February 6, 2015

Marilynn B. Tavenner
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

RE: File Code CMS-1461-P

Dear Administrator Tavenner:

I am writing to you on behalf of the American Psychiatric Association (APA), the national medical specialty association representing over 36,000 psychiatric physicians as well as their patients and families, to comment on certain provisions of the Centers for Medicare and Medicaid Services (CMS) proposed rule for the Medicare Shared Savings Program (MSSP) [CMS–1461–P] (CFR, vol. 79, No. 235, p. 72760), which was published on December 8, 2014. Psychiatrists are experts in the diagnosis, treatment, prevention, and research of mental illness, including substance use disorders. Our members serve in a wide variety of roles in various settings, including inpatient facilities (e.g. hospitals, nursing homes, etc.) and ambulatory care settings (e.g. community mental health centers, public health clinics, etc.). We appreciate the opportunity to provide these comments.

The Affordable Care Act (ACA) has the potential to transform healthcare delivery, including mental healthcare, but achieving better access to quality care will depend on how it is implemented. The APA has significant reservations about the negative effects CMS’s proposed revisions to the two-step assignment methodology for ACOs may have. We recommend that, at a minimum, the methodology that removes psychiatry from Step 2 of the assignment process be reconsidered due to the erroneous determination that psychiatry does not provide primary care services. It is also essential that this reconsideration carefully examine how the assignment rules affect accountability for beneficiaries with mental health and substance use disorders (MH/SUD).

Consideration of Physician Specialties and Non-Physician Practitioners in the Assignment Process

APA is very concerned about the proposed revision to the assignment methodology that would move psychiatry, geriatric psychiatry, addiction medicine, and neuro-psychiatry to the list of specialties in Table 3 (p. 72797) that are to be excluded from Assignment Step 2...
on the basis that psychiatry does not provide primary care services. This change could have a negative and avoidable impact on access to appropriate care coordination for disabled and elderly beneficiaries with psychiatric disorders who often suffer from multiple co-occurring medical conditions.

The basis for the CMS proposal has three referenced underpinnings:

1. Recommendations by CMS medical officers knowledgeable about the services typically performed by physicians and non-physicians;
2. A determination that the specialties excluded provide a relatively modest number of services under the codes included in the definition of primary care services (including CPT codes 99201-99215, 99304-99340, 99341-99350); and
3. A determination that the provider is not typically the only physician that a beneficiary sees.

CMS Medical Officer Panel Review
Regarding #1 noted above, from the discussion in the preamble, APA cannot discern the basis or criteria that were applied by the CMS medical officers to determine if a particular specialty warranted a “primary care” designation for the purposes of the assignment methodology. Regardless, the effort was designed to limit the list of specialties that would be excluded from the assignment process to those physician specialties that would very rarely, if ever, provide primary care to beneficiaries.

We believe the decision to include psychiatry on this list of excluded specialties may have been based on common misperceptions rather than on how patients actually receive care, especially the care provided to dually eligible individuals with psychiatric and/or substance use disorders and medical comorbidities.

It is important to acknowledge here that there is no universally accepted definition of primary care. Primary care is a mode of healthcare delivery that entails the performance of certain functions. These functions include: 1) being the first contact for a person with an undiagnosed health concern, and 2) providing continuing care for this patient while coordinating with other physicians regarding his/her varied medical conditions, not limited by diagnosis. Primary care is synonymous with these functions, and it is important to distinguish primary care from primary care medicine as distinguished from primary care physicians or a primary care practice.

Psychiatry is frequently the point of first contact for persons with undiagnosed conditions. Many patients will present with non-psychiatric disorders that become manifest through psychiatric symptoms. Differential diagnosis is a core skill and function of the specialty. The psychiatrist generally establishes a treatment plan for all presenting medical conditions and assumes the role of care manager/supervisor with the required team of healthcare professionals. This includes provision of care for MH/SUD as well as medical comorbidities. The facts show that the mix for general psychiatry includes a very substantial proportion of primary care that, contrary to the popular view, is most similar to those other specialties generally acknowledged to fall within this designation and included in Table 2. Simply put, psychiatrists are often responsible for ensuring that patients are properly diagnosed and triaged, and for securing all needed services even if they do not provide all of them themselves.

There are a number of reasons why most persons with serious mental illness (SMI) would rather see their psychiatrist than a PCP:

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1. Studies that document that primary care physicians are uncomfortable providing care toward persons with serious mental disorders.²
2. Cognitive deficits often limit the ability to navigate the healthcare system and access care in non-specialty settings.
3. Psychiatrists understand how exacerbation or improvement of psychiatric disorders affects behavior and impacts the medical treatment of other systems of the body.

Indeed, for patients with SMI, including dually eligible patients, it is frequently the case that their only physician is a psychiatrist.

**Volume of CPT Codes**
Based on the fact that we conduct routine reviews of the Part B claims files, we were surprised that the psychiatric specialties of concern to us (particularly psychiatry) were denominated as providing a modest number of services under the codes included in the definition of primary care services. We did our own rank order claims analysis by volume and found that psychiatry consistently ranked higher than many of the specialties designated as primary care (Table 2) by CMS, which were therefore included in Assignment Step 2. Hence, this “volume” criterion is by no means a bright-line rule for inclusion/exclusion for Assignment Step 2. In our estimation, this criterion is an inappropriate basis for the CMS proposal to exclude psychiatry for Assignment Step 2³.

For example, a review of claims for codes 99211-99215 (Evaluation and Management-Established Patient) shows psychiatry ranked higher than many specialties designated for Table 2/Assignment Step 2 status. The highest volume claim, CPT 99213, shows psychiatry ranked 6th in total volume, only less than cardiology among those specialties otherwise designated for Assignment Step 2.

Regarding the CPT 99201-99205 evaluation and management codes for new patients, psychiatry does not demonstrate the same pattern of use, but these new patient evaluation and management numbers for psychiatry do not account for the fact that the specialty has, and extensively utilizes, CPT code 90792, Psychiatry Diagnostic Evaluation with Medical Services. If the volume of this code (409,640 claims over the same reporting period) were factored in, the pattern would be similar to that observed for the 99211-99215 services.

For those codes designated as primary care services for Nursing Facility Services, psychiatry ranks in the top five in volume for 99304-99306 services, and the ranking is similar for the 99307-99310 series of codes, and consistently higher than many or most of the specialties designated for Assignment Step 2 for the balance of the designated primary care service codes.

**Typical Physician Encounters for Patients with Severe Mental Illness (SMI)**
The remaining question is whether the last differentiating criterion—that the excluded specialty is not typically the only physician that the beneficiary sees—applies with respect to patients with SMI, including the dually eligible patient population for whom the only physician seen is frequently a psychiatrist.

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² See Healthcare Providers’ Attitudes Toward Persons With Schizophrenia, Psychiatric Rehabilitation Journal, 10/14
http://www.researchgate.net/publication/266944433_Healthcare_Providers%27_Attitudes_Toward_Persons_Wit h_Schizophrenia
³ See attachment 1, Primary CPT® Code Service Data, Final Table
A solid experiential base, predicated on numerous discussions with psychiatric physicians who provide care to these individuals in specialty sector settings, indicates that these patients are very likely to only see their psychiatrist for all of their health care, medical and behavioral. The psychiatrist in turn performs most, if not all, of the core primary care functions discussed above\textsuperscript{4}.

Derivative of this reality, system transformation in the MH/SUD specialty sectors has led to a number of care innovations that bring the requisite primary medical care to the specialty sector sites as well as specialty psychiatric care to primary medical care settings that would otherwise be without the ability to address MH/SUD conditions. The development of Medicaid Specialty Health Homes is another key development based on the primary care roles for individuals with behavioral health conditions\textsuperscript{5} Moreover, the “Draft Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics” released by CMS includes a psychiatrist as Medical Director to assure the facilitation of the medical component of care and the integration of behavioral health and primary care\textsuperscript{6}.

There are workforce training issues attendant to these emerging developments, and the APA has taken a leadership role, for example, by providing training symposia and CME courses that address needed primary care medicine skills for psychiatrists, as well as other skills, in order to perform essential functions in integrated care settings, whether or not they are in the specialty MH/SUD sector. This is significant with respect to the population of patients with SMI in the sense that healthcare costs associated with untreated MH/SUD and unaddressed medical comorbidities are well established\textsuperscript{7}.

As stated above, the ACA has the potential to transform healthcare delivery, including mental healthcare, but achieving better access to quality care will depend on how it is implemented. The Medicare Shared Savings Program is a key provision of the ACA, and its successful operation will depend in a substantial way on how it deals with this population. Hence APA’s concern with a grounded understanding of who the population is and the practitioners that serve them, and that the assignment of accountability (to an ACO) will occur in a meaningful way to assure improvement in quality of care and healthcare costs for this population. How these patients are assigned to an ACO can affect the potential for adverse selection, as well as an ACO’s ability to manage the risk for which it is being held accountable. In summary, the facts do not substantiate the preamble’s assertion that the providers for these patients are not typically the only physicians these patients see.

\textsuperscript{5} See \url{http://www.integration.samhsa.gov/integrated-care-models/health-homes}; see also Joint Commission, \url{http://www.jointcommission.org/accreditation/behavioral_health_home.aspx}
\textsuperscript{6} See \url{http://www.samhsa.gov/sites/default/files/ccbhcdraftcriteriaforpubliccomment.pdf}
Summary/Conclusion
We urge CMS to reconsider psychiatry’s placement in Table 3 for exclusion from Assignment Step 2. The criteria delineated in the preamble do not provide a factual bright-line basis for exclusion from Step 2. We request that the reconsideration include the following:

- Explicit recognition that psychiatry performs many primary care functions and correction of the specialty’s characterization based on the criteria specified in the preamble;
- An analysis of how (per the assignment methodology) and where dually eligible individuals with mental health and substance use disorders are being assigned to ACOs currently (and detail on any individuals who may not have been assigned); and
- An analysis of proper placement of psychiatry in the ACO assignment methodology to include a discussion of: 1) how a particular assignment option may affect assignment of dually eligible individuals, and 2) whether it prevents the ability of the specialty to participate in more than one ACO, and if this will hinder assignment of accountability.

Assurance that care provision and management accountability are achieved, as well assurance that ACOs that take on the management of the sickest populations with greater medical needs are not disadvantaged, is paramount. Development of an assignment methodology that optimizes the role of psychiatrists as both primary care and specialty providers is essential.

Thank you for your consideration of these important issues. We would be happy to discuss this further with you.

If you have any questions, please contact Irvin L. “Sam” Muszynski, JD, Director, APA Office of Healthcare Systems and Financing at imus@psych.org or at 703-907-8594.

Sincerely,

[Signature]

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