The Train Has Left the Station: Understanding the legislative and regulatory trends promoting quality measurement and what to do about it in your practice
Presenters

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  • Director, Research and Special Projects, Practice
• Diane Pedulla, J.D.
  • Director, Regulatory Affairs, Practice
• Bruce Bobbitt, Ph.D.
  • Consultant and President Minnesota Psychological Association
• Carol Goodheart, EdD
  • Independent Practice, Former APA President
• Chris Nettles, Ph.D.
  • Project Manager, Integrated Health Care Alliance
Disclosure

No sales of materials will occur during the workshop; however, the workshop will include a discussion of a product that will enable psychologists and other providers to meet future regulatory needs under federal law by submitting quality measures on the services they provide and bill.

*Disclaimer: We all bring perspectives:*

“The data are always friendly” – Irene Elkin
The (quality improvement) train has left the station...
Learning Objectives

1. Summarize the legislative and regulatory aspects promoting quality measurement and how they apply to your practice

2. Explain the role the APA/APAPO data registry plays in the future of professional psychological practice and psychological science as it relates to quality measurement
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2018 Medicare Update

Diane M. Pedulla, J.D.
Director, Regulatory Affairs
March 11, 2018
Medicare Update - 2018

• Payments for psychologists increased by 2% on average

• Increase due to practice expense adjustments

• May vary by practice
Medicare Update - 2018

• Last year for PQRS 2% penalty

• Sequestration continues to reduce payments for all providers by 2%

• Sequestration is a cost cutting tool imposed by Congress
Changes in Telehealth Services

- GT modifier no longer required
- Place of service code (POS) 02 for telehealth

- Codes added to telehealth in 2018:
  - 90785 – Interactive complexity
    - Must be billed with a base code, e.g. 90832, -34, -37
  - 90839 & 90840 – psychotherapy for crisis
Cognitive Functioning Services G-code

• New code for CFS, 97127, scheduled to take effect on 1/1/2018

• 97127 valued higher than previous 97532 but can only be billed once

• APAPPO alerted CMS this would cause a loss in payment for psychologists who usually bill 4 units of cognitive functioning services

• CMS created G0515 which psychologists can bill multiple times and will be paid at the same rate as previous code 97532
New QPP payment models

• The Merit-based Incentive Payment System (MIPS)

• Advanced Alternative Payment Models (APMs)

• Most clinicians, including psychologists, will be in MIPS
How MIPS affects psychologists

• Psychologists not yet included in MIPS

• No reporting required in 2018

• Expected to be added to MIPS in 2019

• No impact on payments until at least 2021
Low Volume Threshold (LVT) Exemption

- 2018 LVT exemption: ≤200 Medicare patients or ≤$90,000 in allowed charges
- Likely to exempt most psychologists
- LVT expected to change over time
- 1st year providers also exempt from MIPS
MIPS trial option for 2018

• CMS allowing psychologists to voluntarily report MIPS data on a trial basis in 2018

• Trial data will not affect Medicare payments

• You will receive performance feedback
What makes up a MIPS score?

<table>
<thead>
<tr>
<th>Composite score percentages</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Quality</td>
<td>50%</td>
</tr>
<tr>
<td>• Advancing Care Information</td>
<td>25%</td>
</tr>
<tr>
<td>• Clinical Practice Improvement Activities</td>
<td>15%</td>
</tr>
<tr>
<td>• Resource Use</td>
<td>10%</td>
</tr>
</tbody>
</table>
Quality Requirements

• Select individual measures or specialty measure set
  • Only need to report 6 measures

• Mental/behavioral set of 25 measures

• Dementia measures no longer a group
  • Now reportable as individual measures
Advancing Care Information

• Involves certified Electronic Health Record technology

• ACI measures include protection of health information, patient electronic access, health information exchange, electronic Rx, and coordination of care
Advancing Care Information

• Psychologists, clinical social workers not eligible for previous EHR incentives

• Not required to report Advancing Care Information if you did not participate in meaningful use in the previous year

• CMS will reweight the composite score
Clinical Practice Improvement Activities

• Includes care coordination, shared decision-making, safety checklists, expanding practice access

• Mental / behavioral health activities set

• Activities weighted medium or high
Resource Use / Cost

- No reporting - CMS uses claims data
- Compares resources for similar care episodes across practices
- Can be risk-adjusted
- Was not counted in scores for 2017
Participation levels in MIPS

• Individual clinicians report using TIN & NPI

• Groups report using one TIN for 2 or more clinicians

• Report all components the same way (ind. or group)
Group reporting

- Single TIN with billing rights for 2 or more clinicians
- Must aggregate performance data
- Payment adjustment to Part B charges based on group’s performance
Group Reporting

• No payment adjustment for group members excluded from MIPS

• If reporting as an individual and as part of a group you will have two final scores

• Payment adjustment applied to the higher of the two final scores
Methods of MIPS reporting

- Claims
- Registry
  - APAPO MIPSpro
- Certified electronic health records
- Qualified clinical data registries (QCDRs)
New QCDR for psychologists

- The Mental and Behavioral Health Registry (MBHR)
- Designed for mental and behavioral health professionals
- MBHR built by Healthmonix
- MIPSPRO registry transitions to MBHR
Quality Measurement, Payers and Large Delivery Systems: Aspirations and Realities

Bruce L. Bobbitt, Ph.D., LP President, Minnesota Psychological Association
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Workshop: The Train Has Left the Station: Understanding the Legislative and Regulatory Trends and Promoting Quality Measurement in Your Practice

American Psychological Association Practice Leadership Conference, Washington, D.C.
March 11, 2018
Both Sides Now*

• I’ve seen life from both sides now.......  
• Up and down, win and lose.... and still somehow....  
• It’s Life’s Illusions I Recall.....  

• Adapted from Joni Mitchell, Westminster Music Ltd.; First performed by Judy Collins, Recorded in 1967, wildflowers Electra
Healthcare Delivery and Payment - Where are We Now?

- PPACA enacted in 2010 - first major healthcare reform since HMO act of 1973 BH Mandated
- Managed care still the dominate model for payment though more complex than early models
- New structures - accountable care organizations and patient centered medical homes - the system prefers large organizations
- Incentives to focus on quality, population health and attempts to tie payment to outcomes - not just units of service PQRS MIPS
- Quality focus is in early stages - PPACA - death from a 1,000 cuts?
Quality in Healthcare Delivery - Aspirations

• Largely due to advocacy and market acumen by NCQA “Quality” has been a part of managed care
• Conceptually organized by Triple Aim (Berwick et. al. 2008)
• New structures - accountable care organizations and patient centered medical homes are supposed to align cost and quality
• Dominant measure set at the population level is NCQA HEDIS
• Many of the HEDIS “medical” measures are supported by evidence and guidelines - not so much for BH measures
A Model for Idea Adoption

• It’s not an idea - you are speaking a foreign language, don’t bother me, can’t you see that I am dealing with important issues

• It’s someone else’s idea and it’s a bad idea - I think I get it but it really doesn’t make a lot of sense to me. There are lots of reasons why this won’t work because of things you don’t understand

• [An aside: A psychologist might helpful in getting from the above to the next bullet]

• It’s my idea - hey, come to my office - I want to try something out on you. This just occurred to me on the plane when I was heading to our field office
Quality in Behavioral Health Delivery - Aspirations

• The NCQA HEDIS measures for behavioral health have been expanding in recent years - still focused at the payer population level
• PPACA theory is that BH can be modeled in the same as other conditions and issues
• Psychology has begun to recognize the need for quality measurement (O’Donohue & Margakis, 2016)
• Psychology has begun to recognize the importance of outcomes (Carol Goodheart)
• Clinical Practice Guidelines are part of the process of identifying effective treatments but do not address measurement and improvement
Quality in Behavioral Health Delivery - Realities

• The NCQA HEDIS behavioral health measures are not well known to clinicians and are not as universally accepted as the “medical” measures

• PPACA requirement for mandated benefits is being challenged

• Psychology is struggling with how to appropriately address issues of accountability and dissemination of best practices - there are internal disagreements

• Large systems that employee psychologists have scale and funding that exceeds the resources of most group practices and individual practitioners

• While there is increasing understanding and awareness of both QI processes and outcomes we are still at the early part of this trip - it's
Quality in Behavioral Health Delivery: Realities of Payer Behavior

• Payers have different requirements and clinicians and large systems have to adapt to multiple requirements

• Medicare and Medicaid vary in how behavioral health is managed and funded

• Payers use QI measures and outcomes as value differentiators in the market

• Clinicians are dealing with payer difficulties in executing core functions such as claims payment and service. Contracting difficulties abound

• Payers are adopting ever more restrictive networks - and not being clear about how this is done
Quality in Behavioral Health Delivery - From Current Realities to Opportunities

• Despite that realities that exist - future success requires a line of sight to new ways of doing work that challenge the “received wisdom”

• Assertion - measurement of quality improvement and demonstration of improved outcomes is not just an idea - it is a reality coming our way. Entrepreneurs (someone elses idea) will drive change

• Focusing on QI and outcomes requires a change in thinking - from process and theory to results. Theories and models are judged practically and not through internal consistence and elegance [from not an idea, is an idea but bad, to my idea]

• The future toolkit for psychologists needs to have different tools - no more rotary phones

• Qualified Clinical Data Registries (QCDRs) and how to access them is
Selected References and Resources


• Health Affairs Entire Journal and also weekly updates delivered weekly via email

• National Committee for Quality Assurance (NCQA)

• Institute of Medicine (IOM) and America’s Health Insurance Plans (AHIP)
Relevance of the Mental and Behavioral Health Registry for Practitioners

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carol@drcarolgoodheart.com
Disclaimer

- I have no conflict of interest and do not work for or represent
  - APA/APAPO
  - Healthmonix
  - Centers for Medicare and Medicaid Services
Overview – What is the MBHR?

- Our Mental and Behavioral Health Registry (MBHR) is a “Qualified Clinical Data Registry”
- A QCDR = CMS approved dataset that tracks quality outcomes on patients
- Includes measures identified by the discipline as meaningful to both practitioners/patients.
- Allows practitioners to report progress/outcomes to CMS Merit–based Incentive Payment System (MIPS).
Quality measurement is here to stay
Health care costs not sustainable; public and private insurers, consumers want to reduce costs
Improving care AND cost cutting often linked. But........
QI measurement far better than old financial quota system of managed care.
Psychologists can function better and be better reimbursed with QI measurement
History: 2015 Expert Panel*
Recommendations for a QCDR

• Measures “free, elegant and brief;” and include process, outcome and structural measures per IOM
• 4 domains of potential measures: role functioning, dropout (as a structural measure/proxy for alliance), symptom or disease management (including chronic health conditions), and patients’ perception of care.
• Measures must be conceptually or empirically linked to “need to know” aspects of care, not “nice to know”
• Critically, measures should capture change meaningful to patients themselves, as well as clinicians and health systems

*Frank Ghinassi (Western Psychiatric Institute), Carol Goodheart (Independent Practice, Princeton NJ), Josef Ruzek (National Center for PTSD)
APA/APAPO originally contracted with Healthmonix, an established registry platform company, to develop a PQRS registry of measures.

No revenue stream to APAPO/APA from this collaboration. Set up solely as a service for members, at cost.

CMS changed reporting from PQRS to MIPS. Expert panel recommended establishing APAPO/APA sponsored QCDR, like professional associations.

Healthmonix manages/hosts our new MBHR.
Advisory Committee for MBHR to Select Measures

- Open call for nominations
- Committee approved by CAPP and BOD
- Members: Carol D. Goodheart, Chair, David E. Bard, Bruce Bobbitt, Zeeshan Butt, Kathleen Lysell, Dean McKay, Kari Stephens
- New member approval for 2018: social work and consumer representatives TBD
- APA Staff: Vaile Wright (primary), Lynn Bufka, Diane Pedulla
Goals

- Achieve approval of CMS for our MBHR, followed by approval of additional measures that fill gaps.
- Create user-friendly suite of measures to accurately reflect the quality of behavioral health interventions.
- Assure the platform is easier to use and more relevant to practitioners than earlier platforms.
- Measurement is to enhance treatment outcomes, not to identify “bad providers” or “bad therapists.”
2017 Steps

- AC met for first time in July 2017
- Affirmed application for MBHR approval as a QCDR
- Decided to “spec” anxiety measure and submit this first new measure by November deadline.
- Reviewed available measures, identified gaps, and selected additional measures to include.
APA/APAPO Mental and Behavioral Health Registry approved by CMS as a Qualified Clinical Data Registry (QCDR) for 2018.

Vehicle for participation in the Merit-Based Incentive Payment System (MIPS)

37 MIPS measure

2 newly specified non-MIPS measures (which we can declare and use for reporting)
  ◦ Anxiety: Utilization of the GAD-7 Tool (process)
  ◦ Anxiety Response at 6-months (outcome)

The only registry with an anxiety measure
Examples of MIPS Measures

- 107 Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (new 2018)
- 47 Care Plan (advance care plan or surrogate decision maker documented) – high priority
  - 130 Documentation of current medication in medical record – high priority
  - 181 Elder maltreatment screen and follow up plan
  - 131 Pain assessment and follow up – high priority
  - 226 Preventive care and screening: Tobacco Use: Screening & cessation intervention – not high priority

Must report 6 measures; at least one must be high priority or outcome
Additional Measures for Submission in 2018

- Sleep (cross cutting)
- Function/Quality of Life (cross cutting)
Categories Under Consideration

- Social determinants
- Patient satisfaction
- Patient-reported outcomes
- Child, teen, adult
- Diagnoses/common problems: PTSD, trauma, eating disorders, disruption behavior, physical disease
- Quality of life/coping in patients with significant disease
Diversity/disparities

Medical Screening (including transplant, bariatric)

More nuanced substance use disorder items

Violence screening/Adverse childhood experiences screening

Developmental screening

Sexuality disorders

Gender identity
MIPS Reporting in MBHR

- Healthmonix extracts QCDR data and reports it for each provider.
- They validate the data, contact a provider regarding any issues, and send to CMS in appropriate format.
- Participants can select the level at which they will participate. Pricing is as follows:
### Annual Price for Reporting

<table>
<thead>
<tr>
<th>Enrolled user type (i.e., “Pick your pace”)</th>
<th>Non–APAPO member price per provider</th>
<th>APAPO member price per provider</th>
<th>APAPO Revenue Share</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lite</strong> (includes reporting for 1 quality measure OR 1 improvement activity OR 5 ACI measures)</td>
<td>$229</td>
<td>$219</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Basic</strong> (includes quality reporting)</td>
<td>$289</td>
<td>$234</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Standard</strong> (includes reporting for quality and improvement activities)</td>
<td>$399</td>
<td>$314</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Plus</strong> (includes all MIPS reporting elements)</td>
<td>$539</td>
<td>$439</td>
<td>$0</td>
</tr>
</tbody>
</table>
Proposed Fees for a Practice’s Use Only

- APAPO members $60 per year (i.e., $5 per month)
- APA members $120 per year (i.e., $10 per month)
- Non-APA members $180 per year (i.e., $15 per month)

Subject to change if structure of APAPO changes
CMS Payment Impact on Practitioners

- MIPS adjustment for MDs will be +, neutral, or –
  - 2019 will be + or – 4%
  - 2020 will be + or – 5%
  - 2021 will be + or – 7%
  - 2022 will be onward + or – 9%
  - Bonuses for superior performance

- Reporting for a given year affects payment 2 years later

Slide courtesy of Diane Pedulla and Vaile Wright
Psychologists & LCSWs not yet included in MIPS
  ◦ Must be defined as an Eligible Clinician (EC)
  ◦ Expected to be added to EC definition in 2019
Not required to report in 2018 but can practice reporting with no payment adjustment
No MIPS impact on payments until 2021 (due to 2 year time lag)

Slide courtesy of Diane Pedulla and Vaile Wright
If psychologists and other non-ECs are added to MIPS in 2019:

- Individual providers report under their NPI*
- Group reporting using same Taxpayer Identification Number (TIN)
  - Data submitted by all members of the group is combined and group is assigned a composite score
  - A single payment adjustment then applies to everyone in the group
  - Strong or weak performance by any members of the group will impact the score and consequently the group’s future payment adjustments

*unless fall under LVT exemption

Slide provided by Diane Pedulla and Vaile Wright
Benefits of Participation

• Improved reimbursement
• High Registry acceptance rate (98%) vs. claims reporting
• Potential to differentiate psychologists from other providers (e.g., masters-level practitioners)
• The data can be used in marketing materials and efforts, e.g. “badging” on websites and other forums (e.g., Psychologist Locator Service)
• Possible collaboration with ABPP on board certification renewals, and ASPPB in a maintenance of competence (MOC) model for state licensing.
• Connect users with Continuing Education opportunities, possibly free as a benefit
Integrative Health Care Grant and MBHR

- Center for Psychology and Health grant enrolling 6,000 psychologists and other professionals interested in learning about and transitioning into integrated care settings.
- CMS requires enrollees track two declared quality metrics. The MBHR allows enrollees to report measures which can then be reported to the grant. There is no requirement that enrollees report directly to MIPS.
- If interested in being part of the grant training, contact Chris Nettles (cnettles@apa.org).
Roll Out

- PLC program and loop computer information
- Convention programs (2), booth, meeting with group practice representatives
- Podcasts, webinars, articles, State and Division newsletters, journal submissions.
- Presentations to State Associations and clinical training programs
The website for the registry is [https://apapo.mipspro.com/](https://apapo.mipspro.com/)

We invite your feedback and participation in the MBHR

As leaders in your states, please inform your members about the MBHR -- and the work APAPo/APA are doing to make national reporting requirements more reasonable and practical.

Carol Goodheart [carol@drcarolgoodheart.com](mailto:carol@drcarolgoodheart.com)
TCPI Five Phases of Transformation

Set Aims
Use Data to Drive Care
Achieve Progress on Aims
Achieve Benchmark Status
Thrive as a Business via Pay for Value Approaches
VBP Levels and Roadmap Targets (By 2020)

Targets:
- 80-90% of MCO payments paid through VBP arrangements at level 1 or higher
- 50-70% at level 2 or higher is goal, but must meet minimum of 35%
INTEGRATED HEALTH CARE ALLIANCE

Gain support and resources for new business models designed for practicing psychologists

Receive expert training on integrated care and ongoing support of your transformation

Participate in a community of change-making clinicians and health professionals

APA IS HELPING YOU PREPARE FOR THE FUTURE AT NO COST TO YOU
ENROLL TODAY AND TRANSITION TO NEW WAYS OF PRACTICING
WWW.APA.ORG/IHCA

A program of the American Psychological Association in collaboration with the Transforming Clinical Practice Initiative of the Centers for Medicare and Medicaid Services.
Benefits of Enrollment

- Free subscription to Clinical Quality Outcome Reporting Registry
- Use current expertise in new ways while developing new & in-demand skills
- Advocate for psychology by providing data and feedback specific to psychologists to health care leaders
- Earn up to 8 hours of CE credit** at no cost to you

**Continuing Education credits are sponsored by the APA Office of Continuing Education in Psychology (CEP). The APA CEP Office has reviewed and approved the programs to offer CE credits for psychologists. The APA CEP Office maintains responsibility for the content of the programs.