has proposed updates to the malpractice RVUs. CMS provided a summary of the methodology used to develop the new values, including a discussion of the limitations of the information available. There are a number of provider groups for whom there is insufficient data. Included in that list are many of the non-physician provider groups. Due to the lack of data, CMS has once again chosen to crosswalk those non-physician providers to the lowest physician risk factor (Allergy and Immunology). This crosswalk is inaccurate and inappropriate. Absent sufficient premium data from rate filings, it is incumbent on CMS to identify other data sources lest it impact the integrity of the relativity for the full proposal. AMA has pointed out that the data from the Physician Practice Information (PPI) survey process is available and could be used as a point of comparison among the groups rather than making a blanket decision to crosswalk the value to the lowest physician value. **We join the AMA in requesting that CMS use the PPI survey data, or some other measure of central tendency, within the existing collected premium data, to determine accurate PLI premium rates for non-physician specialties.**

Telehealth Codes

APA is pleased to see that CMS is expanding the scope of telehealth services available for reimbursement beginning in 2016, particularly for the psychotherapy codes (CPT codes 90845-7). We also support the broadening of the definition of “originating sites” to include more rural
locations. This expansion of reimbursement will improve patient access to quality medical care and mental health care especially in remote areas that have physician shortage issues. We urge CMS to finalize these proposals and to look for ways to increase telehealth services in the future.

**CPT/RUC Timing Changes**

APA agrees with CMS’s decision to explore ways to increase transparency and the opportunity for comment in the valuation process. APA joined 70 other medical specialty societies and health care professional organizations in submitting a letter expressing concerns with the proposed CMS timeline and offering an alternative. We encourage CMS to adopt the recommendations proposed in the letter. Specifically, we urge CMS to begin implementation of the new timeline and procedures for the CPT 2017 cycle and the 2017 Medicare Physician Payment Schedule; adopt the AMA proposal for modifications in CPT/RUC workflow to accommodate publication in the proposed rule, while ensuring that new technology may be described and valued in an efficient and timely manner and eliminate the need to create separate G codes; and create a fair, objective, and consistently applied appeals process that will be open to any commenting organization.

**Chronic Care Management**

APA commends CMS for moving in the direction of reimbursement for non-face-to-face services through chronic care management (CMM) codes. APA has been a long-time supporter of the CPT codes and RUC recommendations for Medicare reimbursement for these crucial services. Management of mental health conditions is a carefully coordinated effort. There is a substantial evidence base that shows that psychiatric involvement at critical junctures results in better outcomes. A large number of Medicare beneficiaries eligible for such services - those who have two or more chronic conditions - are patients who have serious mental health and/or substance use disorders. There needs to be a mechanism for reimbursement for these types of services that will improve access to care for these often vulnerable patients.

APA and a coalition of medical specialty groups proposed a number of recommendations in a September 2014 letter. As discussed in that letter, there are a minimum of two distinct populations with multiple chronic conditions with different needs requiring different work/services. There is no ‘typical’ patient characterization that describes both groups.

**Therefore, the group supports the adoption of appropriate valuation and payment for two CPT codes - GXXX1 (or 99490 as proposed by the AMA) and 99487 (including the adoption of the RUC recommended values).** The new CPT code and our recommendations, if adopted, will begin to enable key evidence-based integrated care efforts with the psychiatric/substance use disorder population and persons with primary medical conditions and mental health comorbidities to move forward in very important ways. There are other essential psychiatric physician non face to face functions which will need to be recognized about which we will be communicating further with CMS.

We also appreciate that CMS has responded to physician groups, including the APA and AMA, and will drop several planned restrictions on who can bill for these services. However, CMS is now proposing to require the use of certified electronic health record technology (CEHRT), which is certified to at least 2014 Edition certification criteria and includes an electronic care plan. We share the concerns expressed by the AMA and others that apart from general concerns with CEHRT standards, applying them to reimbursement for CCM services will likely harm the
very beneficiaries who need these services the most. This requirement means that many physicians will need to acquire a completely new EHR solely for the purpose of billing CCM. Most physicians do not have certified EHRs, and even fewer have EHRs that are certified for meaningful use, stage II. Additionally, physicians who work in facility settings don’t have a choice of EHR and if the facility’s EHR is not certified then they would be unable to bill the proposed GXXX1 code. Moreover, this requirement will not add any value to the service because most EHRs - physician and facility - are not interoperable. Although we agree that interoperability is important and that it is laudable to promote interoperability - the fact is that it doesn’t exist in 2014. Requiring a certified EHR will mean that the CCM will not be provided to the beneficiaries who will benefit from it. We recommend that CMS revisit this issue in 3 or 4 years hence when it is anticipated that interoperability will be more widespread and purchasing a certified EHR would add value to the service.

Removal of Employment Requirements for Services Furnished “Incident to” Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Visits

CMS is proposing to allow “incident to” billing by a RHC or FQHC for services provided by contracted staff—nurses, medical assistants, and other auxiliary personnel. This could offer RHCs and FQHCs greater flexibility to help meet the needs of rural and underserved communities.

The APA agrees with AMA in support of the proposal with similar caveats. Such flexibility should not be at the expense of quality services or physician-led care teams. As the AMA states, the physician led teams should be enabled to perform medical interventions according to their education, training, licensure, and experience to most effectively provide quality patient care.

Private Contracting/Opt-Out

APA joins AMA in urging CMS to amend its opt-out policy to allow physicians to opt-out of Medicare indefinitely, as opposed to requiring reaffirmation every two years. The current requirement, wherein every physician who opts-out of Medicare must re-file an affidavit every two years in order to maintain his or her opt-out status is unnecessary and is not required by law. Most importantly, this creates an unnecessary burden for these physicians to needlessly submit documentation every two years, and has the potential to catch some physicians unaware, at great peril. Failing to submit such documentation may expose physicians to significant penalties. After the two-year minimum that is required by law, the opt-out period should be effective indefinitely, unless and until the physician chooses to terminate his or her opt-out status. APA appreciates and supports CMS’s clarification that the physicians who have validly opted-out of the Medicare program are nevertheless still permitted to write orders and referrals for Medicare beneficiaries. This assists beneficiaries in receiving the care they need. We strongly urge CMS to amend its current opt-out policy by allowing physicians to opt-out of the Medicare program indefinitely and by ending the required submission of an affidavit every two years.

Physician Compare Website

While APA is very pleased that CMS has taken our recommendations under advisement in the past regarding the Physician Compare website, we remain extremely concerned with the large number of unaddressed problems with the system and the number of expansions that CMS is currently proposing to this flawed system. As APA has expressed in past comments, we remained concerned that many beneficiaries will interpret the quality information listed on the website as an indicator of the standard of care that physician provides, which is not always the case. There
are serious issues surrounding the sample size that would allow for the correct inferences and we urge CMS to continue to only post group information as opposed to individual practitioner data.

CMS’s move away from claims-based reporting on the measures psychiatrists use most within the PQRS could disadvantage many psychiatrists in this system. Beneficiaries will not be receiving the best care if they choose a physician based on a quality measurement system they do not understand and one which does not accurately reflect the actual care the physician provides, only the measures they report on.

Further, CMS has yet to put in place a formal appeals process for contesting Physician Compare information and provides only 30 days for a physician to review information. APA urges CMS to expand the preview period to 90 days at a minimum and delay posting contested information until problems are resolved. It often takes medical practices several weeks or sometimes months to register and obtain their PQRS reports and Quality and Resource Use Reports (QRURs). It is also unclear how CMS plans to notify EPs of the preview period for reviewing their public ratings. We anticipate problems and backlogs with obtaining reports as CMS greatly expands all of its quality programs and moves to profile all EPs.

Additionally, APA has serious concerns about the risk adjustment methodology used to account for race, income, and region type. The lack of adjustment can lead to inaccurate and misleading conclusions about quality and performance measurement. A simple examination of performance scores without adjustment for patients’ socioeconomic and/or sociodemographic situation ignores a number of factors that are believed to influence quality and cost of care. For example, economic and cultural status can affect health status, impede ideal communication between the patient and the physician, and hamper the patient’s desire and/or ability to follow a given treatment plan. Ignoring these factors could lead to the conclusion that physicians and practices that serve low income, or culturally marginalized, patients provide lower quality care than those serving high income patients, when the difference in scores could actually be due to differences in patient mix rather than differences in quality of care provided. To hold physicians accountable if outcomes differ for these patients without accounting for the factors that contribute to that difference would unfairly penalize physicians for factors outside of their control. This also runs the risk of unfairly penalizing those physicians who treat those patients who are most in need. APA urges CMS to reconsider and revise their risk adjustment methodology.

Reports of Payments or Other Transfers of Value to Covered Recipients

CMS has proposed removing the explicit Open Payments Program regulatory exclusion for continuing medical education (CME) that is applicable to certified and accredited CME activities that meet certain criteria for independence. Instead, CMS proposes to apply another regulatory exclusion to certified and accredited CME when manufacturers are “unaware of” or “do not know” the identity of the covered recipient(s) during the reporting year or by the end of the second quarter of the following reporting year. APA strongly opposes this significant policy change and urges CMS not to finalize or modify this proposal to continue to exclude independent continuing education programs. APA has joined the AMA and many other medical specialty groups in requesting that CMS retain this exclusion on the grounds that the exclusion is not “redundant,” as CMS states in the proposed rule, and that such a major policy shift after months of preparation under different auspices should be more carefully considered.
Physician Quality Reporting System

The APA has a major interest in the measures that are included or excluded in the Medicare PQRS schema. The measures we are interested in touch on a major issue – psychiatric comorbidities to one or more chronic medical conditions – and have a major impact on the quality and outcome of beneficiary medical care.

Prevalence/Costs

As CMS notes, “depression is a serious health condition for the Medicare population and can decrease patient adherence to treatment for chronic conditions.” It is well documented that the prevalence of mental health and/or substance use disorders (MH/SUD) in the U.S. population is significant. Most patients with these conditions are seen exclusively in either primary or specialty medical care settings—and most do not receive appropriate assessments and treatment. While nearly 50% of patients with a chronic medical disease have co-morbid MH/SUD conditions, more than 80% of these conditions remain untreated or ineffectively treated in primary and medical specialty settings. For the third of patients who actually receive MH/SUD care in the primary care sector, treatment for only one in nine is evidence based. Fewer than half of all patients actually see a mental health specialist, and untreated MH/SUD conditions in the primary care setting are associated with treatment nonresponse, illness persistence, higher medical illness complication rates, disability, increased healthcare service use, higher healthcare costs, and premature death. In 2014, the American Heart Association published a guideline identifying depression as a risk factor for poor prognosis for persons with acute coronary syndrome.

Medical costs for treating those patients with chronic medical and comorbid mental health/substance use disorder (MH/SUD) conditions can be two to three times as high as those for beneficiaries who do not have the comorbid MH/SUD conditions. People diagnosed with schizophrenia or bipolar disorders are three times more likely to have three or more chronic disorders than those without mental health problems. The additional healthcare costs incurred by people with behavioral comorbidities were estimated to be $293 billion in 2012 across commercially-insured, Medicaid, and Medicare beneficiaries in the United States. Of this, Medicare spending accounts for $3.3-$6.7 billion.

This is also consistent for the dually eligible Medicare and Medicaid beneficiaries. A report by the Congressional Budget Office, “Dual Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending and Evolving Policies” showed that combined spending for dual eligible persons with mental illness and at least one other chronic condition averaged $48,000 per person in 2009. Combined spending for duals without mental illness averaged $28,600 per person. In 2009, there were 7.1 million individuals fully eligible for Medicare and Medicaid. Approximately 30% of them were diagnosed with a mental illness and of these, 20% had three or more chronic conditions.

1 American Psychiatric Association/Chicago IL/June 2014, p.9.
2 The Synthesis Project No. 21, February 2011.
4 APA op. cit., p. 9.
**Evidence Based Practice Example—Collaborative Care Model (CCM)**

The evidence base demonstrates that carefully developed models of care using appropriate measures can have a significant impact.

The CCM integrates behavioral health treatment in the primary care setting. Included in the model is (1) the principle of population-based care, taking care of all patients with mental health conditions; (2) measurement-based care, utilizing metrics with systematic caseload review to determine whether treatment is successful; and (3) stepped care, increasing the intensity of treatment for patients with persistent problems. There is a preponderance of evidence that supports the use of this model with over 80 randomly controlled trials. Two examples are a meta-analysis from British Cochrane Review (equivalent of AHRQ in the US) with a review 79 trials and the 2012 Community Preventive Services Task Force that formally recommended the use of collaborative care for the management of depressive disorders as well as other meta analyses and research papers.\(^5\)\(^6\)\(^7\)

Screening tools are a key measurement component in CCM used to identify, treat, and follow up with patients who have mental health diagnoses (e.g. PHQ-9 for depression, the GAD 7 for anxiety, etc.). The systematic and periodic collection of such data establishes the quality parameters that are required to recognize patients who are not improving as expected and to change treatment as needed. This approach is termed measurement-based. When patients with mental health issues are not improving as illustrated over time by the screens then their care needs to change and be “stepped up.”

Additionally, a recent study by Unützer demonstrated that the CCM has a high probability of significant return on investment with savings of $6.50 per $1 spent over a four year period.\(^8\)

**CMS proposals**

First, APA would like to express our concern that two critically important measures seem be omitted from the list of available measures for CY2015, yet are also not listed for removal. Measure #9: Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD and Measure #173: Preventive care and screening: Unhealthy alcohol use—screening (both of which are registry reporting only) are not listed in the proposed rule for CY2015 but are not listed for removal. **APA supports these measures being included in the PQRS program for 2015. If these measures were selected for removal, APA would strongly**


\(^8\) Unützer, J. Long-term Cost Effects of Collaborative Care for Late-life Depression, The American Journal of Managed Care, VOL. 14, NO. 2, Feb 2008.
object since they are valuable measures in an underrepresented domain and can be used by a wide variety of physicians, including psychiatrists, family practice physicians, primary care physicians, and geriatricians. We ask that CMS clarify their intent on these measures and either include them for CY2015 or put them on the list for removal and allow public comment.

Further, APA would like to express our concern that CMS is removing the ability for claims-based reporting and moving to a fully registry or EHR based system. Many psychiatrists are solo practitioners who simply lack the support staff and resources to have a system capable of such reporting. While claims-based reporting has its disadvantages, it is more widely utilized and accessible for small and solo practices. Moving to a purely registry and EHR reporting system closes off that option to a population of physicians who may already be having trouble finding measures to report on. Many APA members are trying to comply with the PQRS system, but are shut out or are automatically triggering the MAV process because they cannot find enough measures to include in their reporting. APA strongly urges CMS to retain claims-based reporting for at least some measures going forward or to develop some kind of small/solo practice exemption.

Specific Psychiatric Measures

APA would also like to comment on some specific changes to the PQRS measure set that CMS is proposing. APA strongly urges CMS to increase the number of cross-cutting measures available for psychiatrists and amenable to psychiatric care to increase participation in the PQRS program.

CMS has proposed removing NQF 103/PQRS Measure 106: Adult Major Depressive Disorder: Comprehensive Depression Evaluation and Screening, stating that there is already a clinically diagnostic reference and that it does not add value to the PQRS system. APA would object to this removal since the other measure, the PHQ-9, does not include screening for bipolar disorder and could potentially exclude some patients from screening. As we have previously stated to CMS, there are more appropriate measures to use in this program developed by AMA-PCPI and we urge CMS to consider these measures as a replacement for NQF 103.

CMS has also proposed removing PQRS Measure 73: Preventative Care and Screening: Unhealthy Alcohol Use - Screening since the measure steward has indicated that it will no longer maintain this measure. APA strongly recommends that CMS keep an alcohol screening measure in the PQRS since alcohol use screening is particularly valuable in the Medicare population and this measure in particular is widely used by psychiatrists, both addiction specialists and general psychiatrists. APA suggests that CMS select another group to be the measure steward and we would be happy to help find an appropriate steward. We look forward to working with CMS to ensure that this important measure is kept in the PQRS.

Two other measures, PQRS Measure 7: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment and PQRS 9: Anti-Depressant Medication Management, were slated for removal as well, yet CMS has decided instead to propose simply dropping all claims-based reporting on these measures. APA objects to moving to an EHR-only reporting system on these measures. These measures are widely used, extremely valuable, and should be promoted to primary care physicians for reporting in addition to psychiatrists. We urge CMS to consider maintaining claims-based reporting on these measures and to increase promotion of their availability to other practitioners.
APA was pleased to see that CMS is proposing to add new measures for CY2015 and beyond. Among the new measures that would be particularly useful to psychiatrists are NQF 0418/PQRS 134: Preventative Care and Screening: Screening for Clinical Depression and Follow-Up Plan and NQF 0028/PQRS 226: Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention. We look forward to promoting these to our members and hope that they take advantage of the opportunity to report on more quality measures.

We concur with CMS’s proposal to add the NQF 0710: Depression Remission at Twelve Months measure to the measure set used in establishing quality performance standards that ACPs must meet to be eligible for shared savings. Evidence shows that both screening, development of a follow-up plan, and measuring remission at a future point is essential. As CMS notes, “this would enhance our measurement of health outcomes.” Depression is a significant health condition that should be addressed by ACOs.

Separate from the above, eligible professionals can meet the PRQS reporting requirements without submitting a mental health/substance use disorder measure. Furthermore, most recent data show that less than 20% of individual practitioners in an ACO reported on the Screening for Clinical Depression and Follow Up measure.9 Allowing eligible professional to ignore such measures presents CMS with a missed opportunity to improve outcomes for patients with complex and chronic conditions. Such patients suffer because their health status is not monitored in the data collection and measurement processes. When such data and subsequent measures are utilized, there is substantial evidence indicating a significant positive impact on costs and outcomes—like those established by the Triple Aim and healthcare reform.

The APA will be in further communication with CMS regarding these issues and the future rulemaking cycles.

Value-Based Payment Modifier

Since a large percentage of psychiatrists are solo practitioners, APA has been closely monitoring the implementation of the value-based payment monitor for the upcoming application to these practices. APA has concerns about the rapid advancement of the value modifier system particularly given the underlying methodology and issues associated with it. These include how patients are attributed to practices, the development of quality and cost composite scores, and how risk-adjustment factors are applied. We have significant concerns about the phase-in of penalties and CMS’s proposal to double the potential VBM adjustments to 4%. This will be applied to all physicians and alternative payment models in 2017 and will be based on 2015 performance.

A Center for Healthcare Policy and Payment Reform (CHQPR) report shows how the spending measures currently being used can:

- Inappropriately assign accountability to physicians and hospitals for services they did not deliver and cannot control, while at the same time failing to hold healthcare providers accountable for most of the services they do deliver;

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• Financially penalize physicians and hospitals who care for patients with complex problems and who deliver evidence-based services to their patients;

• Fail to provide physicians, hospitals, and other providers the kind of actionable information they need to identify opportunities to control healthcare spending without harming patients; and

• Provide patients with misleading information about which providers deliver lower-cost, higher quality care.

The pace at which the value modifier is being implemented leaves specialty small group and solo practitioners little time for preparation and places them at risk for sharp penalties. CMS states that it will make actionable reports available to providers to help them address problems in advance of the downward adjustments in the value modifier. However, there is insufficient lead time once the reports are prepared. Further, some reports are empty given a lack of data. This results in the assignment of an “average” score for both quality and cost measures.

CMS itself recognizes that the methodology requires further study. In its summary document, 2015 Value Based Modifier Policies, CMS states, “We also anticipate that we would propose to increase the amount of payment at risk for the Value Modifier as we gain additional experience with the methodologies used to assess the quality of care, and the cost of care, furnished by physicians and groups of physicians.” APA would be interested to learn about the additional experience CMS has gained as it proposes to increase value modifier penalty.

APA has serious concerns that psychiatrists who already have difficulties meeting the requirements of the PQRS system due to a dearth of applicable measures and the current shift away from claims-based reporting will be doubly penalized by the VBM system, which uses the PQRS data. Since the proposed rule would maintain the current process where those who do not participate in a PQRS program are automatically subject to both a PQRS and a VBM penalty, our members are in jeopardy of being hit with two penalties amounting to a payment cut of 11% in 2017. Specialty providers face the greatest penalties given the populations that they serve and the proposed modifications to the total per capita cost measure. The APA requests that CMS consider how specialty providers would fare under the value modifier cost methodology given that they typically treat individuals with complex and chronic conditions, such as those dually eligible for Medicare and Medicaid. Related to this is the mandatory application of the quality-tiering process which can also unfairly treat specialty practitioners.

This payment decrease may simply too great for a small or solo practitioner to bear and we fear that may lead to a number of physicians being unable to sustain a Medicare based practice in the future. APA recommends that CMS slow down the phase-in schedule for the VBM implementation and allow more leeway for small or solo practices, which may have difficulty meeting the deadlines and the thresholds set forth in the proposed rule.

The APA also has specific concerns regarding the attribution process. For example, in specialty mental health delivery systems such as community mental health centers, psychiatrists serve as the primary caregiver using E/M codes. In the absence of a primary care physician, all costs of care will be attributed to the specialty physician—the psychiatrist in this case. The APA would appreciate the opportunity to discuss this in further detail with CMS.
Conclusion

APA appreciates that opportunity to provide comments on the CY2015 Medicare Physician Fee Schedule proposed rule. In particular, we are pleased that CMS is expanding the coverage for telehealth services and finding ways to reimburse physicians for more non-face-to-face patient care. We do, however, have some serious concerns about how these policies are implemented and hope that CMS will work with us to improve the program. APA is also encouraged that CMS is adding more cross-cutting quality measures to the PQRS program, yet we remain concerned that CMS continues to add measure requirements to the program while simultaneously dropping the claims-based reporting mechanism which so many small and solo practitioners use. Since there are several upcoming penalty phases for programs that are still facing problems, we hope that CMS will take our concerns into consideration when preparing the final policies and make these programs more flexible and accessible to physicians.

Again, we thank you for your consideration of our comments and we look forward to working with CMS on the final rule. If you have any questions or concerns, please contact the Department of Government Relations at (703) 907-7800 or at advocacy@psych.org.

Sincerely,

Saul Levin, MD, MPA
CEO and Medical Director