September 8th, 2015

Andrew Slavitt
Acting Administrator
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 and Other Revisions to Part B for CY 2016

Dear Acting Administrator Slavitt:

On behalf of the American Psychiatric Association (APA), the national medical specialty society representing more than 36,000 physicians specializing in psychiatry, we are pleased to submit these comments in response to the Center for Medicare and Medicaid Services’ (CMS) Proposed Rule for Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016. APA values the opportunity to comment on the important policy changes that CMS has proposed in the rule and we thank you in advance for your consideration of these matters.

II. E. 2. a. Collaborative Care Models (CoCM) for Beneficiaries With Common Behavioral Health Conditions

APA finds it significant that CMS has singled out the evidence-based Collaborative Care Model (CoCM) for special consideration in its discussion about establishing separate payment for collaborative care. The lack of reimbursement for key components of this model has been the principal barrier to its widespread implementation. Although there may be other treatment models that engage primary care clinicians and behavioral health specialists, the specific Collaborative Care Model that CMS refers to in the July 15 Federal Register is the only model that has compelling scientific data supporting its effectiveness. Over 80 randomized controlled trials have shown the CoCM to be more effective than care as usual. Also several economic studies have demonstrated that collaborative care is more cost-effective than care as usual, a finding that has tremendous importance given the high costs associated with mental health and substance use disorders. In addition to the robust research evidence for the value of collaborative care, there is also substantial practice experience with this model of care from the Medicaid-funded Mental Health Integration Program in Washington State, the commercially funded DIAMOND program in Minnesota, and similar programs in several
other states. When we speak of collaborative care in these comments, we are referring to this specific model cited by CMS.

The need for more effective treatment of individuals with behavioral conditions in primary care settings is a significant health policy issue. Data shows that while depression and other common mental disorders are associated with high health care costs, only about 25% of the patients who experience these disorders receive effective care. The majority of adult patients with mental health disorders receive their health care in primary care settings, but only a minority of patients receive effective behavioral health care in these settings.

The Collaborative Care Model employs a team approach that gives patients seen in primary care settings access to behavioral health care that is effective both clinically and economically. In this approach, primary care providers treating patients with common behavioral health problems are supported by a behavioral health care manager and a psychiatric consultant who help implement effective, evidence-based treatment for common behavioral health problems in the primary care setting. The widespread implementation of this evidence-based Collaborative Care Model under both fee-for-service and value-based purchasing/payment systems could dramatically improve access to effective behavioral health care while at the same time reducing the high health care costs associated with common mental health and substance use disorders (see, “Economic Impact of Integrated Medical-Behavioral Healthcare, Implications for Psychiatry”). This value will grow in importance as the health insurance expansion programs under the Affordable Care Act take hold.

It is also important to note that coverage for the CoCM has positive implications for ongoing CMS care-delivery and payment initiatives. For example, one of the most successful Pioneer Accountable Care Organizations (ACOs), the Montefiore Medical Center, utilizes a CoCM approach as part of its overall operation (see, “Montefiore Medical Center Reports Continued Success as a Pioneer ACO, Remains Committed to Program“). Despite this, reviews of ACOs and behavioral health integration suggest that the CoCM and mental healthcare generally have not been specifically addressed in ACO incentive strategies. There is, however, informal evidence that ACOs are increasingly interested in how to arrange effective clinical care delivery for behavioral health conditions.

In discussing the coding proposition for the CoCM, it is essential to recognize that it is a population-based model of care for a category of health conditions and that it has defined protocols. It is this specific model that has been thoroughly evaluated and has a robust published evidence base for its effectiveness.

The Collaborative Care Model includes these three basic elements: 1.) care coordination and care management; 2.) regular, proactive outcome monitoring and treatment to target using validated clinical rating scales; and 3.) regular, systematic psychiatric caseload reviews and consultation for patients who do not show clinical improvement. Based on the overwhelming evidence base for this

---


2. O'Donnell AN, MPH; Williams, BC, MD; Eisenberg D, PhD; and Kilbourne AM, PhD, MPH. Mental health in ACOs: missed opportunities and low-hanging fruit. AJMC. 2013;19(3). Published online.

model, CMS should adopt a payment methodology as expeditiously as possible that enables covering its approach on a national basis.

Large scale clinical and research initiatives on using the Collaborative Care Model have been conducted:

- In diverse health care settings, including different network and staff model health systems as well as private and public providers;
- With diverse financing mechanisms, including fee-for-service and capitation;
- With different provider practice sizes in both rural and urban locations; and
- With different populations, including both insured and uninsured/safety-net populations.

The research literature on collaborative care in primary care addressed multiple types of collaborative care interventions in all of the settings listed above and concluded that there were several key interventions that must all be present for the care to be effective:

- The use of standardized outcome measures;
- Behavioral health care management;
- Psychiatric consultation; and
- A population-based intervention.

All of these are part of the Collaborative Care Model.

While these core components all have to be present, there is considerable flexibility in their delivery. Both small and large primary care practices and both rural and urban practices have delivered evidence-based collaborative care while incorporating all of these core functions of the CoCM.

There are numerous variations on the treatment of behavioral conditions in primary care settings that are often referred to as collaborative, or integrated care. However, these are not included in what we are discussing here because they do not incorporate all the essential features of the CoCM listed above. Moreover, they do not have the same evidence base supporting their effectiveness (see Appendix A). When we use the term collaborative care in these comments we are referring specifically to the care provided in the CoCM cited by CMS.

Therefore, the development of codes and requirements to be used for collaborative care for behavioral health conditions must be specific to the CoCM to enable its clinical approach and processes. To create codes that would facilitate any or all of the clinical roles or transactions embedded in the model (e.g., co-location of a care manager and screening mechanisms) without being tied to the other elements of the model (e.g., measurement-based care maintained in a registry with psychiatrist oversight) will not realize the substantiated results of the model's utilization: that is, better quality patient care and outcomes and cost efficiencies.

We have developed our comments based on the questions raised by CMS in the Federal Register about the implementation of the CoCM:

*How could coding under the Physician Fee Schedule (PFS) facilitate appropriate valuation of the services furnished under the Collaborative Care Model?*
Coding can facilitate appropriate valuation of the services furnished under the collaborative care model (CoCM) if it:

1. Explicitly incorporates the clinical approach and processes required for an effective implementation of evidence-based collaborative care; and
2. Accurately describes the work entailed in each of the explicit functions for each of the key members/providers on a collaborative care team.

There are three key providers required by the model: a primary care provider (PCP), a behavioral health care manager with adequate clinical supervision, and a psychiatric consultant. The roles of the care manager and psychiatric consultant are new for routine Medicare or Medicaid reimbursement (outside of research and practice demonstration studies including Medicare and Medicaid patients, several CMMI demonstrations, and select implementations by commercial and Managed Medicaid plans) for the treatment of behavioral health conditions in the primary care setting. The functions and responsibilities of these two new team members have standard descriptions, which have been developed for the model and validated in research and real-world implementations. (Evidence- and experience-based summaries of these requirements are available from the University of Washington’s AIMS Center in the form of job descriptions for the care manager and for the psychiatric consultant.)

Under the model, the role of the PCP in treating patients with common behavioral health disorders includes the use of standardized outcome measures such as the PHQ-9 for depression and GAD-7 for anxiety, involvement of the behavioral health care manager in the care of the patient, and consultation with the psychiatric consultant for patients who are not improving.

**Should separate codes be developed for the psychiatric consultant and the care management components of collaborative care services?**

Our review of current CPT and other HCPCS codes did not yield any that accurately describe either the functions and services of a care manager or the services provided by the psychiatric consultant for the CoCM. Moreover, their functions and services far exceed the level of service imbedded in most of the current care coordination codes such as CPT code 99490. Curve-fitting the CoCM and its functions into this code would create a substantial risk that the defined care and treatment algorithms of the effective model would be lost. We view the CCM code as an essential code with a generalized set of functions. We envision codes developed for the CoCM as being specific to the model, and distinct from the CCM code in key respects.

Therefore, we think new codes need to be developed to properly value the services provided within the model. While there could be one bundled payment code that covers primary care practice costs for the care management functions and psychiatric consultation, or two separate codes; one for the care management functions in the primary care practice and one for the psychiatric consultation to the primary care team, we recommend two codes.

The care management code or component would include the functions of the behavioral health care manager such as patient education; outcomes tracking; coordination of care with primary care providers and psychiatric consultants; support of medication management and provision of evidence-based psychosocial interventions such as brief counseling or psychotherapy; facilitation of specialty referrals as needed; routine evaluations of patient outcomes using validated outcome measures such as the PHQ-9 for depression; and the use of information technology such as a case registry to track clinical outcomes for all patients in care.
The second code or component would cover the consultation services provided to the primary care practice by the psychiatric consultant. These include regular (usually weekly) review of all patients treated in primary care who are not improving, diagnostic and/or treatment recommendations to the primary care team, and availability for curbside consultations to primary care providers during work hours.

Either approach, using one or two codes, must account for the flexibility needed to implement provision of these services in a diverse set of primary care practices. With two codes, however, there will need to be documentation that the services incorporated within each code must be present before billing for either code, thereby fulfilling fidelity to the evidenced-based model.

*Should a code similar to the chronic care management (CCM) code be used to describe collaborative care services as well as other inter-professional services, or should the care be reported using the CCM codes and other E/M service codes?*

We think a code similar to the CCM code should be used to describe both the essential processes and essential services entailed in CoCM for the care manager. However, the work of the care manager in an evidence-based CoCM is distinct from that of the case manager in the CCM model and substantially exceeds the level of service the case manager in CCM. The work entailed in the care management function has been clearly detailed and tested over time, and the work is described in a manner that allows it to be valued in the context of the RBRVS. Also, the essential role of the psychiatric consultant is not captured in the CCM codes or in extant E/M codes. The services provided by the psychiatric consultant are not adequately captured or valued in existing CCM or other E/M service codes and should not be reported using such codes.

*Are there requirements similar to those for the CCM services that would be appropriate for a specific collaborative care code?*

There are a number of issues that require review and specifications for new codes for the CoCM that are similar to those for the CCM services. These would include the following:

- Provider eligibility to bill the codes
- Level of supervision under the *incident to* rules
- Patient eligibility
- Patient agreement requirements
- HIT requirements
- Other billing requirements

While we think there is similarity at a general level between the requirements of the CCM codes and codes for the CoCM, the actual details would vary, especially given the fact that the new codes would be specifically directed at evidence-based treatment for behavioral health conditions.

*What resource inputs could CMS use to value the collaborative care services under the PFS (e.g., work RVUs, time, and direct practice expenses)?*
We think the standardized valuation inputs of work and direct practice expenses under the RBRVS paradigm would be appropriate to use in valuing new codes for the CoCM. Based on current operating models, which supply an experiential base to draw from, we would project that the new CoCM codes would have defined time elements, available reference codes for valuing the work components of the care manager and psychiatric consultant, and actual data to define direct practice expenses. Fortunately, there is a substantial base of operating experience with the CoCM in diverse practice settings and with diverse patient populations for CMS to draw on in defining both the work and pricing components so that there is no need to conduct a CMMI demo to finalize the valuation and payment methods.

**How could the resources involved in furnishing collaborative care services be incorporated into the current PFS codes without overlap?**

We do not think there are any significant code overlap issues. Our view is conditioned by the fact that an actual code has not yet been developed, and, in any case, would be subject to the established vetting protocols of the AMA/Specialty Society RVS (RUC) and CMS. All face-to-face patient care encounters performed by the PCP or psychiatrist are currently covered by existing E/M codes but, while essential, these codes do not cover key components of the CoCM that involve care management functions and regular psychiatric case reviews of defined patient populations and development of treatment recommendations that do not involve face-to-face patient contact. The work performed by the psychiatric consultant is not captured by the pre- and post-service times or work times included in the E/M codes. The psychiatric consultant work is new and different and specific to the CoCM.

**How do collaborative care services overlap with quality reporting requirements?**

Collaborative Care Models are designed to deliver measurement-based care. To this end, such models track clinical process and outcomes, i.e., population-based screening and assessment using standardized instruments; initiation of evidence-based treatment for people who assess positive; repeated assessment at defined intervals; inter-professional consultation and treatment adjustment for patients who are not improving; and population-based measurement of remission/recovery. Such measurement is central to care coordination for patients receiving care under the CoCM; and it can also be used to monitor performance at the provider, clinic, and/or system level.

For patients with depression (the predominant behavioral health diagnosis in primary care), the performance of CoCM programs should be monitored via at least two quality measures: (1) a measure showing that PCPs are identifying people with depression via regular/universal screening, and clinical assessment of people who screen positive, using a standardized/validated instrument; and (2) a measure showing that people with depression are remitting/recovering. As of 2015, CMS already requires both types of measures for depression as part of its [Quality Measures and Performance Standards for the Accountable Care Organization Shared Savings Program](https://www.cms.gov/质量标准和绩效/质量标准/质量衡量和绩效标准). It is important that PCPs use both of these measures, rather than just one or the other. Prior research indicates that screening and case identification are not sufficient to improve patient outcomes. If a PCP adopts the outcome measure but not the screening/assessment measure, then he/she may tend to avoid identifying people with depression and focus mainly on patients with good prognosis. For other behavioral disorders treated via the CoCM, analogous measures should be used to ensure population-based identification of patients with a given condition, and to track rates of remission/recovery. Standardized and validated screening and outcome instruments exist for most common behavioral disorders, including the [GAD-7](https://www.convolved.com/gad-7/) for generalized anxiety, the [PC-PTSD](https://www.convolved.com/ptsd-10-item-scale/) for post-
traumatic stress disorder, the **AUDIT** for alcohol use/abuse, and the **ASRS** for adult ADHD. To the maximum extent possible, quality/outcome measures should be based on standardized instruments that can be used both for screening/assessment and to track remission/recovery.

For other behavioral disorders treated via the CoCM, analogous measures should be used to ensure population-based identification of patients with a given condition, and to track rates of remission and recovery. Standardized and validated screening and outcome instruments exist for most common behavioral disorders, including the Generalized Anxiety Disorder (GAD7) scale, the PC-PTSD for post-traumatic stress disorder (pc-ptsd), the AUDIT for alcohol use/abuse (Audit) and the adult self-report scales for ADHD (ASRS). To the maximum extent possible, quality and outcome measures should be based on standardized instruments that can be used both for screening and assessment and for tracking or remission or symptoms and recovery.

We also recommend that pay-for-performance mechanisms be considered for all Collaborative Care programs. Incentives should hold providers accountable for assisting their patients to achieve measurable clinical improvements or remission in common mental health disorders. For some complex populations, including many of those who are dually eligible for Medicaid and Medicare and those who have more severe mental illnesses along with co-morbid medical conditions, achieving remission may be difficult and may take longer than for other populations. In these circumstances, we recommend that pay-for-performance strategies be tied to evidence of fidelity to the CoCM. For example, a measure might reflect evidence of treatment intensification toward a measurable clinical target or goal.

**Are there appropriate care delivery requirements for billing CoCM services?**

In our view, this question partially overlaps with the question on requirements addressed above. Regardless, there are a series of care delivery requirements dictated by the model that would also be appropriate requirements for billing. For example, screening with appropriate validated clinical rating scales would be an essential billing requirement; as would the use of a registry for the tracking of the care manager’s caseload and patient outcomes and for systematically identifying patients who should be reviewed by the psychiatric consultant; weekly caseload reviews with the psychiatric consultant; and documentation of diagnostic and treatment recommendations by the psychiatric consultant.

**Are there necessary qualifications for psychiatric consultants and are there particular conditions for which payment would be more appropriate than for others?**

There are necessary qualifications for both the psychiatric consultant and the care manager. We concur with the job requirements that have been created by the AIMS Center, which were noted earlier. We do not think there are particular diagnostic conditions that would be more appropriate for payment as long as the new codes track the clinical approach and processes defined by the CoCM. Research evidence and extensive experience with the CoCM model in a managed Medicaid environment in Washington State suggest that with appropriate psychiatric support, a wide range of mental health and substance use disorders can be effectively treated in the primary care setting. We expect, however, that most primary care practices would use CoCM programs to treat patients with the most common behavioral health disorders managed in primary care such as depression, anxiety disorders, attention deficit disorder, and substance use disorders like alcohol or opiate misuse.
Are the CCM technology requirements or other technology requirements appropriate for these services?

Technology requirements associated with evidence-based CoCMs are derived from the scope of service and care delivery requirements. Essential to effective collaborative care are the routine use and tracking of patient outcomes using validated rating scales such as the PHQ-9 for depression and GAD-7 for anxiety, tracking of pharmacological or psychosocial treatments, and clinical outcomes entered into a registry to avoid patients falling through the cracks or patients continuing on ineffective treatments. Such registry functionality can be incorporated in electronic health record systems or provided through a separate registry tool. Clinical information such as diagnostic recommendations and interventions, treatment recommendations and treatments used, and relevant clinical outcome measures should be recorded in the patient's medical record where they are easily available to all team members including the PCP, care manager, and psychiatric consultant.

Should written consent for the non-face-to-face parts of collaborative care be required before such collaboration occurs, and, if so, how should this be done?

Primary care providers routinely treat patients with behavioral health problems and the evidence for the effectiveness of the CoCM in primary care is so substantial that we do not believe that a specific consent for behavioral health collaborative care is indicated or necessary for successful implementation of the CoCM. Requiring special informed consent for participating in the CoCM in primary care would single out patients treated for a behavioral health problem and, given the stigma associated with behavioral health problems, might reduce access to this essential and effective service.

As with other medical or mental health conditions, we believe that general consent to confer with relevant specialists including a psychiatric consultant should be obtained prior to enrolling patients into primary care treatment, and this should include participation in a collaborative care management program.

How could CMS assess the application of the Collaborative Care Model for other diagnoses and treatment modalities? Are there particular conditions for which payment would be appropriate?

The Collaborative Care Model is appropriate for patients with any behavioral health diagnosis (e.g., ICD-9 codes 290-318) that is being treated by the PCP. In the Collaborative Care Model literature of randomized controlled trials reviewed by the Cochrane Collaboration and others, there’s stronger evidence of effectiveness and cost-effectiveness for certain behavioral disorders, particularly mood and anxiety disorders, than for others; but there is extensive practice evidence that more severe mental health disorders such as bipolar disorder and schizophrenia can be treated effectively in primary care with a collaborative care program. Additionally, many substance use disorders can be effectively treated in primary care that has both collaborative care and other screening and intervention elements such as screening, brief intervention, and referral to treatment (SBIRT).

It is assumed, based on the experience with mature CoCM programs, that more severe mental health disorders and substance use disorder, after thorough assessment and Psychiatric consultation, will be referred to specialty behavioral programs and that the care manager will be able to assist in the referral process in order to effect a successful transition of care.
We would be concerned that covering only some behavioral health diagnoses and not others could lead to modification of diagnoses to suit the coverage rules (especially in light of substantial symptom overlap, and comorbidity, between various psychiatric and substance use disorders). Also, the reality is that for many patients for whom specialty care is not available, or who choose for other reasons to remain in primary care, primary care treatment will be more effective if is provided within a Collaborative Care Model that includes care management and psychiatric consultation. Several studies have shown that over half of all counties in the US have no behavioral health professional, so the only care available is through a PCP practice.

Experience from both research-based and ongoing implementations of the Collaborative Care Model, such as in Washington State’s Mental Health Integration Program, suggests that a wide range of mental health and substance use disorders can be effectively treated in a primary care setting that has appropriate psychiatric support and care coordination. We expect, however, that most primary care practices would use CoCM programs to treat patients with the most common behavioral health disorders managed in primary care including depression, anxiety disorders, attention deficit disorder, and substance use disorders such as alcohol or opiate misuse.

Should the Collaborative Care Model be implemented through a CMMI demonstration that would allow Medicare to further test its effectiveness with a waiver of beneficiary financial liability and/or through a variation of payment methodology and amounts for the psychiatric consultant and the primary care staff?

- Based on more than 80 randomized controlled trials and large-scale practice experience that has included all major payer types (Medicare, Medicaid, and commercial insurance), we do not believe that there is a need to further study variations in payment methodology or in establishing payment amounts for the CoCM. Extensive research and practice experience with the CoCM exists to enable the development of specific codes and the appropriate valuation of these codes, and we strongly encourage CMS to proceed in establishing payment for the evidence-based CoCM without additional demonstrations.

- Our review with CoCM experts indicates that patient co-pays can be an impediment to the use of care management and psychiatric consultation, key components of the evidence-based model. We suggest moving ahead with establishing payment methods that do not require patient co-pays. In reference to the issue of cost sharing, most research-based and ongoing implementations of collaborative care have not required patient cost-sharing for those collaborative care services that are initiated by the practice (and may not directly involve the patient), i.e., care management and psychiatric consultation. Importantly, the consistent finding that collaborative care is cost-effective, and cost-saving in some settings/populations, is based on programs without cost-sharing — notwithstanding that cost-sharing is mainly intended to control costs and promote cost-effectiveness. This body of evidence represents a very strong basis for covering collaborative care in Medicare without patient cost-sharing for care management and psychiatric consultation.

We know of one CoCM, Minnesota’s DIAMOND program, in which some sites did require patient cost-sharing. DIAMOND found that cost-sharing for these collaborative care services, and the associated requirements for explicit patient consent – as the CCM code requires – were barriers to care. (Among other things, this led the CMMI-funded COMPASS Collaborative Care demonstration, to waive patient cost-sharing in all sites.)
However, we recommend beginning coverage immediately whether or not cost sharing is required or specific consent is required given the evidence supporting this intervention and the need to improve the delivery of care for the majority of the population with behavioral disorders who receive all of their treatment in primary care.

- There may be other promising approaches to collaborative care that lack a developed evidence base that may have merit for consideration as part of a CMMI demonstration and we would support their receiving due consideration.

Thank you for your significant interest in this area and for consideration of these comments. We look forward to our continued collaboration and hope to be a resource to CMS, Congress, and interested third parties on CoCM going forward.

II. E. Improving Payment Accuracy for Primary Care and Care Management Services

APA appreciates the discussion by CMS in this section. We recognize that there is physician work being done that’s consistent with Medicare’s system reform delivery objectives that is not currently being reimbursed (i.e., improved outcomes through consultation, collaboration). CMS proposes to explore additional add-on codes in lieu of revamping the evaluation and management (E/M) codes. The original E/M service codes were developed at a time when the pre- and post-service realities were very different than they are today. We are supportive of any development efforts CMS takes to identify and capture the new reality of that work, whether it be through the creation of new add-on codes, payment for existing E/M services not currently covered (i.e., telephone evaluation and management, 99441-99443), or the re-valuation of existing E/M services through what may be a multiyear effort. We think it is essential to the success of this effort that CMS consider how new health care delivery arrangements have changed work expectations for clinical care in ways that are either not captured by the current codes or not paid for by CMS.

In the process of developing new codes, CMS must remain sensitive to not creating overly burdensome requirements that will impede use of the codes even as these codes capture the new realities of population-based care management. Effective codes for new ways of providing services may require a different approach to how codes are written and how their corresponding services are paid for (e.g., beneficiary cost-sharing).

As a start, CMS should consider payment for existing E/M codes, such as the interprofessional telephone/Internet consultation service codes (99446-99449) and the codes describing prolonged services without direct patient contact (99358-99359), that enable more effective treatment but are not currently reimbursed.

II. E. 3. Chronic Care Management (CCM) and Transitional Care Management (TCM) Services

CMS has solicited comments on ways to further improve beneficiary access to transitional care management and chronic care management services while balancing practitioner burdens associated with providing these services. While not within CMS’s authority, due consideration needs to be given to the beneficiary cost-sharing obligation for these services. Even though the copays are small, we believe they present a barrier to beneficiary consent, which is required for the services. While these may not
seem to be preventive services like those services exempt from cost-sharing by statute, they are similar in an economic sense since they reduce unnecessary and costly health service utilization that would otherwise occur.

There are a variety of health reform imperatives that require and/or enable different care delivery arrangements and services, yet the payment system is not yet in step with these realities. Beneficiary cost-sharing for care management and coordination services is a case in point. **We look forward to working with CMS and Congress to address issues related to beneficiary cost sharing and other barriers to care.**

### III. I. Physician Quality Reporting System (PQRS)

APA has a major interest in the measures that are included or excluded in the Medicare PQRS since these measures affect both the day-to-day practice of our members and the quality of care that is available to our patients. The measures we focus on touch on a major issue: that many psychiatric patients have co-morbidities of one or more chronic medical conditions. These co-occurring medical disorders have major impacts on the quality and outcome of beneficiary medical care. APA members have had difficulties in the past reporting on many of the measures included in PQRS because they aren’t components of standard psychiatric encounters and therefore are burdensome to include as de facto requirements. Utilizing measures that have little to no value on the clinician’s encounter with the patient then takes away from time that could be spent focused on necessary relevant treatment. For these reasons, APA does not support measuring for measurement sake. Additionally, while we support the various reporting mechanisms (i.e. claims, registry, EHR) we have seen a decrease in our clinicians’ ability to report on measures since many are now only available via EHR or registry reporting. Ensuring that all psychiatrists (no matter how or where they practice) can report on as many meaningful measures in as many formats as possible is critical.

APA is pleased to see that CMS has not reduced the measures available for claims-based reporting for this reporting period. While claims-based reporting has its disadvantages, it is more widely accessible and more often utilized by small and solo practices, which comprise the majority of psychiatric practices. As we have commented previously, moving to a registry and EHR-based reporting system closes off that option to a population of physicians who may already have trouble finding relevant measures to report on. Many APA members are trying to comply with the PQRS system, but are shut out of the program or are automatically triggering the MAV process because they cannot find enough measures to include in their reporting. **We appreciate that CMS is maintaining the claims-based reporting option for this reporting period and we strongly urge CMS to retain claims-based reporting for at least some measures going forward or to develop a small or solo practice exemption.**

As noted above, many APA members must use the MAV process due to a lack of available measures to report. APA has several concerns about the MAV process, particularly regarding the timing of this process. Clinicians who are attempting to successfully report in PQRS and avoid the penalty are expending a great deal of time and resources to report on as many measures as possible. Most of the time this is with fewer than 9 measures that do not address 3 of the National Quality Strategy (NQS) domains - and then these clinicians learn at the close of the reporting year that they have missed measures that would have been appropriate for them to report. By this time it is too late to make any changes and improvements. APA believes this unfairly penalizes clinicians who are making a good faith effort to comply and report in PQRS. We are pleased that CMS will make minimal changes to the
measures available for reporting for this current year. What this means is that clinicians who may have failed to report specific measures will be informed at the close of 2015 of what measures they could have reported on, and will have the benefit of this knowledge for the 2016 reporting year. However, enforcing reporting and penalties without the opportunity to complete the measures that CMS deems appropriate is a serious flaw of this process. **APA urges CMS to address this issue by establishing timely feedback for clinicians so that they may attempt to report on all available measures by the end of the relevant reporting period.**

**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 and psychiatric-specific measures available for clinicians that are amenable to care in order to increase participation in the PQRS program. While there are a generous number of cross-cutting measures available to report, not all of these measure specifications can be completed as part of a psychiatrist’s standard patient encounter. **APA supports the integration of the Multiple Chronic Conditions Measures Group, but maintains concerns about the measure group criteria.** We are pleased to see that it allows for the reporting of at least 9 measures that address 3 of the NQS domains and are pleased that CMS has provided a measures group that covers behavioral health. However, APA has serious concerns that the Multiple Chronic Conditions Measures Group is only available via the registry reporting mechanism and we have concerns that some of the specifics in the measure do not improve the quality of care in the psychiatric setting. Much of the criteria in the measure group is measuring for the sake of measurement, and forces psychiatrists to spend time on care which does not directly benefit the priority needs of our patients. This time could be better spent providing more time for therapeutic interventions and providing assistance with other issues, like identifying adequate housing, identifying methods to improve medication adherence, etc.

APA concurs with CMS’s proposal to move towards group measures by specialty since we believe this will assist in the effort to more easily identify measures for appropriate use requiring less guess-work. Further, APA appreciates the addition of the NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling since alcohol use screening is particularly valuable in the Medicare population and utilized by both addiction specialists and general psychiatrists. **We urge CMS to finalize the move to group measures by specialty and include NQF #2152 in the PQRS program in the future.**

As noted in our comments on CMS’s Proposed Rule regarding the Physician Fee Schedule for CY 2015, we have concerns that eligible professionals can meet the PQRS reporting requirements without submitting a mental health/substance use disorder measure. Recent data show that less than 20% of individual practitioners in an ACO reported on the *Screening for Clinical Depression and Follow Up* measure. Allowing eligible professionals to ignore such measures presents CMS with a missed opportunity to improve outcomes for patients with complex and chronic conditions, many of whom suffer from psychiatric disorders including depression that impact upon their physical health. Such patients suffer because their mental 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—such as those established by the Triple Aim. We remain concerned that allowing eligible professionals to successfully report in PQRS without reporting on a mental health/substance use disorder measure negatively impacts the quality of

---

patient care and we urge CMS to require such reporting in future reporting periods.

III. J. – Electronic Health Records

CMS has stated that it is seeking comments on whether they should substitute or add another measure that would focus specifically on the use of health information technology, rather than meeting overall Meaningful Use requirements (e.g., the transitions of care measure required for the EHR Incentives Program). Psychiatrists are already experiencing significant challenges in using health information technology to report on existing measures; adding a new measure would add to these challenges. However, substituting a general “use of” in place of measures that are not psychiatry-oriented could be very beneficial to psychiatrists with regards to these reporting programs. Therefore, APA would prefer that such a measure be a substitution rather than an addition to the measures in the reporting programs and would support that change. CMS also seeks comment on whether this measure should be expanded in the future to include all eligible professionals, including specialists, in regards to the “Percent of PCPs who Successfully Meet Meaningful Use Requirements.” Currently, the measure focuses only on primary care physicians. This measure hinges on the ONC’s Interoperability Roadmap, which details a “set of actions that will enable a majority of individuals and providers across the care continuum to send, receive, find and use a common set of electronic clinical information at the nationwide level by the end of 2017.” APA has serious concerns that many psychiatrists practicing in solo and small group settings tend to use less-common “boutique” EHR systems that are tailored to behavioral health. These smaller systems have very little business incentive to engage with the ONC’s Interoperability Roadmap, thereby creating a barrier to meeting the aforementioned measure, should it be expanded to include specialists. Thus, APA recommends that if the measure is expanded to include specialists, the measure should be optional with respect to being used to attest to the Meaningful Use program.

APA appreciates that CMS is aligning various quality reporting and payment programs that include the submission of CQMs in order to avoid duplicative efforts on the part of the physician. However, as in previous years, it is clear that many of the electronic reporting requirements that qualify for incentive payments and that are necessary for eCQMs align more favorably toward primary care rather than specialty practices. This is of special concern to psychiatry, since there are a limited number of eCQMs for psychiatrists to choose from in reporting. Moreover, the eCQMs that are aligned with the practice of psychiatry may not be relevant to all psychiatric practices given clinicians’ varying scope-of-practices (e.g., the dementia measures that psychiatrists could potentially use are only relevant to those practitioners who see patients with that specific diagnosis). Finally, the limited number of CEHRT geared toward behavioral and mental health may not contain these psychiatric-specific eCQMs, which results in an additional barrier to reporting for psychiatrists. Both of these issues can be mitigated if CMS continues to identify additional measures relevant to psychiatry for inclusion into the eCQM reporting program. A review of psychiatry-focused EHR systems would reveal the types of data that are commonly captured within the specialty that might be used to develop these additional eCQMs.

Low-volume Threshold
The establishment of a low-volume threshold to apply for the purposes of excluding certain eligible professionals from the definition of MIPS was a necessary component of MACRA. The risk of not establishing an exemption will be that low-volume providers will either not participate and accept whatever penalties are imposed - or opt out of Medicare entirely (which would present serious access issues for the affected beneficiaries). We believe there is an inherent cost-benefit ratio respecting reporting requirements and the bonuses and penalties that attach to them, and that for low volume providers, the costs outweigh the benefits. We will be analyzing and communicating to CMS on Part B claims data for further consideration of this question, as well as to develop potential criteria that would define such an exception.

Single method for Eligible Professional (EP) identification
Currently, the PQRS uses tax identifier numbers (TIN) to identify EPs, and the meaningful use program uses national provider identifiers (NPI). This may present problems when consolidating these systems and lead to confusion among clinicians. Further, integrated care arrangement participation among EPs may present additional administrative demand for a single method for EP identification. APA recommends that CMS establish a single method for EP identification.

Robust opportunities for measuring self-improvement under MIPS
As stated previously, APA strongly encourages CMS to improve the availability of real-time feedback as CMS develops new compliance requirements under MIPS. For example, MIPS performance criteria should include specific feedback by program (e.g., PQRS, meaningful use, etc) so an EP can see areas of necessary measure improvement and have the ability to make an effort to address either the administrative or clinical aspects of measure-related care.

Requirements for publishing quality measures in peer-reviewed journals prior to CMS consideration
MACRA requires that in order for CMS to consider the adoption of measures to be used for MACRA-implementation quality reporting purposes, measures must be published in a “specialty-appropriate peer reviewed medical journal”. APA recommends that CMS explicitly permit the publication of an executive summary of the measure set (with fuller information available on the web or as a separate attachment). This will ensure the education of relevant clinicians and fulfill our interpretation of MACRA’s statutory requirement without unnecessary publishing burden since full CQM set details may be tens or hundreds of pages.

We understand that CMS will continue to solicit feedback on MACRA implementation this Fall, and we look forward to providing more fulsome input.
Thank you in advance for your consideration of our comments. APA looks forward to working with CMS as it develops its CY2016 final rule concerning payment policies under the Medicare physician fee schedule.

Sincerely,

[Signature]

Saul Levin, M.D., M.P.A.
CEO and Medical Director
APPENDIX A
Approaches to Integrating Behavioral Health in Primary Care that Lack Consistent Evidence of Effectiveness and Cost-Effectiveness

Researchers and clinicians have looked at various ways to improve the detection and treatment of mental health and substance use disorders in primary care settings. This includes screening for common mental disorders, co-location of mental health providers in primary care clinics, provider education and training, facilitated referral to mental health specialty care, and disease management. These approaches, alone and in combination, have not been found to improve patient outcomes.

Screening

Although some studies have shown that screening through the use of brief structured rating scales that measure the severity of psychiatric symptoms is helpful in detecting mental health disorders in primary care, the research clearly indicates that screening alone is not sufficient to improve outcomes for patients. A Cochrane review found that patients with depression randomized to depression screening did not have better outcomes than patients randomized to usual care.\textsuperscript{1}

Co-Location

Another approach to improve care for patients with behavioral health problems is to simply co-locate mental health specialists within primary care clinics. The research literature on co-location is limited. Several studies demonstrate that co-located behavioral health specialists can deliver effective interventions in the primary care setting\textsuperscript{ii,iii,iv}, but a large randomized controlled trial (RCT) comparing co-located care to referral found no differences in outcomes and somewhat worse outcomes for patients with more severe symptoms.\textsuperscript{v,vi}

Co-location does increase the opportunity for the behavioral health specialist and primary care provider to consult on patients, either informally or formally.\textsuperscript{vii} Co-location, however, does not ensure that providers collaborate effectively in the treatment of shared patients. Overall, simply co-locating a mental health provider into primary care without effective collaboration between mental health and primary care providers and without the use of evidence-based treatments has not been shown to improve health or mental health outcomes at a population level.

Provider Education and Training

Primary care practices are the \textit{de facto} location of care for common mental health disorders and numerous education and training programs have been developed to improve primary care providers’ ability to treat psychiatric disorders. Approaches range from structured training programs that teach providers how to detect and treat psychiatric disorders to training in the use of evidence-based treatment guidelines to be followed when treating psychiatric disorders. However, even the most comprehensive of these programs resulted in only minimal or short-lived changes in providers’ practices and patient outcomes.\textsuperscript{viii,ix,x}
Facilitated Referral

Patients who are referred to specialty mental health providers, similar to being referred to a cardiologist or a pulmonologist, often fail to follow through with their referral, especially those patients who are members of ethnic minority groups. Those who do follow through often don’t continue care long enough to get effective treatment. To address this problem, researchers developed the enhanced, or facilitated, referral model, where supports such as free transportation and follow-up reminders were used to increase the likelihood of follow-through. Research on facilitated referral suggests that enhanced referral is less effective than co-locating mental health specialists in primary care settings with regard to promoting the use of specialty mental health services.

Even if facilitated referral were effective, there are not enough specialty mental health providers available to whom patients can be referred. Primary care providers view specialty mental health providers as being far less available than other specialists. Referral to specialty mental health services is helpful and necessary for some individuals, and we recommend primary care practices make every effort to facilitate referrals since this will improve outcomes for those people who do connect with the specialty mental health system and engage in treatment. There is little evidence that enhanced referral assistance alone is unlikely to improve patient outcomes at the population level.

Traditional Disease Management Programs

In telephonic disease management programs, nurses from a centralized call center operated by the health plan, but who work in isolation from the providers who are treating the patient, attempt to support treatment provided in primary care. There have now been several large studies of such disease management programs, and they have generally not been shown to improve disease outcomes or to reduce health care costs when the programs are separated from the treating providers. A critical element missing from the disease management model is that nurses do not communicate directly with the primary care providers and they do not provide evidence-based treatments for depression. Rather, they attempt to educate patients and motivate them to improve communication with their providers. In effective Collaborative Care Model programs, care managers, who are closely supported by psychiatric consultants, work directly with patients and are in close and direct contact with the patients’ primary care providers, who remain in charge of the patients’ overall care.


V. Bartels SJ, Coakley EH, Zubritsky C, Ware JH, Miles KM, Arean PA, Chen H, Oslin DW, Llorente MD, Costantino G, Quijano L, McIntyre JS, Linkins KW, Oxman TE, Maxwell J, Levkoff SE. Improving access to geriatric mental health services: a randomized trial comparing


