



AMERICAN
PSYCHOLOGICAL
ASSOCIATION
PRACTICE ORGANIZATION

June 24, 2016

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: Proposed Rule on the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule and Criteria for Physician-Focused Payment Models [CMS-5517-P]

Dear Administrator Slavitt:

I am writing on behalf of the American Psychological Association Practice Organization (the Practice Organization), an affiliate of the American Psychological Association (APA). APA is the professional organization representing more than 117,500 members and associates engaged in the practice, research and teaching of psychology. The Practice Organization advocates on behalf of psychologists engaged in the practice of psychology in all settings. As explained below psychologists participating in Medicare face many challenges. We are providing the Centers for Medicare and Medicaid Services (CMS) with comments on the Proposed Rule concerning the Merit-Based Payment System (MIPS) and Alternative Payments Models (APMs) to address the challenges that psychologists will face under MIPS.

Background

Psychologists independently furnish psychotherapy, testing and assessment, and health and behavior services to Medicare beneficiaries in all settings. As doctoral-level clinicians with on average seven years of graduate education, psychologists are uniquely qualified to assess and treat beneficiaries' mental and behavioral health needs. Many provide psychotherapy that allows beneficiaries to cope with mental health conditions and substance use disorders. Others conduct neuropsychological testing to determine beneficiaries' cognitive abilities and deficiencies. A growing number of psychologists use their skills to help beneficiaries address physical conditions such as diabetes, cardio-vascular disease, cancer, and obesity.

Having access to psychologists in Medicare is critical for our nation's senior citizens. Without psychologists, many mentally ill beneficiaries will not be properly diagnosed and could be left untreated. The situation would be even worse for beneficiaries needing behavioral health

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services as psychologists provide over 95% of the health and behavior services in Medicare. No other healthcare professionals have the level of expertise that psychologists do when it comes to psychological and neuropsychological testing.

Although psychologists have been part of Medicare for many years beneficiaries should not assume they will always be able to find a psychologist when they need one. Because psychologists are underpaid for their services in Medicare many can no longer afford to treat Medicare beneficiaries. A 2013 Practice Organization member survey found that 26 percent of responding psychologists previously participated in Medicare but left the program, primarily due to low reimbursement rates.

Psychologists have long been at a disadvantage in Medicare as their practice models are different from those of primary care clinicians. Compared to physicians, psychologists see relatively few patients and provide a limited number of services. Medicare's payment formula under the Resource-Based Relative Value Scale (RBRVS) methodology paid more for technology-driven services with higher amounts of practice expense. Consequently psychologists, as providers of low-cost, cognitive-based services, have suffered losses in payment for over a decade to offset other higher-priced healthcare services.

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 remain in Medicare.

In addition to low payments, psychologists have been especially frustrated by the demands of the Physician Quality Reporting System (PQRS). Psychologists, along with other mental health providers, found most of the PQRS measures were not relevant to their practices. Using a registry was costly and many concluded it made financial sense to *not* report PQRS measures and just take the 2% penalty. Claims-based reporting, originally the preferred reporting option by psychologists, kept getting scaled back, with fewer new measures being eligible for claims-based reporting each year. As the number of PQRS measures required for reporting rose from three to nine psychologists found it even more difficult to successfully report.

The growing frustration with lower Medicare payments due to sequestration and PQRS penalties is leading psychologists to question their role in the system. Many have chosen to opt out of Medicare, thus limiting their availability to only those who can afford to pay out of pocket, or significantly cut back on the number of Medicare patients they see. Either way the result is the same: fewer opportunities for Medicare beneficiaries to access psychologist services.

The Practice Organization urges CMS to reverse this trend as it implements MIPS. Psychologists should be able to treat Medicare beneficiaries without being underpaid for their services. Psychologists must not be trapped in a system designed for primary care that does not fit their practices. New models such as MIPS must appropriately value psychologists' services without being overly burdensome.

Below we discuss changes to the proposed rule that we believe are critical for keeping psychologists in Medicare. Several comments reflect points raised in our November 13, 2015 letter responding to the Request for Information on the implementation of MIPS and APMs.

Comments on the implementation of MIPS

MIPS is a new program that combines key facets of three current programs in Medicare: PQRS, the Value-Based Payment Modifier (VM), which compares quality of care to cost, and the Electronic Health Record (EHR) incentives, often referred to as “meaningful use.” Psychologists have been eligible to participate in PQRS since its inception in 2007 but are not subject to the VM or meaningful use requirements.

MIPS will impact Medicare payments by assessing clinicians on four categories and then assigning a composite score. The composite score will be compared to a threshold score. Those falling below the threshold score will incur a payment penalty while those scoring above the threshold will receive a bonus. MIPS is designed to be budget neutral and many clinicians will see no adjustment, positive or negative, to their payments. MIPS is also intended to facilitate the integration of behavioral healthcare, an area in which psychologists are supremely qualified to both treat beneficiaries and train other healthcare professionals.

The low volume threshold

First and foremost we want psychologists to fully participate in MIPS and other new Medicare payment models. The models must, however, be designed so that psychologists are competing on a level playing field and are not unfairly disadvantaged due to the specialized nature of their practices. CMS must understand that establishing an appropriate low volume threshold is a major priority for our members and is critical to keeping psychologists in Medicare.

CMS proposes to exempt MIPS eligible clinicians if they bill Medicare for no more than \$10,000 in annual charges and they treat no more than 100 Medicare beneficiaries. The Practice Organization agrees that clinicians who see relatively few Medicare beneficiaries should be exempt from the multiple reporting requirements of MIPS. We do not, however, believe that the low volume threshold as currently proposed will protect enough of these clinicians.

Many psychologists see few Medicare patients. According to 2012 Medicare data the majority of psychologists treat fewer than 50 Medicare beneficiaries annually. Many, however, still have Medicare charges over \$10,000. To illustrate, a psychologist treating a patient with psychotherapy may see the patient weekly or biweekly. At the national rate of \$85 for a 45-minute psychotherapy session a psychologist would have over \$11,000 in Medicare charges after seeing just five patients for biweekly psychotherapy. Clearly this is a low volume Medicare practice but under the current proposal this psychologist would not be exempt from MIPS.

The Practice Organization is asking CMS to bifurcate the proposed low volume threshold so that clinicians may seek an exemption from MIPS if they bill Medicare for no more than \$10,000 or they treat no more than 100 Medicare beneficiaries. We believe that allowing clinicians who see few Medicare patients to be exempt from the burdensome reporting requirements of MIPS reduces the risk that they will leave the Medicare program altogether.

We want to be very clear, however, that it should be the clinician’s choice whether or not to seek the low volume threshold exemption from MIPS. If clinicians who treat few Medicare patients still wish to report under MIPS and potentially earn bonuses for furnishing quality healthcare than they should be allowed to do so.

Quality reporting mechanisms under MIPS

The Practice Organization commends CMS for proposing to retain a claims-based reporting option for MIPS. Even though claims-based reporting has the least successful performance record in PQRS clinicians should not be forced to use more expensive methods.

While we support the idea of requiring fewer quality measures under MIPS we do not believe the proposal to reduce the number of measures from nine to six goes far enough. Psychologists who provide a narrow range of services will still struggle to find six measures relevant to their practices. We ask that the number of quality measures that clinicians must report be reduced to three. In our experience psychologists, no matter what their practices involved, did best under PQRS when the reporting requirements called for just three measures.

If CMS does not further reduce the number of required measures then the agency must maintain some type of Measure-Applicability Verification (MAV) process. Without something like MAV clinicians with small and/or specialized practices, such psychologists and most mental health providers, will be continuously penalized due to the limited number of measures applicable to their practices.

The Practice Organization supports the CMS proposal to discontinue the requirement that measures must cover a specified number of National Quality Strategy domains. Again, moving away from multiple requirements will help make performance reporting less burdensome on solo and small group practices.

The Practice Organization recommends moving 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:

- Specific treatment recommendations within each report;
- Recommendations to help maximize cognitive health and quality of life (e.g. physical and cognitive exercise, socialization); and
- Recommendations that may decrease the risk for future hospitalization (e.g. medication monitoring to compensate for memory impairment).

We see the value of moving clinicians 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.

The Practice Organization 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 do not have data that suggests that outcomes measures are better than process measures as a mechanism for determining quality of care.

Measuring resource use performance

The Practice Organization has serious concerns over how CMS will measure resource use for psychologists. First, the concept of measuring cost and resource use is entirely new to psychologists who were never included in the VM. Second, not one of the 40+ episode specific measures outlined in the proposed rule applies to mental and behavioral health. It is unclear from information provided by CMS whether specialties without applicable episode measures will

have their claims data compared to other benchmarks or if the resource use category will be reweighted. Without episodes specific to mental and behavioral health psychologists will be severely disadvantaged under the resource use category and therefore at risk of having a low MIPS composite score that will reduce their Medicare payments.

Since psychologists will not be added to MIPS until 2019 the Practice Organization asks CMS to work with us during this time to design applicable episode measures for psychologists. CMS must recognize that the concept of resource use for primary care physicians who furnish a multitude of services to many 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. In addition, CMS must also take into consideration subspecialties within clinician types. For example, some psychologists concentrate on psychological or neuropsychological testing services while others only provide psychotherapy.

As we stated in our November 13, 2015 letter, the level of care (frequency, intensity of service) varies depending upon the needs of the patient. 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.

Different tiers may be established allowing the clinician 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.

Defining clinical practice improvement categories

A new category under the proposed rule, Clinical Practice Improvement Activities (CPIAs), involves activities that improve clinical practice or care delivery as defined by “eligible clinical organizations and other relevant stakeholders.” With this in mind we have several recommendations for changes needed in the CPIA category.

The CPIAs listed under Table H in the proposed rule have either a “high” or “medium” weighting. Many of the activities rated as high would not be relevant to psychologists and other mental and behavioral health clinicians (e.g., participation in a systematic anticoagulation program; attestation of documentation of an individualized glycemic treatment goal for diabetes patients taking medications; participation in the CMS transforming clinical practice initiative; consultation of prescription drug monitoring program; seeing new and follow-up Medicaid patients in a timely manner, etc.). With so few high weighted CPIAs to choose from psychologists’ ability to achieve full credit will be limited. Selecting six medium weighted CPIAs could be burdensome and there is no evidence that doing so will improve clinical practice. More specifically, if a psychologist must implement six different activities concurrently or nearly concurrently (as they have to be continued for 90 days each), it will be impossible to discern which were effective and which were not. For these reasons the Practice Organization suggests CMS consider incorporating one or two improvement activities for a longer period of time (12 months) rather than numerous activities for a shorter period of time (90 days).

The patient safety and practice assessment subcategory lists activities related to participation in maintenance of certification programs which applies to physicians but not psychologists. Consequently we are requesting that CMS include activities that incorporate board certification and continuing education language that would be applicable for psychologists.

In the subcategory for integrated behavioral and mental health care activity the examples appear to deviate substantially from the activities listed for the other subcategories. For example, five out of the eight listed activities seem to be NQF process measures that would have been reported under PQRS. Further, these five activities seem like they would be captured under the second to last integrated behavioral and mental health care activity on the list: *"Offer integrated behavioral health services to support patients with behavioral health needs, dementia, and poorly controlled chronic conditions that could include one of more of the following: use evidence-based treatment protocols and treatment to goal where appropriate, use evidence-based screening and case finding strategies to identify individuals at risk....etc."* We view this as redundant and question why they are included as separate activities.

Advancing care information

This category represents the largest potential barrier to successful MIPS reporting by psychologists. Psychologists 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 clinicians to adopt and make meaningful use of EHR technology. In addition to the lack of financial incentives many psychologists are reluctant to embrace EHR technology because of concerns about privacy and confidentiality.

A survey of our members in 2013 revealed that over 75% of the psychologists responding did not use EHRs in their practices. With EHR use highest among early career psychologists the data indicates that the percentage of experienced psychologists with EHRs is much lower. Psychologists have never been required to meet the conditions of meaningful use.

If CMS applies the current scoring for this category to psychologists we predict many will fail. The scoring is based on key measures of health information technology interoperability and information exchange. While this is familiar to clinicians covered under the HITECH Act it will be totally new for psychologists who are not subject to meaningful use. With the Advancing Care Information category accounting for 25% of the MIPS composite score psychologists will be severely disadvantaged in their attempts to successfully report under MIPS.

The Practice Organization proposes that psychologists have the option to request an Advancing Care Information category weight of zero so long as they are not eligible for financial incentives to adopt EHR technology. Should financial incentives be made available to psychologists there would still need to be sufficient transition time allowing them to purchase and become familiar with EHR technology before scoring under this category should apply. Psychologists must also have the option to request their composite scores reflect the Advancing Care Information category's assigned weight if they choose to do so.

Miscellaneous comments

Defining eligible professionals (EPs) in MIPS

The Practice Organization supports the CMS proposal to use existing TIN / NPI numbers rather than creating an entirely new identifier. We believe this will reduce confusion for clinicians.

Setting parameters for virtual groups

The Practice Organization notes that CMS is proposing to delay the implementation of virtual groups until 2018. We support allowing individual MIPS EPs and small practices to form a virtual group with other such EPs and recommend that virtual groups not be restricted to a certain mile radius as this will disadvantage EPs in rural and frontier states.

Technical Assistance to Small Practices and Practices in HPSAs

We support offering small practices and practices in health professional shortage areas (HPSAs) a reduced reporting requirement in this category. These practices will be allowed to report two clinical improvement area activities of varying weight for full credit or one activity weighted either medium or high for partial credit. In contrast larger practices will be expected to report three high level activities.

It is our understanding that CMS will also technical assistance to these practices. We recommend a central telephone line such as the Quality Net Help Desk now used for PQRS to accommodate those clinicians who do not have easy access to computers or the Internet. In addition, webinars that allowed for audience participation could help address questions on specific topics. The webinars could be recorded and accessed later by clinicians who cannot take time away from patients during the workday.

Conclusion

We thank CMS for this opportunity to present comments on the proposed rule and look forward to working with the agency to make MIPS a payment model that works for psychologists and supports their continued participation in Medicare. If you have any questions about the comments in this letter please contact our Director of Regulatory Affairs, Diane M. Pedulla, J.D. by telephone (202-336-5889) or email (dpedulla@apa.org).

Sincerely,

A handwritten signature in black ink that reads "Katherine C. NORDAL Ph.D." The signature is written in a cursive style with some capital letters.

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