January 27, 2014

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4159-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Final Rule for Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014

Dear Administrator Tavenner:

The American Psychiatric Association (APA) is the national specialty society that represents over 35,000 psychiatric physicians. Our members provide care to Medicare patients in a variety of settings, including private medical practices, hospitals, community health centers, group practices, and accountable care organizations. CMS’s adoption of the recommendations we made to the Proposed Rule will positively impact the professional lives of numerous APA members and the quality of care they provide to beneficiaries.

We believe CMS’s decision to implement the following recommendations will be of greatest consequence to our members.

• Acceptance of the RUC’s increased valuations of the psychiatry codes.
• Creation of a G code to permit physician compensation for the non-face-to-face care management services they provide to Medicare beneficiaries suffering from complex chronic conditions.
• Broadening the definition of “rural areas” to expand the locations qualifying for the delivery of telehealth services to include locations within urban areas.

The changes that provide for the appropriate valuation of psychiatry services are essential for the realization of many of the objectives of health reform. It is well known that a
majority of high cost Medicare patients have primary or secondary mental health and/or substance use disorders. Effective treatment of these individuals represents a step forward in both the quality and cost effectiveness of healthcare. The appropriate valuation of psychiatry services recognizes the value proposition that psychiatry brings to the total healthcare system and should help to make psychiatric care more accessible to Medicare patients.

We offer the following comments in response to the sections of the Final Rule most relevant to our members.

**Sustainable Growth Rate and Payment Update**

We support congressional action to repeal the SGR formula, which has annually threatened payments to physicians at a time when there are significant increases in the need for care by Medicare beneficiaries.

**Potentially Misvalued Services/Relative Value Issues**

The APA appreciates CMS’s decision to accept all of the AMA/Specialty Society RVS Update Committee (RUC) recommended work values for services provided by psychiatrists. Acceptance of the RUC recommendations is important because: 1) it corrects the work values so they more appropriately reflect the actual work done by psychiatrists providing mental health services; and 2) the adopted values correct a rank order anomaly that was created by the implementation of interim values that valued the psychiatric diagnostic evaluation without medical services higher than that of an evaluation that included medical services. The adoption of these increased values is critical to the delivery of psychiatric services to the Medicare population.

We also concur with CMS’s decision to not publish the value for CPT code 90863 (pharmacologic management, including prescription and review of medication, when performed with psychotherapy services), because it is a service that is not recognized by Medicare.

**Expansion of Telehealth Services and Areas**

The APA concurs with CMS’s decision to expand the geographic areas in which telehealth services may be furnished by Medicare. In its response to the Proposed Rule, the APA pressed CMS to adopt a more expansive definition of “rural” areas that would include locations that fall within urban areas, referred to as Metropolitan Statistical Areas (MSAs), where access to care is limited. Broadening the definition of “rural” to include these urban locations will assist a significant underserved population in our cities, within which there is a high incidence of severe and persistent mental illness, in accessing psychiatric care.

**Requirements for Billing “Incident to” Services**

The APA supports CMS’s clarification of Medicare incident-to regulations that confirms the rule employed by most Medicare contractors that “incident to” services must be furnished in
accordance with applicable state law, meaning all health care workers providing “incident to” services must meet the licensure requirements imposed on them by the state in which they practice. This clarification will assist our members, some of whom employ health care providers who perform “incident to” services, in understanding CMS’s expectations about whom can perform “incident to” services.

Chronic Care Management

The APA agrees with CMS’s efforts to design codes that will allow physicians to be compensated for the non-face-to-face complex chronic care management services they provide Medicare beneficiaries. Many of our members frequently perform these services for Medicare’s most complex, chronically ill patients. We are part of a group of specialty societies that is collaborating with a CPT Workgroup on a proposal to create a new CPT code that would mirror the G code established by CMS, simplifying the code selection for all providers.

We see the establishment of this code as a step toward appropriately reimbursing for care management services. There is a growing evidence base supporting the value of integrated care that also includes non-face-to-face clinical oversight by clinicians, work that cannot be captured in the current coding structure. It is our hope that codes will be developed for these types of services.

Physician Compare Website

Our members continue to be concerned that patients exploring the Physician Compare Website to find a physician’s name listed as being a participant in a given CMS quality reporting program or programs will think his/her participation, or lack of participation, is causally linked to the health outcomes he/she achieves with his/her patients. We continue to request that CMS include prominent disclaimers on the profile pages of physicians listed within the Physician Compare Website that explain that a physician’s participation, or lack of thereof, in CMS quality reporting programs should not be interpreted as being indicative of whether or not a physician meets the standard of care required of his/her medical specialty or achieves desired health outcomes with his/her patients.

Additionally, the APA remains concerned with the timeliness of being able to correct or update information in physician profiles posted on the Physician Compare Website. APA members want to be able to reach Physician Compare staff in a timely manner if their information is erroneously reported. They also must have an appropriate period of time to correct misinformation included within their profiles on Physician Compare prior to their profiles being made public.
Quality Measures

We encourage CMS to continue to streamline the reporting of quality measures so physicians can benefit from participation in multiple quality reporting programs while incurring less of an administrative burden. CMS should continue to look for ways to make quality reporting across multiple programs, including PQRS, Electronic Prescribing, and the Electronic Health Records Meaningful Use Incentive Program, less complex and more causally linked to patients’ health outcomes.

We will continue to inform CMS through comments and personal discussions about our members’ experiences with existing quality reporting programs, so they can assess the need for modifications to existing reporting requirements.

We support maintaining measures that are psychiatrically-focused and claims-based, rather than those only reportable by registry (e.g., reportable to a physician society’s registry). For example, Measure #9—“Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD” has transitioned from claims-based reporting in previous years to registry only this year. As a claims-based measure, measure #9 has been widely reported on by psychiatrists. We anticipate the utilization of this measure will drop dramatically this year, since many APA members do not yet have the capacity to do registry reporting. APA understands the importance of registries and is committed to developing options (e.g., psychiatric registries) for our members to participate.

We would like to see the development of more psychiatric-focused measures that are applicable to the treatment of substance use disorders and we plan to meet with CMS in the near future to discuss the possibility of incorporating more measures relevant to the treatment of substance use disorders into Medicare’s quality reporting programs.

Physician Quality Reporting System

CMS’s finalization of its plan to increase the number of PQRS measures that must be reported by individual physicians to be eligible for the payment incentive from 3 to 9 via claims-based reporting will be overwhelming for many APA members. This is a steep increase in measures that must be satisfied. Also, it remains challenging to find enough psychiatric-focused measures across three separate measure domains to meet the requirements. While more psychiatry-relevant measures are being created, trying to satisfy 9 measures that are relevant in psychiatry per year will pose a challenge for numerous APA members. This is due to insufficient PQRS psychiatry measures being available across three domains.

Beyond these concerns, we concur with CMS’s decision to reduce the percentage of patients a physician must report on to be considered a satisfactory reporter from 80 percent to 50 percent and support CMS’s addition of 57 new individual measures and two measure groups to fulfill existing measures gaps.
Electronic Health Records Incentive Program (EHRIP)

We agree with CMS allowing physicians to report clinical quality measures by attestation for EHRIP. CMS’s requirement that physicians seeking to report clinical quality measures under EHRIP must use the most recent version of electronic specifications for the clinical quality measures and have certified EHR technology (known as CEHRT), which is tested and certified to meet the most updated version of electronic specifications for clinical quality measures, is presently unattainable for the vast majority of our members who treat Medicare beneficiaries. Those who currently participate in EHRIP will likely be reporting their quality measures by attestation.

Value-Based Modifier (VBM)

We recognize payment systems for medicine are evolving so that “pay for performance” is becoming the norm. In preparation for the beginning of the value-based modifier (VBM), which will affect most of our members seeing Medicare beneficiaries in 2017, we ask CMS to create educational tools that will assist us in better understanding the likely effects of the VBM on the practice of psychiatry.

Backdating of payments - The APA disagrees with CMS’s decision to base its payment adjustments in any given year for the VBM on a “performance year” two years prior. This decision means VBM payments made in 2016 will be based on how physicians performed in 2014. We think the back-dating policy is quite difficult for members to understand and consequently, complicates their understanding of what their true performance values are for any given calendar year. Backdating payments obscures the acceleration of downward payment adjustments our members will soon be experiencing if they do not fulfill PQRS quality reporting requirements.

Adjustment of physicians cost comparison by specialty - The APA concurs with CMS’s response to its advocacy that physicians subject to the VBM have their payments determined based on the comparison of their in performance with others of their same specialty rather than to the universe of Medicare physicians.

Attribution of beneficiaries - While most APA members will not be subject to the VBM until 2017 when the VBM is set in statute to apply to physicians in individual practice (few of our members practice in groups of 10 or more clinicians), we remain concerned with how CMS plans to attribute Medicare beneficiaries when calculating upward and downward payment adjustments physicians subject to the VBM will receive. In the Final Rule, CMS explains it will use the step-
wise attribution approach it set out in regulations defining the attribution of Medicare beneficiaries to Medicare Shared Savings Accountable Care Organizations (ACOs).

We believe CMS should consider adding a data field that would capture whether patients attributed to a primary care practice have primary or secondary psychiatric or substance use disorders. The known high cost realities of providing care to this population would have utility to CMS for program evaluation and development.

Conclusion

The APA appreciates CMS’s consideration of its comments in response to the Final Rule. Please refer any further questions to the APA’s Deputy Director, Regulatory Affairs, Julie A. Clements, J.D., M.P.P., by telephone at (703)-907-7842 or by email at jclements@psych.org. We appreciate the efforts CMS has undertaken to recognize the value of the mental health and substance use disorders services our members deliver. We will work with CMS to strengthen Medicare policies so more APA members can treat Medicare beneficiaries.

Sincerely,

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