



AMERICAN
PSYCHOLOGICAL
ASSOCIATION
PRACTICE ORGANIZATION

November 13, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS 1631-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models

Dear Administrator Slavitt:

I am writing on behalf of the American Psychological Association Practice Organization (APAPO), an affiliate of the American Psychological Association (APA). APA is the professional organization representing more than 120,000 members and associates engaged in the practice, research and teaching of psychology. APAPO advocates on behalf of psychologists engaged in the practice of psychology in all settings. APAPO wishes to provide the Centers for Medicare and Medicaid Services (CMS) with comments on the Request for Information concerning the Merit-Based Payment System (MIPS) and Alternative Payments Models (APMs).

Psychologists play an important role in Medicare by furnishing beneficiaries with critical mental and behavioral health services including psychotherapy, testing, and health and behavior assessments and interventions. Psychologists are the leaders in assessing mental health and pioneered the development of health and behavior services to assist patients struggling with physical health problems. Despite all they have to offer in Medicare, psychologists are not paid sufficiently for their services and it is becoming increasingly harder for those with solo or small practices to continue seeing Medicare beneficiaries.

Background

Medicare payments to psychologists have declined significantly since 2001. For example, the Medicare payment for a 45-minute psychotherapy session, the service most commonly billed by psychologists, has been reduced by more than 30% since then, when adjusted for inflation. Medicare beneficiaries are increasingly at risk of losing access to these valuable services as more psychologists choose not to continue as Medicare providers. A 2013 APAPO member survey found that 26 percent of responding psychologists were previously Medicare providers but left the program, primarily due to low reimbursement rates.

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Medicare's current payment formula does not ensure that psychologists are paid appropriately and fairly. Under the formula, Medicare increasingly pays more for higher-cost, technology-driven services with high overhead—services which therefore have a high “practice expense” (PE) component within the Resource-Based Relative Value Scale (RBRVS) methodology. Because Medicare is subject to budget neutrality payment to providers with relatively low overhead and PE costs, like psychologists, are being unfairly reduced to offset increases for providers whose services have higher PE costs.

As we have stated before in our comment letters and meetings with CMS, Medicare's payment formula must be changed so that psychologists are appropriately and fairly compensated for treating Medicare beneficiaries. Continuing to apply a flawed formula perpetuates the inequities faced by psychologists and other mental health providers in Medicare.

Solicitation of Comments

Below are APAPO's comments on specific topics pertinent to psychologists. Please note that APAPO has not addressed every question raised in the RFI.

A. MIPS

Defining eligible professionals (EPs) in MIPS

Requiring a distinct MIPS identifier could create confusion and increase the risk of error. We recommend using the NPI as this is something every EP understands and already uses.

Setting parameters for virtual groups

APAPO supports allowing individual MIPS EPs and small practices to form a virtual group with other such EPs. EPs in all specialties and across all geographic locations should have the opportunity to participate in virtual groups. APAPO does not believe that virtual groups should be restricted to a certain mile radius as this will disadvantage EPs in rural and frontier states.

Measuring quality performance

- Should CMS maintain all PQRS reporting mechanisms noted above under MIPS?

CMS should maintain all of the PQRS reporting mechanisms including claims-based reporting. Although claims-based reporting does not have as strong a record of success as other methods it remains the least expensive way for an EP to participate in PQRS. For many solo and small group practices it may not be cost effective to use a registry, especially if they treat few Medicare beneficiaries. CMS should not deprive EPs of this inexpensive option.

- Should CMS maintain the same or similar reporting criteria under MIPS as under the PQRS?

There are too many criteria that are not applicable to psychologists in PQRS, especially since most psychologists are reporting on single measures. CMS should avoid creating that same situation with MIPS. In general, it would be helpful to move from diagnosis-based reporting to procedure-based reporting. MIPS might include performance quality indicators derived from

patient satisfaction scores on commonly used measures (e.g. Press Ganey, etc.). Providing quality services could be demonstrated by the inclusion of:

- o Specific treatment recommendations within each report;
 - o Recommendations to help maximize cognitive health and quality of life (e.g. physical and cognitive exercise, socialization); and
 - o Recommendations that may decrease the risk for future hospitalization (e.g. medication monitoring to compensate for memory impairment.)
- What is the appropriate number of measures on which a MIPS EP's performance should be based?

EPs with small and/or specialized practices find it very difficult if not impossible to successfully report nine measures across three National Quality Strategy domains under PQRS. These EPs simply do not have a large enough number of patients utilizing a broad array of services to make them eligible for many of the measures. If CMS does not reduce the number of required measures significantly then the agency must maintain a Measure-Applicability Verification (MAV) process. Without MAV EPs with small and/or specialized practices, such as most mental health providers, will be continuously penalized for reasons beyond their control. They will suffer financially and may leave the Medicare program altogether, thus depriving Medicare beneficiaries of access to critically needed mental and behavioral health services.

- Should CMS maintain the policy that measures cover a specified number of National Quality Strategy domains?

CMS should consider changing the requirement from three NQS domains to two for at least those EPs with fewer than 20 Medicare beneficiaries, if not for all.

- Should a minimum number of measures be outcomes-based? Should more weight be assigned to outcomes based measures?

APAPO sees the value of moving providers in the direction of outcomes-based measures to inform care at some point in the future. We believe there should be some outcomes-based measures but we are not suggesting a minimum number.

APAPO does not believe more weight should be assigned to outcomes-based measures at this time. As a field Psychology is not routinely using outcomes measures to make care decisions and we don't have data that suggests that outcomes measures are better than process measures as a mechanism for determining quality of care.

- Should CMS require that reporting mechanisms include the ability to stratify the data by demographic characteristics such as race, ethnicity, and gender?

Requiring this type of information would definitely add more work for providers doing claims-based reporting since those data points are not part of most claims. This information is important in terms of understanding disparities but if the goal is to fairly incent providers, these characteristics are not the important ones. CMS needs to have risk-adjusted claims that account for severity of disorder, co-morbidities, etc. Without risk adjustment providers will decline to treat

complicated patients for whom there might not be significant change because they fear being penalized for doing so.

- What are the potential barriers to successfully meeting the MIPS quality performance category?

A huge barrier for psychologists is the Electronic Health Record requirement. Psychologists, as well as clinical social workers, were not included in the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act), which provided financial incentives for medical care providers to adopt and make meaningful use of EHR technology. As a result, the vast majority of psychologists active in the Medicare program have been unable to acquire EHR technology. If faced with the prospect of having to purchase EHR technology with few options and no funding many psychologists may choose to leave the Medicare program.

- If CMS determines that the MIPS EP (participating as an individual EP or as part of a group practice or virtual group) has used a data reporting mechanism that does not meet our data integrity standards, how should CMS assess the MIPS EP when calculating their quality performance category score? Should the qualified registry, QCDR or EHR vendor be disqualified or unable to participate in future performance periods? What consequences should there be for MIPS EPs?

In such a situation the quality performance category score for the MIPS EP should be taken out of the equation. The qualified registry, QCDR, or EHR vendor should be placed under review and subject to a higher level of scrutiny when reporting but not disqualified or barred from future performance periods. Taking such harsh action against these entities will also harm the EPs who are working through them to provide quality data. The EP should be held harmless.

Measuring resource use performance

- What cost or resource use measures should be considered and what data sources should be required to calculate the measures.

Level of care (frequency, intensity of service) varies depending upon need. The more complicated the patient the more intense and frequent the care and greater need for care coordination, time and cost. First, the care needs by patient should be weighted using a simple formulary to determine level of complexity, for example, based upon such variables as number of diagnoses, medical conditions, psychiatric diagnoses, age, socioeconomic variables, available resources, and mobility. Neuropsychologists typically provide both evaluation and treatment services to the more complex and sicker Medicare participants. Some consideration and weight should be given to psychologists who provide multilevel services to complex patients.

- How should CMS apply the resource use category to MIPS EPs for whom there may not be applicable resource use measures?

There should be different resource use measures for different provider types. CMS must recognize that the concept of resource use for primary care physicians who furnish a multitude of services to many different patients is very different from resource use for psychologists who furnish a narrow range of services, use little or no equipment and employ few staff.

Different tiers may be established allowing the practitioner to select the degree to which his/her practice will allow for participation. For example a minimum annual standard may be established with the option of greater merit for increased participation. Psychologists should not be penalized for providing critical services to a narrow range of patients within a private practice.

- What peer groups or benchmarks should be used when assessing performance under the resource use performance category?

CMS must not look only different provider types but must also take into consideration subspecialties within provider types. For example, some psychologists concentrate on psychological or neuropsychological testing services while others only do psychotherapy.

Defining clinical practice improvement categories

APAPO believes that health equality is best achieved through integrated care. In local clinics with familiar primary care providers, services are more likely to be provided in a culturally sensitive manner. CMS should adopt the definition of behavioral health accepted by the Center for Integrated Health Solutions (CIHS) of SAMHSA/HRSA. This definition has three components:

- (1) mental health services,
- (2) behavioral services to address the most common health related behaviors of poor diet, sedentary behavior, and smoking, and
- (3) substance abuse screening and treatment.

Evaluation of the level of integration should use the framework developed by CIHS. This framework has six levels of care, based on three major categories (Coordinated Care, Co-Located Care, and Integrated Care). Measuring the level of integration requires the use of a standardized measure that has been evaluated for its validity of measure and reliability of administration. An example of this type of measure is the Vermont Integration Profile.

Because language is critical in the area of integrated care APAPO recommends that CMS use definitions from the *Lexicon for Behavioral Health and Primary Care Integration* prepared by C.J. Peek, Ph.D., for the Agency for Healthcare Research and Quality (AHRQ).

- Should EPs be required to attest they have met the required activities? If so, how often and what information should be reported?
- What threshold or quantity of activities should be established?
- How should the various subcategories be weighted?
- How should this category be applied to EPs in small (15 or fewer) practices or rural areas? Should they have a lower performance threshold?

CMS should consider making providers who have relatively few Medicare billable hours/patients exempt from all or part of this process. Alternatively, the agency should choose a small number of measures that would apply to the broadest range of providers and ensure that the measures are eligible for claims-based reporting.

Development of performance standards

- Which specific historical performance standards should be used?

APAPO does not know of any current benchmarks that would serve as appropriate historical performance standards for psychologists at this time.

- How should CMS incorporate improvement into the scoring system

In terms of patient improvement, CMS needs to consider both patient improvement and patient stability. Ideally, there would be appropriate benchmarks. What would be preferred is some agreement about what is the sign of good care, with that being the standard everyone needs to try to meet. We do not support a “bell curve” system in which it is determined up front that a certain percentage of providers are good. We urge CMS to adopt a system in which everyone can pass for providing good care.

- What should be the threshold(s) for measuring improvement?

Possible thresholds for measuring improvement include a change in the patient’s number of the symptoms or severity or distress.

B. Alternative Payment Models

Section 101 of the MACRA promotes the development of alternative payment models (APMs) by exempting eligible professionals (EPs) from the MIPS if they participate in APMs and by providing incentive payments for certain EPs participating in APMs.

While APAPO supports the APM concept and the possibilities these models hold for the greater integration of psychologists’ services into primary care, we are concerned that the APM participation requirements will block the vast majority of psychologists and other mental and behavioral health providers from participating in APMs.

Psychologists are considered EPs for purposes of the APM program (see §1833(z)(3)(D) and §1848(k)(3)(B) of the Social Security Act (SSA)). Beginning in 2019, EPs who are qualifying APM participants (QPs) will receive an incentive payment equal to 5% of the estimated covered professional services for the preceding year (see §1833(z)(1)). An EP becomes a QP if a specified percentage of the EP’s payments during the most recent relevant period are attributable to services furnished through an “eligible alternative payment entity” (EAPM entity) (see §1833(z)(2)).

An EAPM entity is an entity that: (1) participates in an APM that requires participants to use certified EHR technology and provides for payment for covered professional services based on quality measures comparable to the MIPS quality measures, and (2) either bears financial risk for monetary losses under the APM that are in excess of a nominal amount or is a medical home expanded under section 1115A(c) of the SSA (see §1833(z)(3)(D))

The element of the EAPM entity definition requiring the use of certified EHR technology presents a serious obstacle to the involvement of psychologists in EAPM entities for the near future (and possibly longer). As stated previously psychologists have not been eligible for the financial incentives under the HITECH Act and as a result have been unable to acquire EHR

technology. Because they lack EHR technology psychologists cannot participate in EAPMs, which means they will not qualify as QPs and will be unable to receive the 5% incentive payment available to other providers.

In light of this, it is likely that the vast majority of psychologists will simply not be able to participate in APMs in the near and medium term, which would represent a significant lost opportunity for all concerned, especially patients, and would run counter to MACRA's and the Secretary's stated goal of promoting provider involvement in APMs.

APAPO suggests that CMS define the "use" of certified EHR technology by participants in an APM, until at least 2021, as requiring the use of such technology only by those EAPM entity professionals who were eligible for incentives under the HITECH Act.

C. Technical Assistance to Small Practices and Practices in HPSAs

CMS should offer multiple options for technical assistance. A central telephone line such as the Quality Net Help Desk now used for PQRS is critical as not all providers utilize computers or the Internet. Webinars that allowed for audience participation could help address questions on specific topics. Recorded videos that could be accessed at any time would be beneficial for providers who cannot take time away from patients during the workday.

Conclusion

APA thanks CMS for this opportunity to provide comments on the RFI for MIPS and APMs. We look forward to working with the agency to address the issues raised in this letter. Should you have any questions please contact our Director of Regulatory Affairs, Diane M. Pedulla, J.D., by telephone at 202-336-5889 or by email at dpedulla@apa.org.

Sincerely,



Katherine C. Nordal, Ph.D.
Executive Director for Professional Practice